MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Innovate, Involve, Inspire

UC SAN DIEGO SHARED GOVERNANCE

Nurses making decisions about clinical practice standards, quality improvement, professional development, and nursing research

Shared Governance Nursing Cabinet

UC San Diego
SCHOOL OF MEDICINE

## Five Magnet Componets

Transformational Leadership

Structural Empowerment

Exemplary Professional Practice

New Knowledge and Innovation

Empirical Outcomes

Shared Governance committee membership is a great way to become personally involved in the Magnet journey and to help shape the future of nursing at UCSD. For more information go to our nursing website at http:// medinfo.ucsd. edu/nursing/ committees/ to learn about committee membership opportunities.
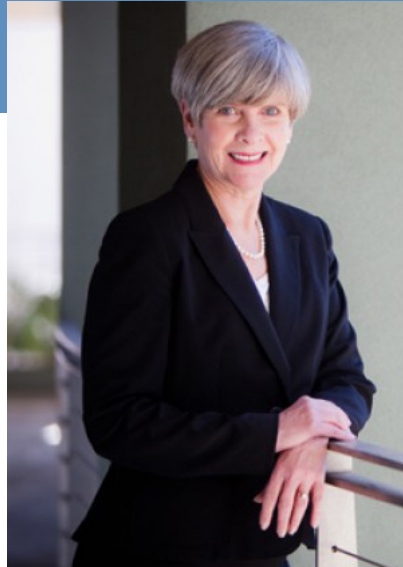
Welcome to our 10th edition of the UC San Diego Health System Journal of Nursing! The spotlight of this issue is our Shared Governance Councils. Shared governance (SG) is a model of shared decision-making that gives staff nurses autonomy over their practice. In ANCC Magnet Recognition Program® facilities across the country, staff nurses have indicated participation in shared governance as the most important aspect of their work.

In this journal, you will learn how Hospital wide Councils and Unit Based Councils have evolved since Shared Governance was initiated resulting in many positive outcomes. The following articles will share some of these outcomes. You will learn how our shared governance structure has evolved to include a Nursing Cabinet; the coordinating council.

Readers will discover how ICU reduced CRRT errors by 17% and helped the UC San Diego Health System to achieve our Comprehensive Stroke Center Certification; 11PCU reduced patient falls by 25%; PACU helped increase their patient satisfaction scores; Thornton ICU developed a trigger list to assist with Palliative care; and 5 West PCU developed better bedside hand off and communication which increased their patient satisfaction scores and made the patients feel more informed by their nurses.

Hospital wide councils such as the Patient Education Council helped increase patient awareness and education by introducing Emmi videos. The Nursing Research and Evidence Based Practice Council hosted their 5th annual Nursing conference where over 100 nurses attended. Our APC (Advanced Practice Council) held their 3rd annual Nursing conference during National Nurses Week and covered information regarding Healthcare Trends and how healthcare will be affected with healthcare reform changes. The Image Council, a Shared Governance Council, along with their subcommittee Future of Nursing, put together another fabulous Nurses Week celebration! Our nurses enjoyed a combination of gourmet food truck events, the APC Symposium, Bannister House Fiesta, Nursing Movie Night and the new MAGNET focused Nursing Excellence Awards. I am pleased to share our 4 Nurse of the Year winners:

Overall Clinical Nurse of the Year: Dahlia Tayag, MSN, RN, CCRN,

Overall Advanced Practice Nurse of the Year: Patricia Graham, MSN, RN, CCRN, CNS, Overall Nurse Consultant of the Year: Cheryl Cross, MSN, RN, PHN,

Overall Nurse Leader of the Year: Laura Vento, MSN, RN, CNL

The hospital has created an environment that supports nurses making decisions about clinical practice standards, quality improvement, professional development and nursing research.

This can only be accomplished with the support and participation of all the departments and employees in the hospital that place patient care first and foremost in the mission of their daily work. I encourage each of you to find a council that speaks to you and join!

Sincerely,

MARGARITA BAGGETT, MSN, RN
CHIEF CLINICAL OFFICER

UC San Diego
HEALTH SYSTEM

FALL 2013

Inside

Evolution of Nursing
Shared Governance

By Karen Jones, MS, RN

In January of 2007, with the purpose of creating a shared governance structure for nursing at UC San Diego Medical Center, a group of representatives from nursing staff and leadership from all areas within the medical center convened. Driven by their desire to create an environment of empowerment for nurses, that initial meeting provided the foundation and structure for what was to become our shared governance model, a model that embodies shared leadership and participative decision making; not just in theory, but in practice. Initially, nine Shared Governance Councils were formed. Seven were made up of direct-care nurses from throughout the organization and two councils were composed of nurse leaders.

Below is a list of each council and a description of their mission as defined at the onset of shared governance:

Clinical Practice

Guides clinical practice that values and empowers UCSD nurses by ensuring staff involvement in evidence-based practice, patient and family- centered care, and nursing autonomy.

