UC San Diego Health

JOURNAL OF NURSING

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Advancing PCU Nurses

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Inside

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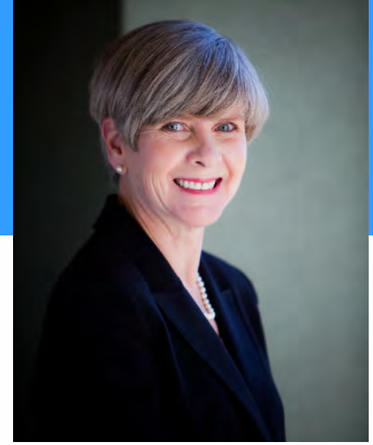


Message from the The Chief Clinical Officer

Welcome to the 16th issue of the UC San Diego Health Journal of Nursing. We are proud to produce this year's journal centered on the topic of progressive care nursing. We asked each of our Progressive Care Units (PCUs) to provide stories about their unit, and received a wide range of material on a variety of topics. In 2016 UCSDH expanded the number and types of patient care units. This was done for many reasons. First, we needed to increase the number of ICU beds available for tertiary care needed by patients transferred from our new affiliations with other health centers. Secondly, as our market-share continued to grow, we needed to provide more patients with treatments that required closer monitoring than can be done on a medical-surgical floor.

You will read about the experience of opening a new PCU, where nurses were often asked to care for new types of patients at a new level of care. Many of these nurses had not expected a change like this in their career. Whole units that were once medical-surgical level of acuity were transformed into PCUs. Nurses had to make the hard choice of advancing their skills or leaving the department they had been a part of for many years. I recognize the professional strain that this caused them, and you will hear the emotion in some of these testimonies. Looking back, they tell us it was stressful and challenging, but in the end they report being proud of their newly acquired skills gained through thoughtfully planned education. They express clear appreciation for the support they received from their peers, managers, and educators in the transition.

Then there are the messages of teambuilding, the bonding that occurs as new workgroups settle into their new roles and find their niche in the fabric of UCSDH nursing. The sentiment of pride comes through loudly from those who have transitioned past the 'change' process to the other side where they practice nursing in a 'new normal'. Further, as our professional practice model depicts, teamwork is not just the relationship you have with other nurses. Our relationships with other disciplines are just as important to producing quality care. One team describes how they successfully improved nurse-physician communication through joint rounds, a process usually found only in the intensive care units. You will learn about uniquely specialized PCUs, like the epilepsy monitoring unit, and unique treatments like CAR-T being delivered in oncology PCUs.

When Jacobs Medical Center first opened, there were many challenges with the environmental design and new workflows. One team describes novel strategies towards teambuilding and overcoming these challenges in an article entitled, 'Igniting Innovation'. They found that even now, well past the move, the same strategies are helpful for everyday operations. These new approaches have been so successful that they have been adopted widely by many other units as a way to enhance employee engagement and provide nurses the resources they need while stimulating new ideas to advance practice. Finally, the Trauma PCU describes the process of working through an ethical dilemma that resulted in changing the way we interact with law enforcement to improve safety of our employees and patients, while maintaining appropriate patient privacy. That article was originally published in Critical Connections, a publication of the Society of Critical Care Medicine, and we are making it available to you through our UCSDH Journal of Nursing.

I hope you enjoy reading these articles as much as I have. I have always encouraged nurses to journal about their work, reflecting back on what it means to be a nurse. This year's journal is just that; a reflection of each nurse's piece of the process of advancing progressive care. I am thankful to all of the nurses who so diligently learned new skills and embraced caring for new and different types of patients. I am grateful that all of these nurses helped us to reach our goals of being able to provide this care to a greater number of people in our community.

I wish all of you a wonderful Nurses Week.

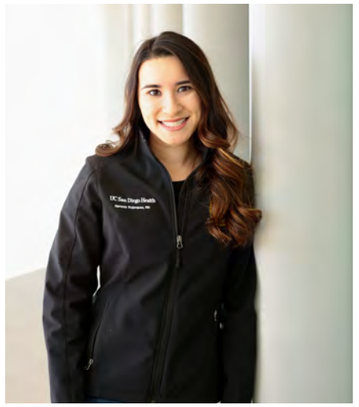
With Gratitude,

Margarita Baggett, MSN, RN
Chief Clinical Officer

Progressive Care Certified Nurse (PCCN): A Specialty Certification

By: Genesis R. Bojorquez, MSN, RN, PCCN

Progressive Care Certified Nurse (PCCN) is a credential granted by the American Association of Critical-Care Nurses (AACN) Certification Corporation and designates certification in adult progressive care nursing. Progressive care is the term used by AACN to collectively describe areas of which acutely ill patients are cared for, such as: intermediate care, direct observation, step-down, telemetry, transitional care, and emergency departments. The acuity of patients admitted to these areas are often transferred from critical care units while still requiring an increased level of vigilant nursing care. National practice analyses of the progressive care environment, patient populations served, and core competencies of progressive care nurses validated these areas as part of the less acute critical care continuum. Nurses who have achieved the PCCN certification provide patients and their families with validation that the nurse caring for them has demonstrated experience and knowledge in the complex specialty of progressive care.



Genesis R. Bojorquez, MSN, RN, PCCN is a Clinical Nurse II on the 11th floor surgical progressive care unit at UC San Diego Health. She earned her BSN at San Diego State University, her MSN at University of San Diego, and is currently enrolled in a PhD program in Nursing at the University of San Diego. She has been with UC San Diego Health since graduating with her BSN in 2015 and was a recipient of the 11th Floor PCU Rookie of the Year award in 2017. She is a member of the Sigma Theta Tau International Honor Society of Nursing, the National Society of Collegiate Scholars, and is a Progressive Care Certified Nurse (PCCN).

PCCN EXAM

ELIGIBILITY

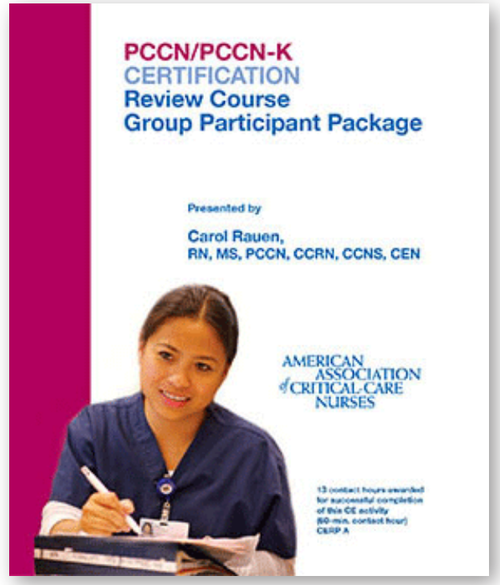
Nurses seeking PCCN certification must have a current unencumbered licensure as an RN or APRN in the U.S. and meet one of the following clinical practice requirement options:

Option 1: Practice as an RN or APRN for 1,750 hours in direct care of acutely ill adult patients during the previous two years, with 875 of those hours accrued in the most recent year preceding application.

Option 2: Practice as an RN or APRN for at least five years with a minimum of 2,000 hours in direct care of acutely ill adult patients, with 144 of those hours accrued in the most recent year preceding application.

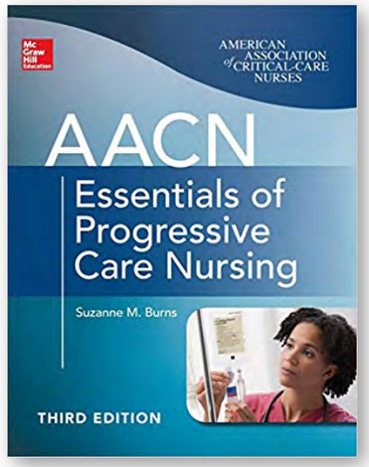
EXAM CONTENT

The PCCN Exam is 2 ½-hours and contains 125 questions; 100 questions are scored and 25 are used to gather statistical data on question performance for future exams. The items are based on the AACN Synergy Model for Patient Care, with 80% focusing on Clinical Judgment and 20% focusing on Professional Caring and Ethical Practice. The exam is offered by computer-based testing year-round across the U.S. and the score report becomes available immediately upon completion of the exam. **AACN offers an online PCCN review program at:** https://www.aacn.org/store/books/pccnod13/pccnpccnk-certification-review-course-online



PCCN RENEWAL

The PCCN certification is recognized for a 3-year period. During the 3-year certification period, the nurse must maintain a current, unencumbered RN or APRN licensure and complete the Continuing Education Recognition Points (CERPs) program outlined by AACN. The CERPs system awards credit for activities that don't fall into the direct clinical practice category, such as writing articles, serving on committees or being a mentor/preceptor. In addition to CERPs, the nurse must meet the clinical practice requirement of 432 hours in direct care of acutely ill adult patients, with 144 of those hours accrued in the 12-month period prior to the renewal date.



SIGNIFICANCE OF PCCN CERTIFICATION

The PCCN certification provides patients and their families with validation that the nurse caring for them has proven specialty knowledge, experience, and clinical judgment of progressive care nursing. Acutely ill patients require intricate care from a team of highly skilled health professionals and as healthcare becomes more complex, nurses are encouraged to validate their knowledge and abilities through certification. As a voluntary process, obtaining a specialty certification points to nurses' commitment to career development and dedication to patient care. Furthermore, by becoming certified, nurses position themselves for appropriate recognition, advancement, and a sense of confidence and achievement. In progressive care areas, the PCCN is a mark of excellence to patients, their families, employers, and nurses.

CONCLUSION

PCCN certification promotes continuing excellence in progressive care nursing by assisting registered nurses in maintaining an up-to-date knowledge base of care of acutely ill adult patients. Achieving certification provides nurses with a sense of professional pride and commitment to the progressive care specialty, and reinforces the core competencies, special knowledge, and experiences required for progressive care nursing.

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The Evolution of Progressive Care Unit in Acute Care Settings

By: Rachel Lantacon MSN, RN, CCRN and Dorothy Macavinta MSNc, BSN, RN-BC, PCCN

The Progressive Care Unit (PCU), also known as the Intermediate Care Unit (IMU) or Step-down unit, was developed to care for those patients who do not require ICU but need closer monitoring than can be provided with medical-surgical (med-surg) level of care. Table 1 reflects the number of PCU units in the UC San Diego Health system, which have evolved throughout the years with the opening of more hospitals and units. Bed capacity has increased with more patients being monitored. PCUs are equipped with telemetry monitoring, continuous pulse oximetry machines, and arterial and central venous pressure monitors. This technology requires nurse knowledge on a list of educational topics such as vascular access, hemodynamic monitoring, pacemakers, automatic implantable cardiac defibrillators, pharmacologic infusions, advanced cardiac life support, and conscious sedation (Berke & Eckland, 2002). The additional technology and higher acuity of the patients requires education and training, and develops skills for nurses working in this environment (Stacey, 2011).

The evolution of the PCU and the rate that it is expanding and being utilized in hospitals today is a testament to how effective they can be, in both cost and care. The American Association of Critical-Care Nurses (AACN, 2010), explains that PCU patients are "moderately stable with less complexity (who) require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care." PCU patients can span from med-surg, telemetry, or intermediate care and

Rachel Lantacon, MSN, RN, CCRN was hired as new graduate nurse at UC San Diego Health in 2010. She now holds a Master's degree in Nursing from San Diego State University. In her current role, she serves as the Assistant Nurse Manager in the Medicine PCU in Hillcrest.

Dorothy Macavinta, MSNc, BSN, RN-BC, PCCN is the nurse manager of the 7 West and 9 West Medicine Progressive Care Unit at UC San Diego Health in Hillcrest. She earned her Bachelor's Degree in Nursing from San Diego State University and is currently finishing her MSN program. In 2006, Dorothy was the recipient of David and Alice Miller UC San Diego Health Nurse of the Year. Dorothy holds specialty certifications in Medical-Surgical Nursing and Progressive Care Nursing.

staffing is adjusted according to the patient's needs. Creating a PCU level of care criteria offers patients who would unnecessarily be kept in the ICU the possibility to be transferred or downgraded to PCU, thus increasing ICU capacity, allowing a bed for a patient who is more critical and could potentially benefit more (Vincent & Rubenfeld, 2015). PCUs are able to use telemetry monitoring devices to monitor cardiac rhythm and continuous oxygen saturation. With adherence to the mandated nurse to patient ratio, the nurse can monitor vital signs and patient condition more frequently. Due to the vast ways patients are able to be monitored, these units are able to manage higher acuity patients and care for a large proportion of inpatient admissions.

Bed availability and placement are important factors when assigning patients to a room or unit. There are strict acuity criteria for med-surg and intensive care units. The usage of PCUs helps with quicker and more efficient triage. The PCU is used as a middle ground to monitor patients that may be improving or deteriorating but not yet critically ill. Patients with changing level of care requirements also affect the admission, transfer, and discharge rates. Admissions can come from both med-surg and ICU beds; they can also be admitted directly from the emergency department or transferred from other health care facilities. The transfers and discharges are also dependent on the rate the patient is recovering or declining. The PCU is able to work with the patient's individual care, promoting the care for a patient with the right technological monitoring and invasive lines with nurses who have the knowledge and familiarity with a wide range of diagnoses and conditions.

Proper education and knowledgeable nurses are necessary in caring for any patient in the hospital. With the extensive range of patients being cared for in the PCU, nurses need to be competent. The completion of the competency based orientation makes the nurse accountable and aware of their responsibilities and scope of practice in their respective floors. According to our professional practice model, teaching and staff development is a core value in the nursing division. Exercising this core value through PCU education courses was essential to prepare nurses for specializing in this select patient population with proper hands-on practice-based learning and didactic PCU courses.

Initially, UCSD Hillcrest started with one PCU originating from the 11th, 9th and 7th floors. This unit previously catered to a variety of patients and diagnoses including but not limited to orthopedic, trauma, transplant surgeries, neuro-critical, medical: heart failure, and liver failure. There appeared to be no limitation on patients the unit could accept. Expansion of the Progressive Care units occurred as more nurses were cross-trained from the 11th, 9th, and 7th floors to transfer to the new hospitals and units were developed in the months and years following. With the opening of Sulpizio Cardiovascular Center in 2011 and specialized Trauma Unit in 2012, skills and knowledge were shared amongst these staff from the original PCU. In addition to shadowing with a designated preceptor, further allocation of funds and resources were utilized to ensure that specialty PCUs became highly skilled and knowledgeable in their respective fields. Such distribution of knowledge and training occurred again with the advent of Jacobs Medical Center in 2016. Multiple specialties and divisions arose: Medical, Surgical, Neuro-critical, and Oncology, from which many nurses were hired and trained from the original PCU. Development of specialized units may be advantageous in terms of improving patient outcomes. One example in the literature, in a Respiratory Intermediate Care Unit in the University Hospital of Cattinara, reported a reduction of inpatient mortality rates, length of stay and timely transfer to the ICU. Here the nurses specialized in proper utilization of noninvasive ventilation, administration of specific medications not normally provided in med-surg care, skills in chest physiotherapy, and arterial gas interpretation. (Confalonieri et.al, 2015). It is with these specializations that UCSD can boast expertise. One example is the unique care required to provide care in the highly specialized pulmonary thromboendarterectomy (PTE) patient opulation. The UCSD program has been shown to have the most successful PTE outcomes including the lowest post-operative mortality rate worldwide (2019).

There is a continuous trend in having multiple med-surg floors converted to PCU floors, allowing their nurses to take on higher acuity patients. The main goal is to soon have PCU floors of all specialties, thus improving patient flow. The PCU's evolution was a necessary and important shift in UCSD's history, allowing more nurses to grow and develop their skills, ensuring patients receive the proper level of monitoring, encouraging appropriate utilization of resources, and aiding with bed capacity throughout the hospital.

Table 1: Progressive Care Units at UCSD Health

UCSD Medical Center (Hillcrest)	Thornton (La Jolla)	Sulpizio Cardiovascular Center (La Jolla)	Jacobs Medical Center (La Jolla)
Opened: Former County Hospital -1963	Opened: 1993	Opened: Aug 2011	Opened: Nov 2016
UCSD- 1966	2E Surgical 27 beds	3B PTU 15 beds	4FGH Surgical Oncology 36 beds
5W Trauma 24 beds	2W Surgical 27 beds	4 A/B PTU 27 beds	5FG Medicine Oncology/Palliative Care 24 beds
7W Medicine 18 beds			5H Neuro 12 beds
9W Medicine 6 beds			6FGH Oncology 36 beds
11th Floor Surgical PCU 36 Beds			

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Oh, the Places You Go!

A Glimpse Into the Life of a 2-East PCU nurse

By: Kimberly Noumi MSN, RN and Kimberley Connors-Mabry BSN, RN

It is 1999, Bill Clinton is in office, the women's soccer team won the World Cup, Backstreet Boys are topping the charts, and we are pirating their music off of NAPSTER. The Columbine massacre brings gun control into the nation's spotlight, an end to Camelot with a plane crash and the death of JFK Jr, and all the while, we are partying like it's, well, 1999. During this time a young nurse, Kim Connors, began her career at UCSD working on 2-West Intermediate Care Unit (IMU), a mixed medicine-surgical floor.

Kim started her career at UCSD the year AB 394 passed in the California Legislature, mandating RN staff ratios. The implementation would not take effect until January 1, 2004, so it was still the 'Wild West', so to speak. During Kim's first year at UCSD, 2-East was a senior behavioral health unit, and the IMU occupied 9 beds on 2 West. She had 4-5 patients per shift, the acuity was high, and the unit was always full. Often, the IMU would expand to 12 beds due to patient needs. This precipitated a permanent move to 2 East a few years later due to the growing acuity of the patient population. Kim spent her shifts honing her skills with a mixed medicine and surgical patient population, including ortho spine patients. To this day, Doctor Garfin still sends his patients to 2-East.

Kimberley Connors-Mabry, BSN, RN is a California native who has spent most of her life in beautiful sunny southern California. She spent several years in Alabama, where she attended the University of South Alabama for her nursing degree and went through ROTC. She received her commission as an Air Force officer and her nursing degree on the same day. It was truly one of the most special days of her life. She served as a nurse in the Air Force for 4 years in northern California and then returned to southern California. She found her way to UC San Diego Health in late 1999 and has been a part of the IMU ever since. In her free time, she likes to spend time with her husband of 14 years, her 7 1/2 year old son and her Siberian husky. In the rare moments of peace and quiet, you can find her curled up with a good book.

Kimberly Noumi MSN, RN has been with UC San Diego Health for almost 4 years and has been the Assistant Nurse Manager at Thornton 2 East IMU since 2016. She started her career in Massachusetts working at Lahey Clinic in Cardio-thoracic surgery and neurology/trauma, and at Massachusetts General Hospital in their Neuro ICU. Kim has been a nurse for over 9 years, her previous career was in the Hospitality Industry. She earned her BSN from the University of Massachusetts, Boston, a MSN from the University of Arizona, and also has a degree in Psychology/Biology from the University of Massachusetts.

Kim, what was it like working in the IMU in 1999. Who did you work with?

It was my first IMU experience. There was a big learning curve. I worked with a lot of travelers and a small core group of nurses. We had CCP's, with one of our night CCP's, Al, starting a few months after I did. We had 3-4 nurses on each shift, no resource, and the charge RN took patients.

What kind of training did you receive when hired to work on the IMU unit?

We took a critical care symposium with other RN's in other facilities throughout San Diego. Patty Graham taught the classes (and still does). I learned a lot. We used a large purple critical care textbook. It was intense! Also, we all took ACLS, not the ART we take today.

This was the year the California legislature passed the RN ratio law. It was implemented in 2004. Is there anything back then that sticks out to you as being different when it comes to nursing care compared to now?

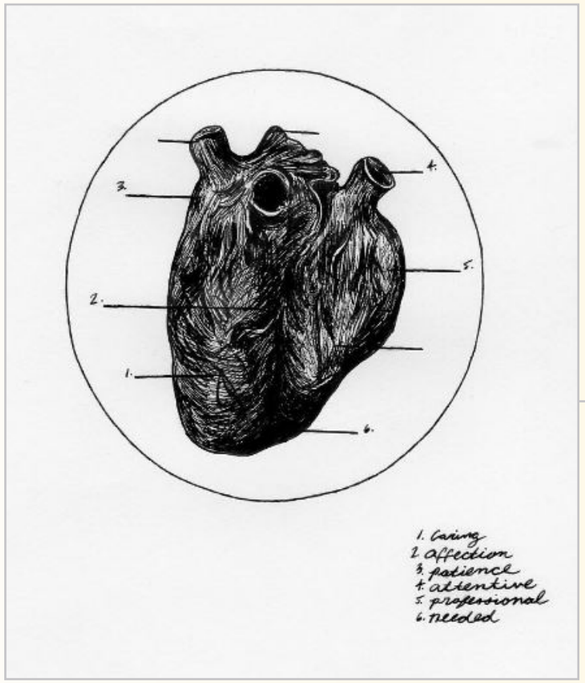
Well, we had paper charting that was huge. Our patients were more diverse, but not sicker. We had Flolan, post op CT surgery patients. We titrated drips, not as may strict guidelines that we have today.

Having such a diverse patient population, do you feel that this was the basis of a good foundation regarding your skills as a nurse?

Yes. I feel that by doing a little bit of everything, it gave me the exposure to feel comfortable with a variety of patients and service lines.

When did you move over to 2 East?

I don't remember the exact year, but I do remember a situation. We had moved over to 2-East and only had the front half of the unit from Room 206-200 and Room 218-222. Room 200 was still a semi-private like today. We had a WOW, workstation on wheels, at the back of the unit, and because we were never full, someone snuck up the back stairwell and stole it. That instance empowered me to become the go-to person when it comes to keeping our equipment safe and accounted for.



ARTWORK BY:
Carrie Anne Hudson
Matters of the Heart

Kim's personal history continues as she marries Pat in 2004. He was the Office Depot delivery man who dropped off supplies to the unit. 2-East was the spot where Kim and Pat met and became soulmates. UCSD continued to grow which resulted in increased admissions, more complex patients, and more buildings to accommodate the growing patient population.

As the years pass by, each new day brings a new challenge. This occurs both professionally and in our personal lives. It's 2014, Kim now has an almost 3 year old son Ben, and her husband Pat, has made some professional changes as well. A little roughhousing with a toddler can sometimes bring your life to a screeching halt. One afternoon when wrestling with Ben, Kim gets kicked in the chest. That is when Kim first notices a lump in her right breast. A self-diagnosed hematoma turns into a breast cancer diagnosis by her primary care physician on her 42nd birthday. She was working the day she received the diagnosis. One of her caring coworkers made her call her primary care physician for an appointment. Funny how life throws road bumps in your path. Now, Kim's major focus is throwing the most epic 3 year old Birthday party, because she does not know how much time she may have.

Kim, it must have been scary not knowing what the future would hold after your diagnosis.

Absolutely! Sitting at work that day when my doctor's office called was one of the most surreal days of my life. If it wasn't for the people on 2-East, I would have completely broke down. They were all so supportive and understanding. During my illness we were also moving. About a dozen people showed up at my house, wanting to help and did it because they cared about me and my family. To this day, it makes me so very happy to know that I am surrounded by that much love and support.

Wow, that is truly an outpouring of love and support! How long were you out?

I was out from around the end of 2014 to January 2016. I had to do CrossFit three months prior to coming back because I did not have the physical stamina to keep up with the pace on the unit. I also did some shadowing with one of the nurses and did light duty work as the unit secretary to get me back in the swing of things. I was cancer free and ready to get back to work!

Kim was back working on 2-East in early 2016. At this time, 2 East was a BMT/Oncology Progressive Care Unit (PCU) with complex surgical and medical oncology patients. Kim states she forgot how physically demanding the job can be on the unit. Once again, she was amazed by the outpouring of support and love she received from the team on 2-East. In November of 2016, 2-East switched service lines again, pivoting to the Cardiovascular service line, specifically congestive heart failure patients with Left Ventricular Assist Devices.

Kim, besides the obvious changes in service lines over the years. Is there anything that sticks out as a major change in the caring for people as a nurse in the PCU?

Yes, service lines have changed. I do miss the smorgasbord of patients. I enjoy helping patients who are very sick when they are admitted and helping them to feel better during their stay motivates me. Cardiac is interesting, but I personally believe that having a diverse patient population with varying diagnoses makes you a better critical thinker. Also technology has changed, some for good, and some not. One of the faults of technology is that it takes you further away from the bedside. That's the good stuff, being in the moment with your patients and families, following them on their journey. Technology and the business aspect of hospitals has shifted the focus from the personal aspects of nursing. I think it is something that needs to be brought back into nursing.

I agree, Kim, technology is a double-edged sword. Today, if we are not using the most cutting edge technology we lose our relevancy in healthcare. There is a happy medium. What are some of the similarities between early IMU/PCU days and now?

Teamwork and the true caring nature that nurses have for one another and our patients. We are truly one of the most loving dysfunctional families that I am proud to be a part of. Just the other day we had a code at 5:30 pm and we all walked out at 7:30pm, together. We all worked together to stabilize a sick patient, care for the other 25 patients, and got out on time. That is a true testament to the teamwork that has always been on display over the years on 2 East.

The team that surrounds you really can make or break you overall experience on a unit. What do you see in the future when it comes to nursing, your career and what advice do you have for nurses in the future?

For nursing in the future, I see a shift more to outpatient and with the really sick patients' inpatient, needing more IMU/PCU training for nurses. Unfortunately, I think that with that push to outpatient, the inpatient resources will get scarcer. People are wanting a quality of life that can only be afforded when you are surrounded by things and people that are familiar. Focus on outpatient will be the next wave, and more home care, I think.

Personally for me it is getting harder to be a nurse on the floor. The PCU is a physically taxing unit. My endurance and stamina is not what it used to be. I see myself moving more towards the outpatient arena. I would really like to work in the Breast Clinic here at UCSD. Pay it forward, so to speak. I think that nursing will evolve, but the backbone will always be the camaraderie and teamwork that makes nursing so special.

For me nursing was a calling, I was always destined to be a nurse. For others entering into this profession, I would tell them that you really need to feel that this profession is a calling. It is a special career to have, with a whole lot more positive experiences that negative. I wouldn't know what else I could have done when it comes to a career. I am a nurse and my team is my family.

REFLECTIONS OF 4 NEW-TO-PCU NURSES

Eleanor G. Yoshisaki-Yusi MSN, MPH, RN, ONC
Chau Nguyen, BSN, RN
Odette Punsalang, MSN, RN, ONC
Laura Lembi – Vitale, MSN-FNP, RN

In December of 2016, two units were joined to make the Hillcrest 11th Floor Surgical Progressive Care Unit (PCU). To support this new unit, many medical-surgical (med-surg) nurses made the personal commitment to advance their clinical knowledge. Their dedication and enthusiasm for this challenge has made all the difference. This article will describe the experience of transitioning from a medical surgical to a progressive care unit for both the leadership team and the clinical nurses.

Chau Nguyen, BSN, RN, CMSRN is a Clinical Nurse II on the 11th floor Surgical Progressive Care Unit at UC San Diego Health. She earned her BSN at Texas's Women University. She has 18 years of experience as a registered nurse. She has been with UC San Diego Health since 2004 and was a recipient of the 11th Floor Nurse of the Year award in 2015. She is a certified medical-surgical registered nurse (CMSRN).

CHAU NGUYEN, BSN, RN

For eighteen years of my nursing career my primary experience was that of med-surg level of care. As a transplant nurse, my role included monitoring the patient, providing specialty care, patient education, and preparing the patient for a safe discharge back to their home and family. I worked with the transplant population for over 10 years and loved it. Although interesting and exciting, the fast pace of the intensive care unit (ICU) and telemetry made me nervous.

My home unit went through a significant change and I knew I would have to adapt. When the day came to start my PCU training, I was nervous and scared. I completed my PCU classes and orientation. Thanks to all my preceptors, I became a brand new PCU nurse. There are many things that I like about PCU nursing care. I like the nurses, the 1:3 patient ratio, automatic vital signs, and the electronic monitoring that helps to preemptively detect a patient's change in condition or deterioration. After almost a year into the PCU setting, despite my occasional nervousness that patients are sicker and can deteriorate any time, I have more confidence in myself and my PCU skills.

Becoming a PCU nurse afforded me the opportunity to expand my career and potentially transition to an intensive care unit. There may be challenges, but there are always rewards. I am proud to be able to provide safe and excellent patient care as a PCU RN in a Magnet-designated hospital.