Magnet Champions

Educates employees about shared governance and the Magnet Components and its impact on nursing and the partners of the healthcare delivery system

Professional Development

Provides guidance and resources to support nurses working autonomously and within a multi-disciplinary team to promote professional development

Quality

Provides leadership to positively influence patient outcomes by setting the agenda for quality improvement, and analyzing and communicating evidence-based practice results

Advanced Practice

Strives to improve the health of patients and their families through interdisciplinary participation in clinical, education, research and administrative activities using evidence-based practices; supports the professional growth and development of the members of the Advanced Practice Council and nursing staff at UCSD; and provides consultation, leadership, and resources for the broader healthcare community.

Image of Nursing

Communicates the value of UCSD nurses both internally and externally

Research and Evidence-Based Practice (EBP)

Supports the Department of Nursing by providing education, evidence-based practice literature reviews, and mentorship for publication, presentations, and evidence-based nursing projects or nursing research.

Management Oversight

Aligns with the Components of Magnet by promoting innovative practices, streamlining processes, developing initiatives, and identifying resources that assist managers to achieve desirable outcomes

Nurse Executive (NEC)

Representing nursing in all areas, NEC guides the practice of nursing to achieve the highest levels of quality care delivery, patient and staff satisfaction, while meeting organizational strategic initiatives. Serves as the endorsing body in support of recommendations made by the other shared governance councils

This shared governance structure

Karen Jones, MS, RN has been with UCSD for 28 years. She most recently was the Director of Nursing for the Emergency Departments at both facilities and the Critical Care Units at Hillcrest. She is currently working part time in the Quality Department and assisting the Magnet Coordinator with Magnet preparations. She is the facilitator for the Nursing Cabinet and Clinical Practice Council.

enabled direct-care nurses from all settings and roles to participate in decision-making committees, councils, and task forces that affected their practice. On average, 10-15 members participated in each council. All council members are voting members and tasked with representing all nurses and communicating information with their peers in their units. Chairs of each Council were chosen and generally served for 2 years. A member from the Nurse Executive Council (NEC) served as a facilitator for each council to assist direct care nurses with system and process issues. Organizational shared governance councils met minimally

once a month at regularly scheduled times. Council chairs reported out on the activities of their councils on the first Friday of each month to each other and to NEC. The NEC provided guidance, helped remove any barriers that existed, approved resources needed, listened to suggestions for implementation, and helped the councils to disseminate information to all nurses in the organization.

As the organizational councils were evolving, each unit was charged to begin developing or re-structuring existing unit based councils into a unit based shared governance model led by direct care nurses. These councils were established by nursing staff on each unit and provided a means of decision making at the unit level that directly affected the staff and patients in their area. When these issues had a broader impact, the recommendations were forwarded to the appropriate Shared Governance Council for further collaboration, action, and dissemination as needed. Otherwise, the unit-based councils functioned autonomously to serve their specific patient populations and the needs of their staff. There was no formal reporting mechanism for the unit-based councils which was later considered to be a weak link in the shared governance process. Unit-based councils met regularly as deemed necessary (minimally once/month), on a scheduled, but individualized basis in order to meet their unit-specific goals.

The visual model for the UC San Diego Shared Governance Model was created and is depicted below.

When imagined in three dimensions, the model has a foundation in the Research Council and depicts our belief that evidence-based practice and research are paramount to our nursing practice. The model, based on the original 14 Forces of Magnetism, was designed to illustrate communication of information and decision that goes between all levels and in both directions. This process supports shared leadership and participative decision-making that promotes nursing autonomy.

In addition to the ongoing monthly meetings, the Nursing Executive Council, all nurse managers, Shared Governance Council chairs, nurse educators, and clinical specialists were meeting annually for a day-away retreat to review and revise the nursing Strategic/Quality Plan and to ensure that it is in alignment with the Organization's Strategic/Quality Plan. This plan guided the work of the Councils during the upcoming year.

Shared governance seemed to be working well, but during Magnet preparation, it became apparent that the surface had only been scratched. Many direct care nurses were unaware of shared governance and the strides that had been made. It became clear to the leadership team that there were significant communication gaps. This was discussed at our next nursing retreat and it was suggested that we have a shared governance coordinating council to help facilitate communication among all staff.

As a result, the Nursing Cabinet emerged, new structures were put into place to enhance communication at all levels and the shared governance processes became more consistent across all councils. The Nursing Cabinet was kicked off in March 2012 and includes the chair of each unit council and organizational council, and the Directors of Quality and Education.

Nursing leadership spent many hours educating the cabinet on meeting processes, with the understanding that they would incorporate these elements into running their shared governance councils. Bylaws were developed, co-chairs and a recorder were elected, and roles of all the councils were further developed and disseminated. Image Council and Magnet champions were combined and two new councils were added: Patient Education and Patient and Family-Centered Care.