Eleanor "Leah" G. Yoshisaki-Yusi, MSN, MPH, RN, ONC is the Assistant Nurse Manager of the newly formed 11th Floor Surgical PCU unit in Hillcrest. She started her nursing career as a floor nurse in 2006 in 8th floor Orthopedics. Leah holds Bachelor's degrees in both Medical Technology and Nursing in the Philippines, including her Master of Public Health which she earned from the University of the Philippines. She also earned her Doctor of Medicine from Far Eastern University – Dr. Nicanor Reyes Medical Foundation and was a practicing physician for 10 years. She recently graduated her MSN at San Diego State University with concentration in Leadership and Healthcare. Leah formed the Resource and Charge nurse committee in 11th Floor in an effort to support these nurses in their new and challenging roles. The committee meets every quarterly to discuss expectations on how nurses can support each other and identify peers who are ready to step up and assume charge or resource roles. Leah is currently a member of the National Association of Orthopedic Nurses and Sigma Theta Tau International Honor Society of Nursing.

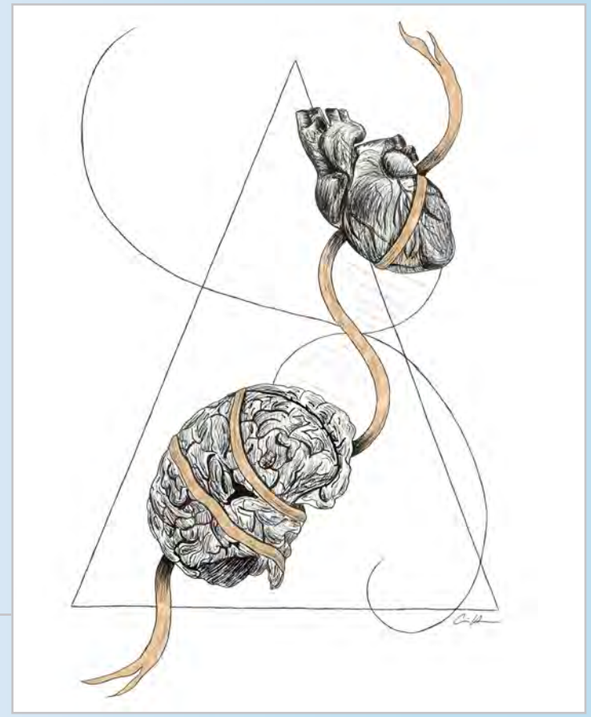
ELEANOR G. YOSHISAKI-YUSI MSN, MPH, RN, ONC

Becoming an Assistant Nurse Manager on a surgical PCU was a big challenge. My role as an administrative nurse requires me to be clinically competent on the unit as resource nurse or as charge nurse. It was really important that I learn the necessary skills. PCU patients require vigilance in monitoring because changes in condition could happen in an instant. I was struggling to figure out how I would learn the role of the PCU nurse so that I could provide quality supervision and service to the department.

My solution was to get in the mix of the unit. I learned many new skills, including how to take care of patients on complex and critical medication infusions, reading telemetry rhythms, drawing blood, and care of arterial lines. I started connecting with the nurses by learning their routines and began to understand the risks involved in taking care of patients at the PCU level of care. I now see why attendance to the series of PCU classes, 2-day EKG classes, and annual ART classes are mandatory. They were constructed so that nurses would be equipped with all the knowledge needed to safely and competently care for patients.

The PCU is where specialty-educated and trained nurses combine the knowledge and skills of assessment, surveillance, and provision of complex nursing processes to provide high-quality patient care. According to the American Association of Critical Care Nurses, every nurse should be provided with specialty education and training to achieve a set of core competencies unique to the PCU (ACCN, 1998). The leadership team at UCSD made sure that requirement was met.

Having attended the PCU series, I am integrating what I have learned and applying it on a regular basis. This helps me better understand what PCU nurses do. I am most grateful for all the support I get from the management team and from all the 11th floor surgical unit that I learned to call my home.



ARTWORK BY:
Carrie Anne Hudson
Matters of the Heart

ODETTE PUNSALANG, MSN, RN, ONC

Odette Gamalinda-Punsalang, MSN, RN, ONC
is a Clinical Nurse II on the 11th floor Surgical Progressive Care Unit at UC San Diego Health. She completed her undergraduate nursing course at Olivarez College in Manila, Phillipines and earned her MSN degree at San Diego State University (SDSU) with a concentration in Leadership in Healthcare Systems. She has been with UC San Diego Health since July 2004 and is a frontrunner in changing the best practices in Nursing Care of Gender Non-Conforming patients at UC San Diego Health. She is also a member of Sigma Theta Tau International Honor Society of Nursing.

Change is a simple word, but it has enormous influence. I took a leap of faith and changed my perspective. This change allowed me to expand my knowledge in another specialty of nursing. I was excited for the challenges this would bring. I was optimistic about how this transition would bring advancement to my nursing career. The PCU 1:3 patient ratio provides added time to interact with my patient, meaning more time at the bedside and ability to care for patients intimately.

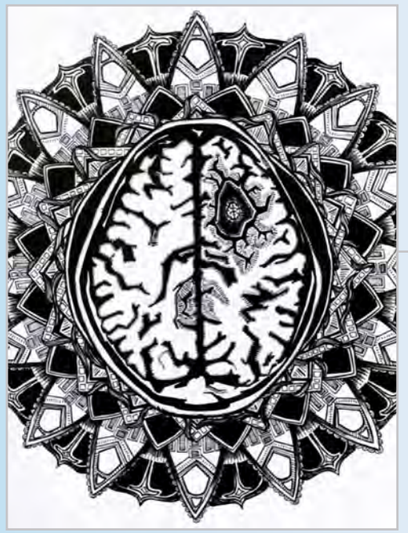
When the day came for my orientation on 11 PCU, I was partnered with a senior nurse who had extensive experience in PCU level of care. Equipped with my knowledge in basic nursing care, I thought it would be a jovial day knowing that we only had two patients, but the night charge nurse assigned us two patients for a reason. I could say that my world turned upside down that shift.

The patient that was assigned to me was the most challenging one in my PCU experience to date. This patient had a tracheostomy and multiple co-morbidities which made suctioning a challenge. She had multiple lines and tubes, a critical medication infusion that was not used in med-surg nursing, and telemetry monitoring. Her condition made even basic care a team activity.

After that day, I paused and asked myself if becoming a PCU nurse was worth it. It was definitely not in my comfort zone. I gained additional knowledge which is interesting and advantageous, but the demands of extra work, patience, and time is a challenge for me. Does the PCU fit my personality and work needs? Do I like to be constantly busy with unexpected challenges? Or do I prefer a slower pace with a fairly predictable routine?

PCU level of care has a lot to offer me. It bolstered my clinical expertise and I am better able to think on my feet. My sense of accountability increased. I have advanced competencies, skills, and education that are required of a PCU nurse. I am more confident and competent in caring for patients with complex needs. Intense training provided necessary skills to detect deterioration and manage invasive monitoring of these high acuity patients who are at risk for life-threatening events.

I am delighted that I made the decision to become a PCU nurse. Not only has becoming a PCU nurse had positive outcomes, it made me more certain about what I would like my nursing career to be. Every day is a challenge, but it gives me satisfaction knowing that I am a PCU nurse.



ARTWORK BY:
Hannah Saarinen

Laura Lembi – Vitale, MSN-FNP, RN
has been working as a clinical nurse at UC San Diego Health since July 2015. She graduated from UCSD in 2011 with a B.S. degree in General Biology and then attended Cal State University of San Marcos for her BSN in Nursing. While working at UCSD she also completed her MSN in Family Nurse Practice at Azusa Pacific University and is now a board certified Family Nurse Practitioner.

LAURA LEMBI – VITALE, MSN-FNP, RN

Many nurses begin a career in one specialty but end it in a completely different one. Over the last two years, I have had the opportunity to make a subtler transition from a med-surg level of care (5:1 ratio) to PCU level of care (3:1 ratio) on the 11th floor Surgical Progressive Care Unit.

The differences between med-surg and PCU are subtle but noticeable. The amount of critical thinking going into care plans and proactive communication with the team increases. Patients are higher acuity and less stable, therefore, the nurse needs to be more vigilant. The patients seem to teeter between improving and declining in any instant. Their clinical status can completely change day to day, shift to shift, and it can feel like a roller-coaster ride to both the nurse and the patient.

As the name 'Progressive Care' implies, many patients do improve clinically. They are able to downgrade to med-surg and can be taken off continuous cardiac and oximetry monitoring. It is usually a feeling of relief for the patients. Cords can finally be disconnected, they can get out of bed, walk more, and eventually be discharged. Discharging a patient who I've had the opportunity to care for and see improve clinically throughout their stay, is one of my most rewarding experiences as a nurse.

Other patients decompensate. Their blood pressure drops, they may become septic, or have respiratory decline. This is when the critical thinking becomes essential and nurses must use all their knowledge, training, and resources. This includes utilizing the resources of the interdisciplinary team members and Rapid Response Team to help think through why the condition is changing and advocate for the appropriate changes to the treatment plan. This teamwork, active contribution to the treatment plan, and prevention of further decompensation is professionally fulfilling.

Working on a progressive care unit has been both challenging and rewarding. For me, transitioning from med-surg to PCU was a smooth and natural transition. I was ready for the challenge and embraced it.

There is a decided trend at UCSD toward a Progressive Care model. There are benefits for patients, staff, and the organization. Many UCSD nurses have been trained in Progressive Care, and many more will be soon. As the stories above illustrate, this transition is difficult and challenging. Some degree of fear and anxiety are inherent in most life changes, and a change in career specialty is significant. Those who find themselves anticipating this change in their career can know their worries were shared by most who have already made the change. They can also be assured there are opportunities and benefits that go along with growing their skill set. As each of these authors have written, the rewards of this growth exceed the challenges they faced.

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Building A PCU on 2-West

By: Cristy Clarete RN and Cecilia Caronongan MSN, RN, PCCN

Thornton 2-West has 27 beds and approximately 70 employees. As part of the UCSD's Mission and Vision and as a Magnet organization, over 90% of the nurses have their BSN and over 30% have an ACCN recognized certification. Thornton 2-West cares for a wide variety of patient populations but not limited to: medicine, general surgery, bariatric surgery, cystic fibrosis, and pre-liver transplants patients. The unit is also designed to care for epilepsy patients requiring 24-hour Video Electroencephalogram (VEEG) monitoring.

Thornton 2-West started as a medical–surgical (med-surg) telemetry unit, however, as the healthcare needs of the community evolved, and as part of our commitment to provide exceptional service to our patients, 2-West transitioned to a progressive care unit (PCU). By definition, a PCU bridges the gap between intensive care units and med-surg units. The PCU level of care reduces transfer of patients because surgical ward and PCU care can be provided in the same unit. The PCU also promotes effective use of ICU beds, and provides patients with a high level of skilled nursing and surveillance to meet their unique needs.

As the need for more PCU's increased, and despite initial hesitation and ambivalence to change the culture on 2-West, the journey began. The planning and training started early 2016, spearheaded by Melissa Deming, BSN, RN, Nurse Manager with the support of the Margarita Baggett, MSN RN, Chief Clinical Officer, and Jill Deetz, BSN RN, Service Line Director. While some of the nurses embraced the process, others were hesitant to undergo PCU training. Preparation entailed ordering new cardiac monitors, collaboration with the organization's information technology department, and coordination with other PCU managers. Katie Winslow MSN RN, Nurse Educator, also designed the educational programs needed for nurses to learn about role expectations in their new level of care. Training included attending PCU and procedural sedation classes, PCU Advanced Resuscitation Training (ART), completion of a variety of online nursing modules, as well as hands-on training. Charge and resource nurses received practice-based learning in other PCUs for 2 weeks and developed competencies to operate new equipment. Eventually, those nurses were able to cross-train our core staff and newly hired staff. Currently, 95 percent of nurses on 2-West are PCU trained with the remainder of nurses caring for only surgical patients.

Cristy Clarete, RN began her nursing career at St. Luke's Hospital in New York on a progressive care unit. Since marrying an active duty military member, she has spent the last 12 years of her travelling across the United States, working at different institutions and different levels of care. Cristy has been a staff nurse on Thornton 2 West for the last 4 years. She is one of the charge nurses on 2 West and one of the first staff to be trained for 2 West's transition to progressive care. Cristy was Employee of the Quarter for the summer of 2018.

Cecilia Caronongan, MSN, RN, PCCN completed her BSN at Lyceum Northwestern University, Dagupan City, Philippines in 2004 and passed the Philippine National Licensure Exam the same year. The following year, she successfully passed the NCLEX and joined Mercy Hospital in Cincinnati, Ohio as an IMU nurse for 4 years. In 2010, she moved to California and worked in various healthcare organizations. She joined UC San Diego Health in 2013 as Clinical Nurse II on 2-West and performed various roles, such as charge and resource nurse, as well as preceptor for new hires and students. She pursued her Master's Degree in Nursing and graduated in 2016 from Grand Canyon University, Arizona. She was promoted to her current position as the assistant nurse manager on 2-West in May 2016.

After much rigorous training and preparation, 2-West successfully converted to a PCU in April 2016. While initially, caring for lower acuity IMU patients to help ease the transition, many 2-West nurses' biggest challenge was the fear of unknown. The nurses had countless questions regarding adapting to their new level of care, from of setting up a patient on the heart monitor to providing patient care for patients requiring telemetry monitoring. For every new patient encountered, nurses sought out their resources and researched nursing guidelines and nursing policies specific to their patient population. At times, the cumulative effect of these iterative challenges seemed like the learning curve was insurmountable. Some nurses did not find the challenges a good match, and went to pursue other career goals. However, the team members that weathered what felt like a storm are now the backbone of the unit. Together, 2-West has become a stronger unit of highly skilled nurses, proficient in UCSD policies and procedures that govern our nursing care, and are very capable in taking care of high acuity PCU patients. With the guidance and support of the 2-West leadership team, and the amazing support of the Rapid Response Team that held our hands through difficult times, the support of our adjacent unit 2-East, and the interdisciplinary teamwork of every department involved in the care of our patients, 2-West nurses never felt alone. Currently, the 95 percent of 2-West nurses that are PCU trained are now also training nursing nurses from other units such as 3-West in their PCU transition.

Creating the standards and competencies necessary to provide PCU level of care was not easy. It was anticipated that ambivalence and hesitation to change would be a common obstacle towards complete transition into the new role. Factors that stimulate hesitation to change and training include fear of the unknown, fear of greater responsibility that may demand work with a higher degree of difficulty, and inadequate understanding of the change process. To deal with forecasted barriers, the unit manager ensured that staff understood the vision for change, their roles, and how would directly and indirectly impact each person in the unit. Communication was directed through unit huddles and the shared governance unit-based practice council. Proper communication and clarity of the planned change created partnerships in achieving the desired outcomes. The huddles also allowed nurses on 2-West to share their experiences and perceptions about the change process.

Through this experience we have learned that change can be viewed as an opportunity for improvement. We have learned that while preparing for change the vision should be clearly communicated. Understanding the nature of the transition process and its potential benefit will decrease resistance and hesitation, promote teamwork, and foster staff commitment. Adequate training should be provided to promote staff confidence in taking care of high acuity patients and protect patient safety. Currently, 2-West has six (6) PCU beds. We look forward increasing the percentage of PCU beds to meet the changing needs of the organization and the community we serve.

Phillips cardiac monitor and nurses training each other on how to set up the Phillips monitor for our PCU patients.

Neuro Nurses Have All the Brains!

Elevating PCU Nurses through Interdisciplinary Collaboration with ICU Counterparts & Neuro Leaders to Promote Continuity of Care for Stroke Patients

By: Dawn Carroll BSN, RN, MS, Abigail Edilloran BSN, RN, CHPN, Christine Wood BS, BSN, RN

There is no other unit like the 5H Neuro Progressive Care Unit (PCU). Established in 2016 with the opening of Jacobs Medical Center, the 12-bed 5H Neuro PCU was essentially a grassroots project. 5H started with five UC San Diego (UCSD) nurses transferring internally to build the unit, along with, approximately, 18 external new hires from various organizations throughout San Diego county and the nation, who brought their expertise from other hospitals and their fresh new perspectives with them. Designed and built from the ground up by frontline staff, 5H was the creation of a group of pioneering nurses who utilized their voices and transformational vision to establish UCSD's first dedicated stroke unit. Furthermore, 5H helped pave the way for UCSD's esteemed accomplishment of earning The Joint Commission's Comprehensive (TJC) Stroke Designation at the only health system in the country serving two separate sites (La Jolla and Hillcrest).

5H's neuro nurses engage in rigorous training in order to refine their specialized skill sets, as the medical management of stroke patients relies on the astute assessment skills care providers. Taught by our Stroke Clinical Nurse Specialist, Patricia Graham MS RN CCRN SCRN, and our Neurocritical Care Medical Director, Dr. Navaz Karanjia, each neuro nurse participates in a series of neuro-specific classes (Neuro A, Neuro B, Neuro Bootcamp, Neuropharmacology, Neuro Skills, and more) as a part of their on-boarding and annual training. In this rigorous neuro program, our neuro nurses are trained to be experts in stroke care, equipped with the attentive assessment skills needed to identify the subtlest stroke symptoms and to understand the area of the brain affected. Subsequently, the nurses are empowered through their knowledge to advocate for their patients when changes in the treatment plan are indicated. As

Dawn Carroll, BSN, RN, MS
joined UC San Diego Health in 2014 as 10th floor ICU nurse manager. Currently, she is nurse manager of 3F/5H at JMC since opening in 2016. She received her BS/MS from SUNY at Stony Brook and worked as Senior Nurse Practitioner in Perinatal Women's Health. Dawn brings with her over 15 years of nursing leadership roles in Neuro-Surgical Intensive Care, Cardiovascular and Cardiothoracic Services. Prior to UC San Diego, she served as Director of Neuro/Surgical Intensive Care unit and Director of Trauma/Step Down at Regional Medical Center in Hudson Florida from 2008 to 2013. She was crucial in the development of HCA's first Trauma Center, where her team was recognized, based on her nomination, in Advance for Nurses for adaptability. Her nomination letter was featured in the May 2013 issue of Advance for Nurses. Dawn also served as nurse manager of the ICUs and Rapid Response teams at Palomar. Dawn is an active member of ACNL, ANA, AONE and serves on the Rewards and Recognition committee for ACNL. She plans on pursing her DNP in the fall of 2019.

Abby Edilloran, BSN, RN, CHPN
is an Assistant Nurse Manager for the Jacobs Medical Center 3F & 5H Neuro ICU/PCU team. Abby has been a Registered Nurse for 7 years. As a second degree bachelor's prepared nurse who entered the healthcare profession as a new graduate in the intensive care unit, Abby has witnessed firsthand the complexities of patient care, sparking her determination to not only serve her patients with the best clinical skills possible, but also be their voice and advocate for what they need (and what nurses need) to optimize nursing care and healthcare delivery. Because of this, she has developed a passion for quality improvement and patient and family centered care. She has earned her nursing degree from Azusa Pacific University and holds professional certifications in stroke nursing (Stroke Certified Registered Nurse) and in palliative care (Certified Hospice and Palliative Care Nurse).

Christine Wood, BS, BSN, RN
graduated with her BSN from National University in 2014. She is an active, participating member of the Quality Council, Medication Safety Committee, and Stroke Quality Council Meeting. She has diligently devoted herself to creating an atmosphere of open and honest communication between physicians and staff. Being able to care for patients in their darkest hours after a stroke is something that she is very passionate about. The opportunity to be a stroke nurse has truly been a calling and her dream come true.

active participants in their patient's care, 5H nurses spend a day rounding with the neurocritical care team, review various MRI/CT scans during radiology rounds, and have the opportunity shadow during the most complex of neuro cases in the operating room.

5H neuro nurses are transformational, even beyond the bedside. As masters of their own craft, 5H neuro nurses often teach their peers across the organization about stroke care and nursing management. Many of 5H's nurses have taught at annual Neuro Skills days, participated in Mock Stroke Codes with the interdisciplinary neuro team, and led educational presentations to prepare nurses and leaders for regulatory visits for our stroke survey. 5H neuro nurses are a valuable asset to the stroke program at UCSDH, as they play a role in their patients' hyper-acute care up until discharge planning and rehab. As a sister unit to their ICU counterpart, the 3F Neuro ICU at Jacobs Medical Center, 5H is often called upon to provide expertise in nursing across the continuum.

It is not only because of its highly specialized knowledge regarding stroke care that the 5H staff shines in many of the nursing sensitive indicators, but it is also because of the compassion, teamwork, and culture of caring that it demonstrates

every day. The unit has not had a single incidence of CAUTI or CLABSI in over a year, and the nurses demonstrate a commitment to nursing excellence through tackling nursing sensitive indicators routinely. Additionally, every day on the unit, nurses find reason for celebration, whether it be a patient's birthday while they are hospitalized, a patient's recovery from even the most devastating stroke deficits, or the simple fact that a patient mastered even the most basic tasks for the first time. 5H is a strong proponent of patient-and-family centered care, with multiple on-going projects designed to bring focus back to the patient. Heather Abrahim RN is working to promote personal pet visitation, Bryan Klimek RN has committed to aspiration prevention, Kristy Ames RN is passionately working to reduce shoulder subluxation, and Bree Buckshnis RN is partnering with our neuro providers to refine interdisciplinary communication across the stroke care continuum. Furthermore, 5H nurses volunteer at stroke centers in San Diego county, sharing their passion for community and wellness beyond the walls of Jacobs Medical Center.

5H nurses elevate their practice through their partnership with the Neuro ICU, nursing leadership, and stroke leadership. Daily huddles with the Neuro ICU identify potential downgrades and ICU transfers to facilitate seamless throughput and patient flow within the stroke/neuro service line. Interdisciplinary rounds with stroke leadership, as well as active participation in Stroke Quality Council, have also proven to be valuable in the empowerment and quality of care that 5H neuro nurses deliver. 5H is a driving force in what stroke care looks like at UCSDH.

The successes of this team are not only due to the relentless spirit of the compassionate group of individuals who are proud to be a part of the 5H team; they can also be attributed to the various team building activities that are conducted to maintain engagement and a healthy work environment. Annually, our neuro family (including both ICU/PCU nurses and all neuro providers) participates in team building retreats to maintain personal wellness, an award ceremony (3F/5H Axon Awards) during which we roll out the red carpet for our team members, and weekly debriefs to address process issues and provide an emotional 'check-in' with one another. Needless to say, the morale of our team is very important, and it is our priority to keep caregiver burnout at bay!

Stroke nursing is all-encompassing in its approach to patient care; it requires patience, a specialized knowledge and skill set, and strong collaboration with the interdisciplinary team. The 5H Neuro PCU staff is proud to lead in this growing field and has big plans to shape the future of stroke nursing. After all, 'neuro nurses have all the brains', and 5H strives to be the premier destination for stroke care at UCSDH.

Teamwork, Retention, and Staff Morale, 3B Small but Mighty

By: Megan Hagedorn BSN, RN, PCCN and Kathleen Boughanem BSN, RN

The University of California San Diego Medical Center consists of three hospitals that operate under one license with a current combined capacity of 808 beds: UC San Diego Medical Center in Hillcrest (390 beds), Jacobs Medical Center (JMC) (364 beds) and Sulpizio Cardiovascular Center (CVC) (54 beds). This is then divided out into 26 individual nursing units ranging in bed size from JMC 4th and 6th floors, which are the largest at 36 beds each, to our 15 bed unit located in the CVC. When the CVC opened in 2011, the nurses and clinical care partners (CCP's) from Hillcrest moved into this new building that houses 3 units dedicated strictly to cardiac care. The nurses that opened the new building left the units they knew by heart to start a new type of unit in a new facility, and 3B was born.

When first opened, 3B was primarily a unit that served a patient population of patients receiving observation or procedures with overnight stays. The short length of stay resulted in a place that was fast paced with a high patient turnover. Most of the patient population stayed less than 24 hours post cardiac catheterization. Most units can claim fantastic teamwork but when you are admitting and discharging over two-thirds of your unit in a day, great teamwork isn't just helpful, it's necessary. Because patients are always coming and going, establishing a rapport with patients is sometimes difficult. On 3B the nurses have developed an expertise in this facet of care, or maybe they are so successful because of their natural abilities for relationship-building. To these nurses patients aren't a number, but instead they are treated as family. The phrase 'not my patient' is just not uttered here, just the opposite, it's considered taboo. They say there is no 'I' in team and here on 3B that statement rings true.

Through the years the patient population has changed. There are less one night stays and more chronic congestive heart failure and post heart surgery patients, but the esprit de corps remains the same. One might say that the teamwork on this unit was born of necessity. While there may be some truth to that, the teamwork here has remained because of the highly skilled and dedicated nurses that call this floor home.

The other things that you will notice if you are ever on 3B is that there always seems to be food. We all know that nurses like to eat! Goodies from families and special treats from management help make us feel appreciated. True to form 3B makes that extra effort. The staff here are always bringing in dishes to share. Cookies, candy, and cuisine from any corner of the globe are always filling the breakroom. If there is one thing that can boost staff morale while running around discharging and admitting patients, it is snacks. So, if you're hungry swing by and grab a bite, it's guaranteed to put a smile on your face.

Fifteen; that number is not only significant because of the number of beds on this unit, it is also the average years of nursing expertise on the unit amongst the staff. With one of the lowest staff turnover rates in the hospital it's no wonder it's hard to find an open position on 3B.

When the staff were asked why they stay on this unit the common denominator is family. Everyone here is treated like family, patients and staff alike. In retrospect maybe that is why the food is so good here, food tastes better when you eat it with your family.

Megan Hagedorn, BSN, RN, PCCN is the Assistant Nurse Manager of the 3B Progressive Care Unit at UC San Diego Health Sulpizo Cardiovascular Center. She earned her BSN from University of North Carolina, Greensboro. Prior to working at UCSD, she started at Mission Hospitals in Asheville, NC. From there, she took on several travel assignments in Washington DC and Maui, Hawaii before finding a home here in San Diego.

Kate Boughanem, BSN, RN graduated from St. Louis University in 1996 with her Bachelor's in Nursing. She started her career at UC San Diego Health 17 years ago as a travel nurse at Thornton ICU. She worked as a cardiovascular and heart transplant nurse before becoming nurse manager of Sulpizio 3B.

ARTWORK BY:
Hannah Saarinen

Evolution of the Specialized Nursing Staff on Sulpizio 4AB

By: Krista O'Brien BSN, RN and Meghan Jones MSN, RN, FNP-C

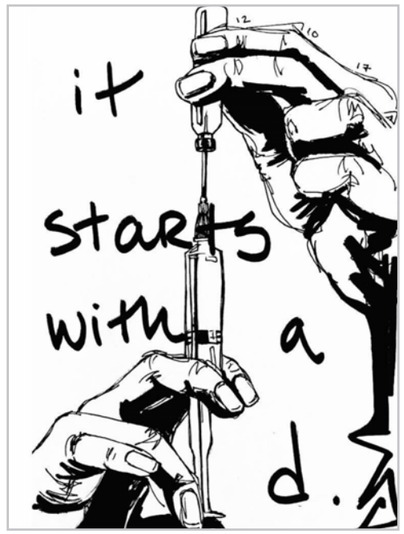
The University of California, San Diego (UCSD) identified a need to provide expert nursing and medical care for a unique group of patients. In response, the Sulpizio Cardiovascular Center (SCVC) was created to offer specialty care to those with cardiovascular and/or pulmonary diagnoses. This new center included an intensive care unit, a procedural area, and two progressive care units. One of those units, SCVC 4AB Progressive Care Unit (PCU), has evolved over time. As nurses on this unit, we would like to share the history of this evolution to a highly specialized unit with complex patients.

Initially, the Intermediate Unit (IMU) in Thornton Hospital provided care to all types of patients needing a higher level of attention than medical-surgical or telemetry level of care. This included patients with a diverse range of conditions: cystic fibrosis, cardiac problems, pulmonary issues, seizure disorders, as well as the geriatric or bariatric patient. Many nurses from the Thornton IMU transferred to help open the fourth floor PCU in Sulpizio in 2011. These RNs, and those subsequently hired, were able to hone their skills and knowledge to these specific patients and diseases. Since then, our unit has continued to flourish and we take pride in our distinctive and exceptional skill set.

Before the SCVC opened, all of the nurses hired to care for patients in the fourth floor PCU attended a program created by the American Association of Critical Care Nurses (AACN) called the Critical Care Internship Program (CCIP). This comprehensive curriculum extended over twelve days and focused on the physiology and pathophysiology of all of the major body systems. Recently the need for unit-specific education for our specific patient populations arose. The masters-prepared SCVC nurse educators created the Cardiac Boot Camp, a four-day series intended for Sulpizio RNs addressing topics relevant to the care of cardiovascular patient in a didactic in-classroom and hands-on setting.

Krista O'Brien, BSN, RN
has been a cardiac nurse for three years. She started as a new grad RN at Sharp Healthcare and after obtaining her BSN in 2017 was thrilled to sign on with UC San Diego Health. Krista plays an active role in committees on her unit and plans to continue to grow in the cardiovascular field after obtaining her MSN and becoming a nurse practitioner.

Meghan Jones MSN, RN, FNP-C
has been a nurse for 4 years. She began her career as a new grad RN at Sulpizio Cardiovascular Center, on the Progressive Care Unit. She recently completed her master's degree in nursing and is now a certified family nurse practitioner. She hopes to transition to a nurse practitioner position in cardiovascular care at UC San Diego Health soon.



ARTWORK BY:
Hannah Saarinen

Day One includes an in-depth review of hemodynamic monitoring, waveform interpretation and vasoactive drips. The overview of cardiac anatomy is accomplished via pig heart dissection.

Day Two focuses on postoperative implications for the cardiothoracic patient, oxygen delivery and ABG interpretation, as well as hands-on practice with Flolan, Remodulin and radial artery punctures.

Day Three provides a review of MI/STEMI care and advanced heart failure. A skills lab reviews arterial compression devices and pericardial drains.

The final day includes a focused examination of Ventricular Assist Devices (VADs). An additional skills lab emphasizes equipment troubleshooting of the HeartMate, HeartWare and Tandem VADs.

Upon completion of the series and associated competencies, nurses have expressed confidence in their ability to provide safe and competent care for the patients of these advanced specialties.

In 2017, the SCVC intensive care unit opened a second unit with twelve additional beds for a total of twenty-four beds. This increase in capacity helped alleviate the need for beds for the critically ill patient in the intensive care unit (ICU). However, the PCU patient is very high acuity requiring frequent surveillance and treatments delivered using technology that cannot be provided at a medical-surgical staffing ratio. This created an opportunity for SCVC PCU to develop into a 27-bed "hybrid" floor. Our patient population expanded to accept and care for ventilated patients and patients with Swan Ganz catheters. At this time, the patient population includes anyone pre- or post-operative cardiovascular or pulmonary disorder. The most common are the heart/lung transplant, pulmonary thromboendarterectomy (PTE), open-heart surgery, general vascular surgery, general surgery and patients with ventricular assist devices. In addition, stroke recovery patients and those with medical conditions such as pulmonary hypertension are admitted to the SCVC PCU.

In order to provide this complex level of care, all nurses have developed knowledge and skills to monitor and care for these patients. Among the required skills are continuous telemetry (ECG) monitoring, hemodynamic monitoring (arterial blood pressure, central venous pressure and pulmonary artery pressure), ultrafiltration, ventilator support, ventricular assist devices (HeartMate and HeartWare) and Prostacyclin therapy.

The process of developing a staff of about seventy nurses to possess the didactic knowledge and clinical skills needed for this complicated population has required significant planning and collaboration. The management team and nurse educators met routinely with the staff to elicit concerns, identify potential problems, and propose solutions. The staff received didactic instruction followed by clinical preceptorships in the ICU. The most experienced staff were trained initially. They then assisted in the mentoring of the more neophyte group. As a result, the PCU staff has acquired a distinctive and exceptional skill set. At the same time, the staff continues to incorporate holistic treatments and education for the patient and their family to provide for the most comprehensive healing and supportive patient care.

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UC San Diego Health System Thornton 3 West Orthopedic Progressive Care Unit Coming Soon Spring 2019!

By: Aldrin Poblete MSN RN, Nelissa Reyes MSN RN ONC, Sherlita Aguilar MSNc RN ONC

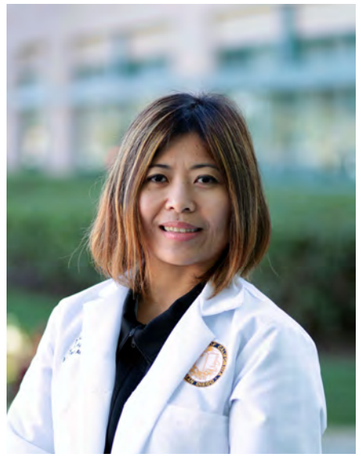
UC San Diego Health is ranked among the nation's top 50 orthopedic programs and Thornton 3-West is the designated inpatient care unit for orthopedic surgery. Thornton 3-West consists of a newly renovated unit with 23 beds and all private rooms. The unit serves patients with joint replacement and arthritis surgery, spine surgery, cartilage restoration and transplantation, foot and ankle surgery, hand and upper extremity surgery, orthopedic trauma, physical medicine, and rehabilitation. Most of the patient population undergoes joint replacements and spine surgery.

The Progressive Care Unit (PCU) conversion journey of Thornton 3-West unfolded in June 2017. We started as a unit overflow of 3-East Medical-Surgical Unit. In the beginning, 3-West was only staffed with 3 RNs and as it gradually became an orthopedic unit, we increased staffing with 43 RNs, 7 clinical care partners and 1-unit secretary. The demand to care for the orthopedic patients that require cardiac monitoring led to the transformation of 3-West into a PCU unit. Currently, the unit is in its final phase of an orthopedic progressive care conversion with a completion date in spring 2019. Thornton 3-West will have 6 IMU beds, 6 telemetry beds, and 11 med-surg beds. The unit currently has 20 PCU trained RNs with an ongoing plan to train the next cohort of nurses. In doing so, the leaders are providing transformational development opportunities for the other med-surg nurses who are eager to learn new skills.

We are proud of our 3-West staff for many reasons. A core group of the 3- West staff is actively involved in the pre-op joint classes for patients which are offered in Hillcrest and La Jolla. In addition, the staff hosts the Annual Bonafide Orthopedic Nursing Educational Symposium (BONES) going on its 15th year offering continuing education units to all nurses in the community. The theme of last years' BONES symposium was, "It's a joint effort" which is the mantra that 3-West staff continue to practice. The whole team promotes a culture of professional collaboration with the physicians, case managers, physical and occupational therapists to help restore function, manage pain, and coordinate resources and services pre and post-operatively for the orthopedic patients.

Aldrin Milay Poblete, MSN, RN
is the Nurse Manager for Thornton 3E Medical Surgical and 3W Orthopedic PCU Unit. He started his nursing career as a new grad on 10 East, transitioned to Assistant Nurse Manager, then became Nurse Manager for 3B PCU Sulpizio Cardiovascular Center in 2012. He graduated from San Diego State University with his MSN in 2017. Aldrin has 12 years of nursing leadership experience and has opened 3 nursing units for UC San Diego Health (11E Surgical Telemetry, 3B PCU Sulpizio Cardiovascular Center, and Thornton 3W Orthopedic PCU). He is also currently serving in the military as a flight nurse with US Air Force Reserve 452nd Aeromedical Squadron. He has multiple deployments and combat support mission in the Middle East transporting wounded soldiers out of harm's way into higher level of care.

We are excited for the PCU Go Live this spring 2019!



Sherlita Aguilar BSN, RN, QIAcm, ONC
s the assistant nurse manager for 3 East Medical Surgical Unit and 3 West Orthopedic Medical Surgical, soon to become Progressive Care Unit at UC San Diego Health Thornton Hospital. Her passion is in Orthopedics and Apheresis. She is a Certified Orthopedic Nurse and the first nurse at UC San Diego Health to obtain Qualification in Apheresis (QIA) certification, an international and national credential in Apheresis medicine for nurses and physicians. She is currently enrolled in the MSN program at San Diego State University with a concentration in nursing leadership.

Nelissa Reyes, MSN, RN, ONC
is the Assistant Nurse Manager for Thornton 3E Medical Surgical and 3W Orthopedic PCU Unit. She earned her Bachelor's degree and Master's degree in Nursing at San Diego State University. She started her nursing career at UC San Diego Health Hillcrest 8th floor (orthopedic/neuro/trauma unit) as a new graduate nurse. Nelissa is the chairman for the BONES Committee and was a past President of National Association of Orthopedic Nursing (NAON) San Diego Local Chapter 37. As a new leader, she had the opportunity to open and hire staff for the new Thornton 3 West Orthopedic PCU unit.

UC San Diego Epilepsy Monitoring Unit on Thornton 2-West PCU

By: Jessica Bejar, BSN, RN, PHN, PCCN, Jacqueline Gerwer, BSPH, BSN, RN, Anna Melendez, BSN, RN, PCCN and Katie Villarino, BSN, RN, PCCN-CMC

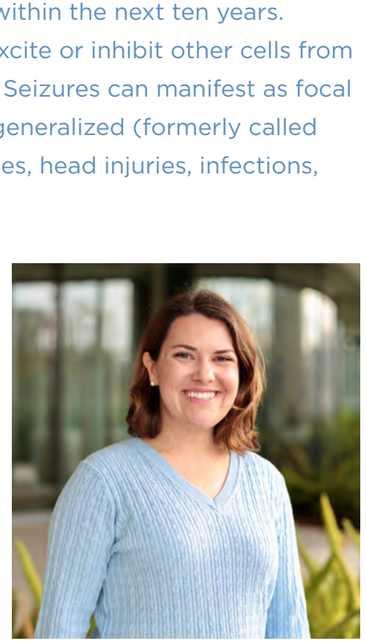
INTRODUCTION: Thornton 2-West Progressive Care Unit (PCU) is home to a Level 4 Comprehensive Epilepsy Monitoring Unit (EMU) that specializes in patients admitted for Video-Electroencephalogram (VEEG) neurodiagnostic monitoring. Thornton 2-West has six beds available for epileptic patients undergoing seizure studies to either diagnose, or rule out, epilepsy. Epilepsy is defined as when two seizures occur at least 24 hours apart or when one seizure occurs with at least 60% probability of recurrence within the next ten years. Seizures are caused by an imbalance between brain cells that excite or inhibit other cells from sending messages, causing too much or too little brain activity. Seizures can manifest as focal (or partial) with or without loss of awareness, while others are generalized (formerly called grand mal). Seizures are linked with brain structural abnormalities, head injuries, infections, metabolic imbalances, strokes, and genetics.

The National Association of Epilepsy Centers provides guidelines for designating medical institutions from Level 4, the highest level of specialized epilepsy care, to Level 1, primary or emergency care. The UC San Diego EMU is a Level 4 Comprehensive Epilepsy Center due to the neurodiagnostic monitoring capability and advanced treatments including surgical options offered. Our UCSD Comprehensive Epilepsy Center team includes most of the seventy nurses and nursing assistants that work on Thornton 2-West. Staff nurses on Thornton 2-West receive EMU training in New Employee Orientation, EMU VEEG Skills Day, 2-West Skills Day, online learning modules, and a new EMU simulation lab course which was launched this year. Additional EMU staff includes Katie Villarino, RN, the Epilepsy Clinical Nurse Coordinator, Rose Bercow, the Patient Care Coordinator, and several EEG Technicians supervised by Ralph Nowacki, AB, who are trained to read the EEG brainwave tracings. The EMU also includes a group of epileptologists including Medical Director Jerry J. Shih, MD, Vicente Iraguimadoz, MD, Evelyn Tecoma, MD, PhD, Leena Kansal, MD, David J. Lee, MD, PhD, and June Yoshii, MD. The staff of Thornton 2-West and the EMU work together to care for the complex patients through Phase I and Phase II of the seizure study.

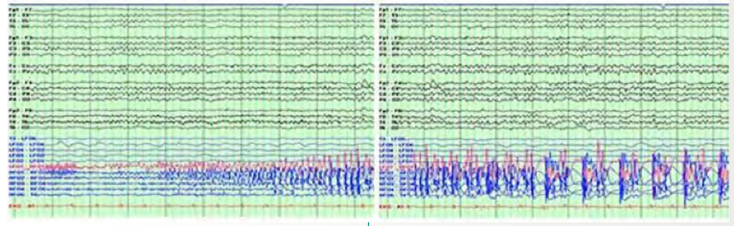
PHASE I VEEG MONITORING

UC San Diego EMU is the premier destination in Southern California for individuals with refractory epilepsy seeking medical or surgical management for their seizures. Phase I of the seizure study utilizes Video-Electroencephalogram (VEEG) monitoring at the telemetry level of care, requiring hospitalization from two to ten days, and continuous VEEG monitoring encompassing 24-hour closed-circuit video recording paired with brainwave recordings from an array of external electrodes. The goal of this phase is to determine the seizures' lateralization and preferably to localize the point of origin of the seizures. To increase the likelihood of capturing seizure events, patients are exposed to common seizure triggers like medication tapering, sleep deprivation, flashing light stimulation, hyperventilation, skipping a meal, and even alcohol consumption. Phase I VEEG is also the gold standard in diagnosing non-epileptic events, which are also called psychogenic events or pseudoseizures. Non-epileptic events are physical manifestations that mimic seizures but have no corresponding abnormal brain activity. A non-epileptic patient's epilepsy drugs are generally discontinued after the diagnostic study, and the recommended treatment is cognitive-behavioral therapy.

Throughout Phase I, nursing considerations involve performing a neurological assessment every four hours, vital signs every 4 to 8 hours, maintaining the scalp electrodes, and continuous cardiac and oxygen saturation monitoring, as well as inducing seizures with sleep and calorie deprivation, tailored to the individual patient. The patient and video monitor observer each have a button that sounds an alarm if either suspects that the patient is beginning to have a seizure to alert the nursing staff. While the patient is having the seizure, an EMU nurse assesses the patient to give more information to the epileptologist in determining what area of the brain the seizure is originating from. The



Jessica Bejar, BSN, RN, PHN, PCCN started her nursing career on a Comprehensive Transplant Unit at Johns Hopkins. She has worked at UC San Diego Health's Thornton 2-West PCU for the last two years. She earned her Bachelor of Arts in Global Studies from UC Santa Barbara and her Bachelor of Science in Nursing from CSU San Marcos. Jessica loves to precept new nurses and is a Clinical Nurse III candidate, a Public Health Nurse, and a Progressive Care Certified Nurse. Jessica is also the Shared Governance Chair for Thornton 2-West and a member of the Nursing Research & EBP Council.

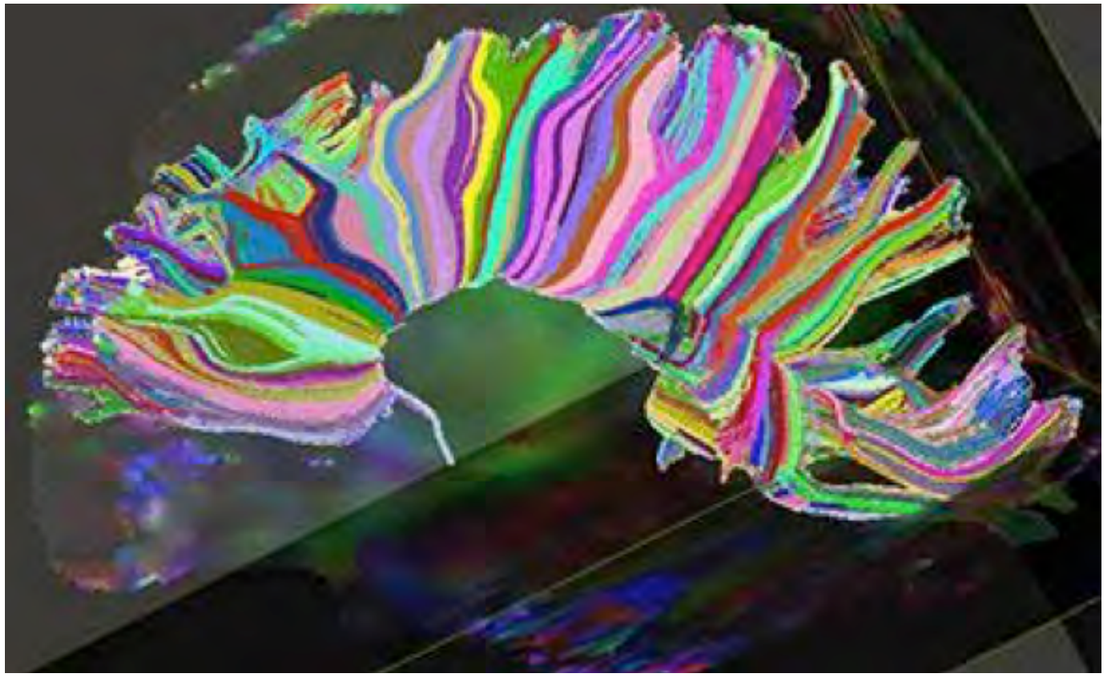


EEG brainwave tracing showing a temporal lobe seizure courtesy of UC San Diego Epilepsy Center website.

Jacqueline Gerwer, BSPH, BSN, RN is from San Diego and has watched UCSD grow into the hospital it is today. She has always wanted to be a part of the nursing profession and was excited to start the New Grad Nursing Program on July 2017 at UCSD Thornton 2-West PCU. Jacqueline enjoys taking care of the diverse population on UCSD Thornton 2-West PCU; especially the Seizure study and Cystic Fibrosis patients. Jacqueline received a Bachelor of Science in Public Health at the University of Arizona and earned her Bachelor of Science in Nursing at Azusa Pacific University. Jacqueline's future plans are to get her PCCN, precept new nurses, and eventually go back to school to get her MSN.

Anna Melendez, BSN, RN, PCCN is a Progressive Care Certified Nurse at Thornton 2-West. She has been with UC San Diego Health since 2007. Anna earned her Bachelor in Nursing from the University of Santo Tomas in Manila, Philippines and is currently pursuing her Masters in Nursing with specialization in Nursing Informatics. She is an active preceptor, resource, charge nurse, and serves as unit representative to Clinical Informatics Council, UCI/UCSD Shared Nursing Governance (SNuG) Council, Diabetes Initiative Group, and Preceptor Development Support Services (PDSS).

Katie Villarino BSN, RN, PCCN-CMC earned her Bachelor of Science in Nursing from San Diego State University in 2015. Katie started her journey at UC San Diego Health on Thornton 2-West PCU, and is now the Epilepsy Clinical Nurse Coordinator.



Advanced imaging at UC San Diego Epilepsy Center showing the corpus callosum beneath the cortex of the brain.

nursing assessment includes verifying orientation, sensation, memory, cognition, language capacity, identifying objects, and testing fine and gross motor skills. Additionally, nurses ensure safety equipment is at the bedside and that patients do not form blood clots by encouraging pedicycling and administering lovenox if indicated. Due to the risk of injury from seizure, EMU patients are considered a high fall risk and wear a safety belt when in bed or when sitting in a chair and they require a staff member present when transferring, ambulating, and toileting at all times. When a patient has a seizure, signs and symptoms are particular to the patient, but common changes include a change in heart rate, altered mental status, automatisms (repetitive movements), staring, convulsions, abdominal pain, unusual behavior, and odd sensations. When a seizure lasts for more than five minutes, it is associated with high morbidity and mortality. If a patient's seizures become too long, strong, or frequent, intravenous medication is given to treat seizures quickly to prevent status epilepticus.

IMAGING/TREATMENT/ CASE CONFERENCE

After a patient complete a Phase I study, a variety of imaging (e.g. MRI, PET, MEG), and a Neuropsychological Evaluation, the patient's case is presented for consideration at UC San Diego's Surgical Epilepsy Case Conference attended by EMU Epileptologists, Neurosurgeons including Sharona Ben-Haim, MD and David Barba, MD, Neuropsychologists including Amanda Gooding, PhD, Carrie McDonald, PhD, and Marc Norman, PhD, and Neuroradiologist, Roland Lee, MD. This discussion determines if the patient should trial more medications, whether surgical intervention is necessary, or further studies such as the Wada test to determine language and memory lateralization, or more detailed intracranial VEEG monitoring is needed in a Phase II study. The goal of surgical treatment is to cure or decrease the frequency of seizures and options include: Responsive Neurostimulator (RNS), Vagus Nerve Stimulator (VNS), MRI-guided Laser ablation, or Lobectomy depending on the type and origin of the patient's seizures. Other complementary therapies include a ketogenic diet and mind-body practices such as meditation and yoga.

PHASE II INTRACRANIAL MONITORING

Phase II intracranial monitoring involves invasive electrodes implanted in the brain of patients whose seizure origin was difficult to localize in the Phase I study. The electrodes are placed by neurosurgeons in or around the suspected areas of the brain as discussed at the patient's surgical case conference. These electrodes allow for seizures to be captured in "high definition" on the electroencephalogram, fine-tuning the identification of seizure origination. The choices for monitoring include Stereo-Electroencephalogram (sEEG), subdural grids, strips, and depth electrodes. sEEG monitors electrical activity from superficial to deep in the brain, as electrodes are threaded through a small hole in the skull. In contrast, subdural grids require a craniotomy and cover the surface of the brain with 16 to 64 electrode contacts. Strips contain 1 x 4 or up to 2 x 8 electrode contacts that can be placed on the brain's surface, or may be inserted through burr holes in the skull. Depth electrodes are usually inserted through burr holes and monitor deep brain structures such as the insula or hippocampus. At the end of the Phase II study, functional brain mapping may be performed to identify "eloquent" cortex or areas of the brain that if removed would result in neurological deficits. Brain mapping involves sending an electrical current through one of the electrodes while simultaneously testing the patient's response. For example, when mapping a patient's somatosensory cortex in the parietal lobe, the provider would brush the patient's face/arms/legs. If a loss of sensation is experienced, the patient should be counseled on potentially losing sensation in that area if a resection or ablation was performed there. It is imperative for the nurses to have emergency and safety equipment at the bedside because the likelihood of inducing a seizure is high.

After the Phase II study electrodes are implanted in the brain, patients spend the first 24 hours when they are most likely to experience complications in the Neuro ICU where they receive frequent neurological assessments. For the remainder of the one to two week seizure study, the patient is downgraded to IMU level of monitoring. Along with the same Phase I nursing safety considerations and equipment management, Phase II study patients require vital signs and neurological assessments every two hours due to the increased risk of injury and complications that come with invasive electrodes. The goal of the Phase II study is to localize the seizure origin point with a high degree of certainty to determine if the patient is a surgical candidate, and what treatment options the physician can offer the patient.

Common Seizure Seminology by Brain Origin	
Temporal Lobe	Feeling of fear, rising epigastric sensation, feeling of déjà vu
Frontal Lobe	Bicycling of legs, laughing or crying, wild movements of arms and legs
Parietal Lobe	Physical sensations of numbness or tingling, electricity, pressure, pain, vertigo
Occipital Lobe	Visual hallucinations

SUMMARY

UC San Diego Comprehensive Epilepsy Center is an essential service improving the lives of epilepsy patients who are often isolated and lack independence. UC San Diego's ability to perform PCU level neurodiagnostic monitoring increases the capacity to diagnose and medically and surgically treat patients at an advanced level. The EMU's multidisciplinary team is dedicated to working together to help these complex patients.

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PCU Nursing Considerations for CAR-T Therapy

By: Caoilfhionn Mulvey, BSN, RN, OCN

In 2018, the blood and marrow transplant (BMT) team at Jacobs Medical Center completed numerous innovative cellular therapy trials as well as UC San Diego's first commercial use of a Chimeric Antigen Receptor T-cell therapy (CAR-T). The patient received Yescarta, the second CAR-T cell therapy approved by the FDA. Despite a brief stay in the Intensive Care Unit (ICU), the patient tolerated the infusion and is currently doing well, continuing their follow-up appointments in the outpatient BMT clinic.

In order to provide CAR-T patients with excellent care, the BMT team has formed a multidisciplinary committee to streamline processes and identify specific challenges from this therapy. The committee's objectives include:

- Education of the Progressive Care Unit (PCU) and ICU nurse
- Planning for staffing considerations
- EPIC flow sheet documentation updates, including related grading scales
- Implementation of physician and pharmacy order sets

While it takes numerous members of the healthcare team to facilitate effective care for these patients, a key member of the care team is the PCU nurse. The patient receiving CAR-T requires a high level of skilled nursing care and surveillance, as they can decompensate rapidly and need to be transferred to the ICU. They can experience a rapid onset of toxicities following the infusion, the most common being cytokine release syndrome (CRS) and a neurological toxicity called cytokine release encephalopathy syndrome (CRES). CRS usually occurs within the first 1-14 days after the infusion. CRES can happen concurrently with CRS or onset can be delayed for weeks to months following, making it important for the patient and family to be aware of the signs and symptoms upon discharge (Locke et al., 2018).

The PCU nurse needs to be aware of early recognition of toxicity symptoms and notify the BMT attending physician for further interventions. Although nurses are knowledgeable of the grading scales for symptoms, the nurse does not officially grade the toxicity. Nursing documentation (see figure 1 below) is crucial to ensure that the physician grades the toxicity correctly so that interventions can be initiated rapidly. Additionally, nurses consider the patient's baseline neurological status into consideration. For example, a patient with a developmental delay or psychiatric history may display different neurological side effects than typically expected.

The Immune Effector Encephalopathy (ICE) assessment is a new and essential tool to help identify the unique neurological deficits that may not have been previously identified with a standard neurological exam. This assessment is completed every eight hours and as needed. A noteworthy part of the ICE assessment (see figure 2 below) is the handwritten portion, in which the nurse directs the patient to write a standard sentence; this exercise can diagnose dysgraphia, one of the first signs of neurotoxicity (McConville, 2018). Nurses need to be aware when to implement seizure and aspiration precautions and monitor patients for symptoms of increased intracranial pressure or cerebral edema. Ultimately, if a patient requires an ICU transfer, a designated PCU nurse continues to round on the patient to assess their condition, as they are the expert in providing this type of care. Collaboration between the PCU and ICU nurses is essential to provide patients with excellent care and promote health after the completion of CAR-T therapy.

Caoilfhionn Mulvey, BSN, RN, OCN is a registered nurse on the Blood and Marrow Transplant unit at Jacobs Medical Center. Caoilfhionn has been a nurse for 3 years, beginning her career in surgical oncology at Memorial Sloan Kettering Cancer Center in Manhattan. She earned her bachelor's degree at Pace University in New York and is currently a doctorate student at the University of San Diego. She is an active participant in the CAR T-cell AD HOC committee and a local board member of the Oncology Nursing Society as part of their student outreach program.

Vitals				
Temperature	97.4 (36.3)	97.6 (36.4)	97.1 (36.2)	98.1 (36.7)
Heart Rate	70	72	70	65
Respirations	18	18	18	18
Blood pressure (BP)	91/44 !	82/46 !	88/50 !	86/50
MAP (mmHg)	61	58	66	62
CRS Syndrome				
Temperature greater than or equal to 38C (100.4F)				
Systolic BP less than 90 mm Hg?				
Shortness of Breath				
SpO2	97	95	95	94
O2 Device	None (Room air)	None (Room air)	None (Room air)	None (Room air)
O2 Flow Rate (L/min)				
Urine				
BMT Service notified				
Immune Effector Encephalopathy (ICE) Assessment				
Orientation (total 4 points)				
Writing Test				
Able to name 3 objects?				
Following commands				
Able to count backwards from 100 by 10s?				
Total ICE Score				
Unable to Perform or in critical condition				
Neuro Symptom Assessment				
Somnolence				
Motor Weakness				
Dysphagia				
Seizure				
Incontinence				
Tremor				
Headache				

Figure 1. An Example of the EPIC flow sheet documentation expected of the PCU RN.

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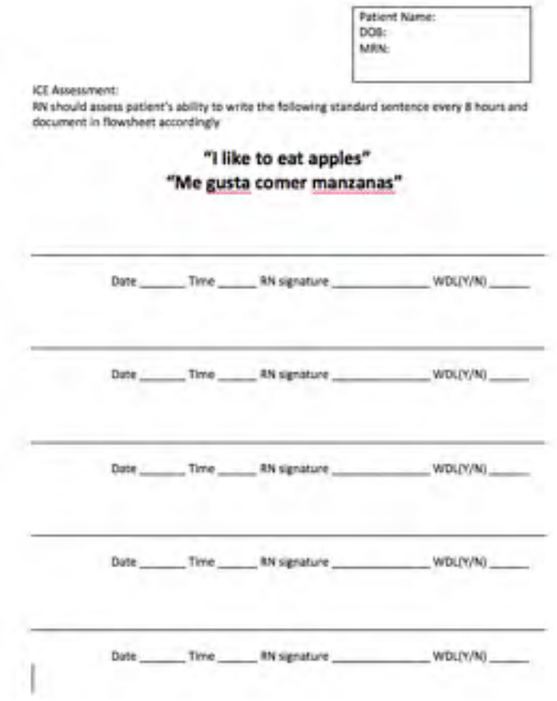


Figure 2. The handwriting portion of the ICE assessment.

FIT Rounds in the PCU

By: Karen Armenion, MSN RN CMSRN, Sarah Horman, MD, William Frederick, MD, Marianne Delos Santos, MSN RN

It's time to get FIT! Yes, it is! On our unit you will hear our clinical nurse leaders (CNL) say "It's time for FIT Rounds." This would be around 10:30 am on JMC 5F every weekday. We continue FIT Rounds on 5G at 11:20 am every weekday. FIT stands for Focused Interdisciplinary Team Rounds.

It's time to get FIT! Yes, it is! On our unit you will hear our clinical nurse leaders (CNL) say "It's time for FIT Rounds." This would be around 10:30 am on JMC 5F every weekday. We continue FIT Rounds on 5G at 11:20 am every weekday. FIT stands for Focused Interdisciplinary Team Rounds.

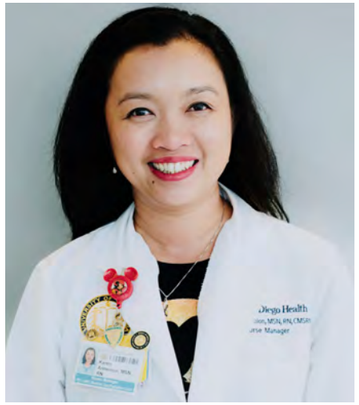
A coordinated interdisciplinary rounding is the ideal way to ensure patient safety through accurate, consistent and regular team communication (1). This is especially important in a progressive care environment where treatment interventions evolve with changes in the patient acuity. Interdisciplinary team rounds involve the various members of the healthcare team and preferably occur at the patient bedside with family present. This work-flow is an opportunity for patients and their families/caregivers to communicate simultaneously with the multiple disciplines involved in their care.

FIT rounding is a collaborative model developed by leaders in hospital medicine, nursing, pharmacy, care coordination and rehabilitation. The FIT "loop" (Figure 1) is a standardized framework of communication; each team member has a designated checklist to maximize exchange of useful information among disciplines. Highlights of this discussion and patient concerns are summarized and addressed at the end of the loop to enhance patient understanding and participation. The goal of FIT is to create a structure for bedside rounds to improve communication amongst team members, patient experience and operational efficiency.

Jacobs Medical Center 5FG was the pilot unit for FIT Rounds implementation. 5FG is a 24-bed medical oncology and palliative care unit with an average daily census of 23 patients. The unit caters to patients with oncology diagnoses and those with specialized palliative needs. The medical management of the patients is led by Hospital Medicine with Team 4 on 5F and Team 5 on 5G. Hospitalists assign patients to Team 4 and 5 based on location on 5F or 5G respectively; geographic cohorting of these patients maximizes the benefit of FIT for these units. Many oncology patients are high acuity with complicated medication regimens and lab monitoring schedules, planned procedures and various consultants at any given time. FIT promotes streamlined communication so that everybody—including the patient--understands the daily care plan and barriers for discharge.

The FIT rounding program is led Dr. Sarah Horman and Dr. William Frederick from Hospital Medicine. 5FG clinical nurse III Marianne Delos Santos is the project leader for the unit implementation. The teams met several times initially to create the structure for rounds and now have monthly working group meetings with leaders from each discipline. Staff nurses were coached daily in the initial pilot phase. We had mock rounds to practice the script that we created. Go live was July 5, 2017!

The charge nurses create the rounding schedule at the start of the shift. This schedule is given to the CNL and the rest of the team. Patients are rounded in an order that provides minimal disruption to nursing care. The CNL is the rounds coordinator on each pod, keeping rounds at a maximum of 4 minutes per patient. The attending physician leads the rounds in the room and provides each team member time to provide updates, including the patient/family. Patient encounter during rounds is maintained at an average of 4 minutes per patient. The nursing management team was available to coach during the initial phase and then 1-2x per week after the first 6 months of implementation. Monthly meetings occurred during the pilot phase to review best practices, re-organize scripts and streamline our process. The same structured process has been implemented in Thornton 2East/2West and will be rolled out to other units in Thornton including 3East. Outcomes on each of these FIT units are being monitored after 6 months and after 1 year of



Karen Armenion, MSN, RN, CMSRN
graduated with a BSN from Cebu Normal University in the Philippines in 1999. Since then, she has worked in several organizations as a registered nurse in the acute care setting. She joined UC San Diego Health in 2003 as a clinical nurse II in the HIV/Infectious Disease Unit (6 East). She pursued her Master's Degree in Nursing and graduated in 2009 from the University of Phoenix.
Karen has 13 years of administrative nursing leadership experience and 8 years as an acute care nurse manager. She has been successful in improving operations, work processes, nurse-sensitive outcomes and patient experience at the unit, divisional and organizational levels. She has been a mentor for nursing staff in their leadership and clinical advancement. She promotes transformational leadership in her daily interactions with staff and patients. She provided leadership in the opening of Jacobs Medical Center 5FG, the Medical Oncology and Palliative Care Unit. Karen received the Nurse Leader of the Year award for Empirical Outcomes in 2014 and 2018.

Dr. Sarah Horman is a hospitalist at UC San Diego Health.
She has helped lead the development and implementation of FIT rounds on JMC 5F and 5G as well as several other units (Thornton 2 East, 2 West, and 3 East and Hillcrest 6 West). As the chair of Patient Experience within the Division of Hospital Medicine, she is passionate about interdisciplinary collaboration to enhance communication amongst staff and patients.

William Frederick III, MD, PhD,
is a hospitalist in the Division of Hospital Medicine, Department of Internal Medicine at the University of California, San Diego. He teaches both residents and medical students and has worked on the project to implement Focused Interdisciplinary (FIT) Rounding since its inception.

Focused Interdisciplinary Team (FIT) Rounding

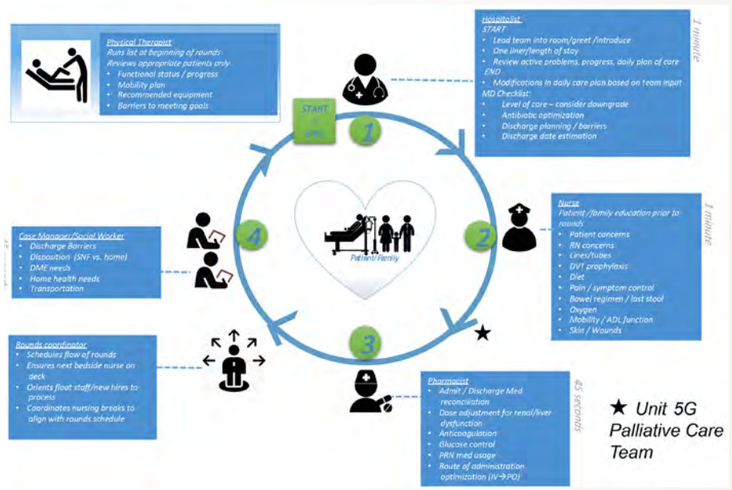


Figure 1. FIT Rounding Loop

HCAHPS Patient Survey Results (Top Box Percentile Rank, All Press Ganey)	Baseline 1/1/17 to 7/4/17	Implementation 7/5/17 to 2/28/18	6 Months Post Implementation 3/1/18 to 6/30/18
Likelihood to Recommend	90 (n=79)	98 (n=82)	91 (n=42)
Communication with Nurses	29 (n=81)	39 (n=82)	21 (n=43)
Communication with Doctors	8 (n=80)	39 (n=82)	76 (n=43)
Communication about Medicines	17 (n=51)	57 (n=200)	66 (n=91)
Discharge Information	74 (n=74)	86 (n=74)	78 (n=42)
Care Transitions	83 (n=80)	94 (n=82)	88 (n=43)

Table 1. JMC 5FG Patient Satisfaction Survey Results

implementation.

Table 1 shows the Press Ganey scores on JMC 5FG. Patient satisfaction outcomes overall improved on Likelihood to Recommend, MD Communication, Communication about Medicines, Discharge Information and Care Transitions from baseline. Communication with Nurses decreased from baseline. Factors that may have contributed to this are changes in nursing and other department personnel. Outcomes continue to be monitored to ensure the sustainability of FIT Rounds on the unit.

The impact of staff experience was assessed through pre and post intervention surveys. Comparison of staff surveys (using a 10-point Likert-type scale) pre and post implementation showed statistically significant improvement in mean scores (range 1-10) for communication among team members (6.29 vs. 7.29, $p<0.001$), satisfaction that concerns raised on FIT rounds were addressed in a timely manner (6.48 vs. 8.04, $p<0.001$), and understanding of daily care plans by all team members (7.21 vs. 8.07, $p<0.05$). Furthermore, improved estimates of discharge date by Care Managers (35% versus 51% pre and post FIT implementation respectively) indirectly reflected improvement in team communication.

FIT Rounds has been implemented for about 1.5 years on 5FG. It has been part of the unit routine and has shifted the milieu to a team-based culture. Our nurses look to FIT Rounds to clarify plans. It has been successful in integrating the healthcare team into a daily rounds process and has proved to be sustainable. Ongoing challenges we face include time limitations, fluctuations in census and cohorting, new hire onboarding and inconsistent staffing.

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Igniting Innovation

By: Melissa Callahan BSN, RN, OCN, Jessica Mathers MSN, RN, CNL, CCRN, Laura Vento MSN, RN, CNL

Monitoring quality improvement is a cornerstone of a nurse leader's role and responsibilities. While there is a substantial amount of time devoted to optimizing the quality of patient care and service, there is no standardized methodology with which to share what is being done with everyone in the department and system wide. With two assistant managers and one manager all working on issues simultaneously, we found a need to improve our own leadership process. In an effort to break the pattern of operating in silos, the leadership on Jacobs 4th floor reimagined quality improvement structures and in doing so has expedited innovation and optimized communication within the microsystem of operational activities.

Purpose Rounding Recognition and Improving System Efficiencies (PRRAISE) is the first standardized system, which promotes solution-oriented problem identification and peer recognition. On a weekly basis, the leadership team rounds for two hours on both night and day shift. During rounds, they ask the following questions:

1. What is working well?
2. Is there an individual, group or department that I can recognize for dong exceptional work?
3. Are there any systems that need improvement?
4. Do you have the tools and equipment you need to do your job?

Through the consistency of the questions presented and time dedicated to the process, team members have begun to anticipate PRRAISE rounds and formulate ideas prior to the formal rounds. Leadership facilitates innovation brought forth by bedside team members and maximizes communication, which accelerates

Channel guide for patients like SH has?	emailed Dawn (manager of SH) for a copy	
Supplies	Storehouse working on increasing bin size	
ostomy/IV cover resources for shower	clear plastic bags now stocked	
Clarifying med to bed proccess and communication with RN to avoid DC delays	left message with pharm to discuss process	presenting at Oct UBPC
when a sample sent to lab is invalid, they often cancel the order requiring RNs to page MD for another order	emailed lab to discuss process	emailed staff
Can we have additional Bedside commodes?	done and delievered!	
Can we have a storage of toilet paper when EVS can not be reached?	done! ! In equipment room by team elevators	
Can we have a book shelf for book club?	done!!	
Can we have stools for nutrition rooms?	done!!	
Patient tray process	Emailed nutrition to discuss rationale/ possible process change	emailed staff
Who is a direct admit vs admitted directly to pre op?	Emailed Uriel to meet at discuss	
Create a sign in break room to remind nurses to shred PPI	n/a	
Sign for Zan Dan when in use- thanks Kristina J!	n/a	
Request for more dry erase markers- order and received- they are stored in G Cove	n/a	

Melissa Callahan, BSN, RN, OCN was an Assistant Nurse Manager on the Surgical Oncology Progressive Care Unit at UC San Diego Health Jacobs Medical Center. She was recently promoted to Nurse Manager for the JMC 6th Floor BMT Unit. She earned her BSN and BA in Spanish at California State University San Marcos. She is currently enrolled in a MSN program at the University of Alabama with a concentration in nursing administration. She has been with UC San Diego Health since graduating with her BSN in 2012. Her experience ranges from bone marrow transplant, to surgical oncology. She is a member of the Association of California Nurses Leaders (ACNL), the National Collegiate Honor Society, Sigma Delta Pi, and is an oncology certified nurse (OCN).

Figure 1

Jessica Mathers, MSN, RN, CNL, CCRN is an Assistant Nurse Manager on the Surgical Oncology Progressive Care Unit at UC San Diego Health Jacobs Medical Center. She earned her BSN from Medical College of Georgia and her MSN from the University of Alabama. She has been a nurse for 16 years, joining UCSD in 2009. Prior to working at UC San Diego Health, she worked on a Coronary Care Intensive Care Unit as well as various medical intensive care units. Jessica has certification as a Clinical Nurse Leader (CNL) and in Critical Care Nursing (CCRN). She is a member of the American Association of Critical Care Nurses (AACN) and the Association of California Nurse Leaders (ACNL).

Laura Vento, MSN, RN, CNL is Nurse Manager of the Surgical Oncology Progressive Care Unit at UC San Diego Health Jacobs Medical Center. She earned her BS from James Madison University and her MSN from the University of Virginia. Prior to working at UC San Diego Health, she served as a Peace Corps rural health extension volunteer in East Timor. Laura has been at UC San Diego Health since graduating with her MSN in 2008. She began her career on the HIV/Infectious Disease unit, and is also experienced in Abdominal Transplant and Surgical Oncology patient populations. Laura was the recipient of the 2011 Nurse of the Year and the 2013 Nurse Leader of the Year. Laura has certification as a Clinical Nurse Leader (CNL) and is a member of the Association of California Nurse Leaders (ACNL).

the rate at which solutions are identified. Furthermore, the quantity of issues presented has decreased significantly over the course of implementation. Once a process issue is recognized by staff and communicated to leadership, it is added to a color-coded spreadsheet (green=done, yellow= in progress, and red= cannot complete at this time), (see figure 1), and emailed weekly with status updates to all staff. In evaluation of the spreadsheet, improvements that were a product of the PRRAISE process, and thus led by team members, are highlighted.

The PRRAISE process has directly increased staff satisfaction and communication. It has produced an accountability structure for leadership and as a result increased transparency. It provides insight for staff as they witness the multiple steps necessary to fix a process issue and gives staff real time updates. For example, if an opportunity for improvement or clarification is identified within an ancillary department, the leadership team contacts the leadership of that department to review and discuss next steps. Historically, this communication would occur without staff knowledge or input in the process. Furthermore, staff generally had limited access to the exact status or actions of leadership without inquiring directly. Due to PRRAISE, staff can access updates on the shared database in real time. Over the course of nine months, 22 issues have been identified and solved through this process. Additionally, the integration of this model has led to an increase in interdisciplinary collaboration as many departments have presented at the unit based practice council meeting.

The second structure introduced to the microsystem was the Idea Team Collaborative. After completing Kim Scott's Radical Candor within a summer leadership book club, Jacobs 4th floor implemented a process inspired by their reading that supported innovation led by bedside team members. Scott discusses her structure within the text in which ideas are critically evaluated:

"The ideas team had to commit to listening to any idea that anyone brought to them, to explain clearly why they rejected the ideas they rejected, and help people implement ideas that the ideas team deemed worthwhile" Radical Candor

The Ideas Team methodology was born from the notion that those at the frontline are the most capable of identifying inefficient processes and thus have the greatest ability to make meaningful change. While the PRRAISE process catalogs daily operational system issues and aims to correct these identified deficits quickly, the Idea Team standardizes the quality improvement process on a larger scale and develops projects over time. This collaborative now serves as the platform for all project development and implementation under the oversight of Jacobs 4th Floor's Unit Based Practice Council. Every member of the collaborative is encouraged to critically think and appraise idea proposals. The collaborative considers the project objective in terms of whether it is applicable now, later, or perhaps never and if it will yield outcomes that are in alignment with the professional practice model and Magnet. The collaborative does not merely say "yes" to every proposal.

The structure of the collaborative is conducive to stimulating constructive feedback and purposeful discussion. The process for a team member with a project idea is as follows:

- Idea is emailed to leadership team
- Leadership teams responds via email with attached PowerPoint template for presentation to the Ideas Team and schedules date for presentation
- All project proposal presentations occur within the first hour of the two hour meeting
- Implementation plan developed and objective statement honed collaboratively directly after team decides if proposal is approved
- Monthly check in and update of implementation plan from all team leaders of ongoing projects
- Process supported by weekly "Office Hours". Leadership team devotes 1.5 hours to mentoring, answering questions, and identifying next steps for in-progress projects.

ANCC Category	Percent of Work Units above the National Average	National Nursing Excellence July 2018 Average	National Nursing Excellence July 2018 NURSE MANAGER Average	2018 UCSD Overall RN Average (1213)	Nurse Manager Score (166)	JACOBS MEDICAL CENTER 4-PCU - 250304 - Laura Vento (61)
Adequacy of Resources & Staffing	41.67%	3.51	3.91	3.21	3.81	3.99
Autonomy	66.67%	3.92	4.38	3.76	4.38	4.13
Fundamentals of Quality Nursing Care	58.33%	4.14	4.47	3.96	4.39	4.30
Interprofessional Relationships	58.33%	3.82	4.01	3.69	4.01	3.89
Leadership Access and Responsiveness	66.67%	3.90	4.32	3.73	4.28	4.39
Professional Development	66.67%	3.99	4.26	3.80	4.05	4.18
RN to RN Teamwork and Collaboration	66.67%	4.27	4.51	4.11	4.39	4.52
Percent of work units with three or more categories above Natl Benchmark	91.67%	Number of Categories Above Natl Benchmark			0.00	7.00
Engagement Score						4.4
Tier						1
Action Plan Readiness						95

Figure 2

The outcomes associated with the implementation of the collaborative have been an expedited clinical advancement of three nurses to Clinical Nurse III, an elevation in peer oversight and comprehension of evidence based practice and research, and a significant improvement in manager time efficiency. Additionally, bedside team members are able to refine their public speaking skills and their ability to speak directly to quality outcomes. Those with active projects are encouraged to bundle their identified needs to discuss during Office Hours or during the meeting time. Ongoing tracking of project status is simple with up to date implementation plans housed in a shared database.

Effective communication, standardization of processes, facilitating and expediting innovation, and peer oversight are the core foundation of both PRRAISE, the Ideas Team Collaborative. Nurses are able to identify process improvement opportunities, classify them appropriately, and succinctly identify solutions. Additionally, tier 1 staff satisfaction was achieved on Jacobs 4th floor, outperforming benchmark (see Figure 2). The paradigm has slowly shifted and now, frontline staff are empowered to lead innovation with the support of leadership.

Case Study:
The Ethics of Law Enforcement in the PCU Setting

By: Danisha Jenkins MSN, RN, CCRN, NEA-BC, Dr. Judy E. Davidson DNP, RN, FCCM, FAAN, Dr. Lynette C. Cederquist, MD

CASE STUDY

A middle-aged man presented to the emergency department with a gunshot wound to the face. He underwent a significant facial reconstruction surgery. During his recovery, a police officer came to the unit and notified nursing staff that the patient was a felon. The officer stated that the police department did not have the funds to keep the patient in custody while the patient was hospitalized, but that nursing staff were obligated to notify the police department when the patient was discharged, to facilitate his arrest. The nurse directed the officer to the hospital's security department, but the officer continued to come to the unit and call the unit repeatedly. According to hospital policy, no patient information was released to the officer.

During numerous encounters, the police officer informed nursing staff that the patient was "very dangerous" and that not providing updates on the patient's condition was "interfering with law enforcement." Given the extent of his wounds and medical needs, safe discharge directly to an incarcerated status could not be coordinated. Medical staff attempted to coordinate discharge to home with family for extended antibiotic therapy, care of the oral mucosal wall graft, and continued adjustment of the jaw wires. As the patient neared discharge, police officers arrived on the unit and proceeded to arrest the patient. Medical staff reiterated that the patient was not cleared to discharge to a custody setting. The officer removed the patient from the ward and took him to the emergency department, presumably for medical clearance. The patient was not seen again.

On reviewing the case with the privacy office, it was ascertained that the hospital did not have a clear process to address this situation. It was suggested by the privacy office that, because reported lack of funding prohibits law enforcement from placing inpatients in custody, it should be the nurses' responsibility to notify law enforcement of impending discharges to facilitate arrests. Those involved felt that to expect nurses to participate in the guarding and reporting of alleged criminals for the purpose of arrest upon discharge constituted an ethical dilemma. The lack of structured guidance and expectations of nurses' interactions and collaboration with law enforcement complicated the issue. Because the patient had continued healthcare needs and the team did not have the opportunity to ensure that the receiving providers were prepared for his needs, there was a potential patient safety issue. Clinician safety and the safety of the other patients on the ward were also concerns. Those involved felt that the tension between obligations to care nonjudgmentally versus acting as agents of the law conflicted with the established nursing code of ethics.[1]

Danisha Jenkins MSN, RN, CCRN, NEA-BC is the Nurse Manager for the 5W Trauma PCU at UC San Diego Health, Hillcrest. Danisha is also a PhD student at UCI, and is passionate about advocacy for nurses and their care of vulnerable populations.

ETHICS ANALYSIS

BACKGROUND

Caring for accused and convicted criminals is an inherent duty in trauma care. While law enforcement and custodial institutions operate with rigid and clear guidelines, their normal operations become convoluted in the inpatient healthcare setting. Because of law enforcement budget cuts, patients who previously had an officer posted at the bedside are now arrested upon discharge. The goals of law enforcement and those of nurses in this situation are at odds. There is an inherent dissonance between the culture of custody in prison versus the culture of caring in healthcare. Moral and ethical dilemmas can be expected when seemingly incompatible cultures such as these coexist.2 Further, it may be construed that, because imprisonment is an act of punishment, there is an intention of deliberate harm in being imprisoned, whereas the intention of healthcare is to optimize wellbeing and prevent harm. In the worldview of healthcare clinicians, liberty is a positive construct and optimal health includes freedom from physical and existential pain. These juxtaposed intentions function in ethical opposition to each other and are likely to produce dilemmas where the intentions collide.[3]

Where law enforcement officers see a criminal, nurses see a patient, and the nurse's duty remains unchanged. When asking a nurse to mentally and emotionally act on a patient's alleged crimes, care can be affected. Disclosing details of the potential prisoner-patient's alleged crimes presents an opportunity for clinicians to make judgments regarding the case, thereby transforming these clinicians into an arm of the law. In turn, caregivers can become directly involved in the process of punishment.[3] On the contrary, nurses are educated and expected by their own code of ethics to eliminate biases to optimize development of a respectful, caring, nurse-patient relationship, which in itself is part of the healing process.[1,4]

A community assessment was conducted, which found that other local hospitals experienced similar situations and had the same difficulties in devising an effective, safe, and ethical means to handle the requirements of law enforcement. Attempting to solve the problem through the security department and privacy office alone were ineffective. It was not until the ethics team was consulted and all parties subsequently met together that a solution was reached.

The ethics team was consulted to assess the organizational ethics of this one case, under the assumption that the situation would occur again in the future. While the process of a formalized policy was underway, it was determined that the ethics committee, nursing division, privacy office, and security department would come together to create a process that would remove the primary nurse from responsibility for calling for the arrest of patients. In this unique situation, both the law and ethics needed to be considered equally.

It was ultimately determined that all law enforcement inquiries would be directed to the security department, and strict adherence to HIPAA and state and federal information release guidelines would be followed. In situations in which it was confirmed that an in-hospital arrest would be likely, it was determined through the creation of an algorithm that an emergency huddle with unit leadership, the security department, and the clinician would take place to determine the interventions necessary to maintain the safety of all involved. It was agreed that the security department, privacy office, and ethics team would be available and would participate as appropriate. Patients would not be arrested in a multi-bed ward. The arrest would need to be timed so that the discharge plan could include communication with the receiving healthcare team before transfer, to ensure patient safety.

Establishing therapeutic and trusting relationships is at the core of ethical practice. Health centers are safe havens in which all patients have the right to receive unbiased care. Clinicians must continue to assess for and advocate against impeding societal and structural forces that could negatively impact their ability to provide holistic care.

Judy E. Davidson DNP RN FCCM FAAN serves University of California San Diego Health as a nurse scientist supporting nurses with project development, presentation and publication. She holds an appointment as a Research Scientist in the UCSD School of Medicine, Department of Psychiatry. Dr. Davidson is also an editor of the Journal of Nursing Management.

Lynette Cederquist, M.D is a Clinical Professor of Medicine at UCSD in the Division of General Internal Medicine and is the Director of Clinical Ethics for UC San Diego Health. She is Board Certified in Hospice and Palliative Medicine. Dr. Cederquist's clinical practice is focused on chronic pain management within Internal Medicine. As Director of Clinical Ethics, she runs the Ethics consult service, the aid-in-dying program, and chairs the hospital Ethics Committee. In addition, she teaches in the medical school's Primary Care Course, and is Director of the Internal Medicine Chronic Pain elective.

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PROGRESSIVE CARE CERTIFIED NURSES

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Cortney Marsh, BSN, RN, PCCN
Daniel McCarthy, MSN, RN, PCCN, SCRN
Monica Rivera, BSN, RN, PCCN
Erick Russell, BSN, RN, PCCN

PRESENTATIONS

Hillcrest 5-West

Nicole Tronco, MSN, RN, PCCN
Standing up to falls in the trauma PCU: an introduction to a fall prevention bundle.

Poster presentation, CalNOC, San Diego, October 21, 2018.

Stephanie Chmielewski, BSN, RN, PCCN
Reducing restraints and delirium in traumatically injured patients.

Poster presentation, CalNOC, San Diego, October 21, 2018.

Hillcrest 7

Jiraporn Rouyasen, BSN, MAS, RN, CCRN, CMC
Increasing the emotion of feeling cared for in the workplace.

Poster presentation, Magnet ANCC, Denver, CO, October 2018.

Thornton 2-West

Helen Lobo, BSN, RN, PCCN; Jessica Bejar, BSN, RN, PCCN
Preventing CAUTI and CLABSI through peer review.

Poster presentation, ACNL Conference, San Diego, CA, March 23, 2019.

Jacobs Medical Center 4 FGH

Laura Vento, MSN, RN, CNL and Melissa Callahan, BSN, RN, OCN
A transformational tool to develop bedside leaders.

Poster presentation, ACNL 41st Annual Conference, Pasadena, CA, February 5, 2019.

Poster presentation, 11th Annual UC San Diego Health Nursing Inquiry and Innovations Conference, San Diego, CA, May 31, 2018.

Melissa Callahan, BSN, RN, OCN
Understanding the altered airway: a collaborative approach to laryngectomy education.

Poster presentation, 11th Annual UC San Diego Health Nursing Inquiry and Innovations Conference, San Diego, CA, May 31, 2018.

Roxana Hazin, MSN, RN, CNL
Crushin' CLABSI: CNL impact on central line quality of care.

Poster presentation, ACNL 41st Annual Conference, Pasadena, CA, February 5, 2019.

Poster presentation, 11th Annual UC San Diego Health Nursing Inquiry and Innovations Conference, San Diego, CA, May 31, 2018.

Natalie Hoshimiya, MSN, RN, PCCN
Improving the discharge experience for post-cystectomy patients with bladder cancer.

Poster presentation, 11th Annual UC San Diego Health Nursing Inquiry and Innovations Conference, San Diego, CA, May 31, 2018.

Jacobs Medical Center 5 FG

Marianne Delos Santos, MSN, RN
Fit rounds.

Poster presentation, ACNL Innovations Conference, San Diego, CA, March 23, 2018.

Jacobs Medical Center 5H

Mia Douglass, BSN, RN, CHPN; Abigail Edilloran BSN, RN, CHPN, SCRN; Dawn Carroll, BSN, RN, MS; Patricia Graham, MS, RN, CCRN, SCRN; Dr. Navez Karanjia, MD
Weekly debriefs improve process issues, increase staff engagement, and promote interdisciplinary relationships in the neuro ICU/ PCU

Poster presentation, ACNL Conference, San Diego, CA, March 23, 2018.

Abigail Edilloran, BSN, RN, CHPN, SCRN
Improving Communication with Structured Family Care Conferences

Podium presentation, 11th Annual UC San Diego Health Nursing Inquiry and Innovations Conference, San Diego, CA, May 31, 2018.

Poster presentation, ACNL Innovations Conference, San Diego, CA, March 23, 2018.

Jacobs Medical Center 6 BMT

Andrea Bogardus, BSN, RN, CHPN
Workplace bliss.

Podium presentation, ACNL Innovations Conference, San Diego, CA, March 23, 2018.

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