To improve communication among all staff, each month councils report out on their activities and members are expected to share the information with their colleagues. The cabinet members find this a useful exercise because many ideas have emerged that have been adopted across units. A shared governance iShare a (web-based shared document library) was developed and is actively used for communication with the Cabinet members.

The cabinet is in its infancy but the members are engaged and excited to have a voice. They are currently working on the nursing strategic plan and will work with their units to implement tactics to meet the goals. Since the implementation of the shared governance model, UC San Diego Medical Center's direct-care nurses have developed a strong voice for change.

They are actively involved at all levels with policy changes, quality initiatives and self-governance on their units.

Building on the momentum of the past several years, UCSD nurses are poised to lead the way to a healthcare model that guarantees an environment that supports nursing autonomy, nursing excellence and unsurpassed quality in patient care.

UC San Diego Shared Governance Model

Reflections on the Voice of Nursing

By Manuel Brasely, BSN, RN , PHN, CCRN

The nursing voice is the heart of a magnet institution. It is from our experiences that we learn and grow into professional nurses. I always wondered what it would be like to take what I have learned from my nursing experience and share it with other nurses; not like a teacher with a student but a peer to peer relationship that would improve our practice. Unlike those casual conversations I have had with other nurses about the direction of care with one of my patients at 2am, I wanted to make an impact that reaches throughout our organization. About a year ago that idea started to become a reality with the formation of the UC San Diego Health System Nursing Shared Governance Cabinet.

The nursing cabinet is a structured nursing committee that helps improve information sharing, gathering and support from our bedside nurses to our executive leaders. During one of those first few meetings, I asked how I could help with this cabinet. I first started attending as a representative for the SCVC ICU UBPC. It was new and exciting, a bit scary and an unfamiliar direction for our organization – we had never brought together all our units to meet monthly and have this kind of authority to make changes and vote on new nursing practices. This was a great opportunity to participate in helping with the new makeup of our organizational structure. When the call came for co-chairs to lead the cabinet, I knew I would wonder what the heck I was thinking… But I did it. I volunteered to be a co-chair of the Nursing Cabinet.
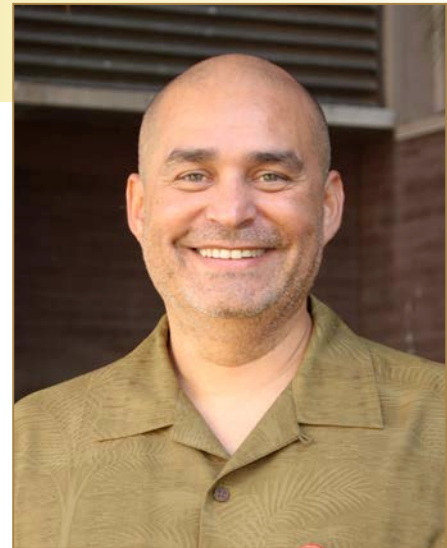
Our structure is simple.

Representatives of our nursing units shared governance chairs or co-chairs will sit on this cabinet, as well as the chair or co-chair of the hospital nursing councils, including the Nursing Executive Committee. Every unit in nursing that has a shared governance unit-based council is represented at this meeting. Every month, designated unit councils or hospital councils provide an update of what their group is doing projects, activities and any significant changes that are being made to our practice. While this may sound unexciting, what has come out of this practice is the sharing of ideas, practices and an exchange of how things are getting done on other units and specialty areas in the hospitals. I feel as though I understand our hospital so much better now, and feel proud to know that our units have all done excellent work in advancing nursing practice and improving patient care.

If you asked me what I have brought to this group and why I chose to participate and help lead in a direction we have never gone before, my answer is simple. I bring no more skills than the next person who attends these meetings. I believe that as we change the way we do things we will transform our culture from "that's the way it has always been" to "This is the best practice." I sincerely believe that.

There are still many things I would like to help or participate in to make changes or improve our practice.

However, what I have learned in my journey over the last year as the co-chair of the Nursing Cabinet is just because we venture in a new direction to make change doesn't mean change will happen but if we promote and participate in change we will be heard. And that creates the change in how we do things. Whether you are an ICU nurse, a PCU nurse, a Med-Surg. Nurse or an administrator, the Nursing Cabinet provides you an avenue to be heard; gives you an opportunity to share information; and promotes a way to transform into a culture supportive of nursing practice and leadership.

This new nursing organizational structure promotes communication, participation, collaboration and ultimately improves patient care and outcomes. Over the last year the challenges I have had in helping run the nursing cabinet have only been silenced by the greatness of the people who participate in the cabinet meetings.

There are many of you out there who want to be heard and make change. I know this because I work alongside you and I have met you at these and other meetings. For the coming year I challenge you to step forward, be heard and in the process, make change.

Manuel R Brasley, BSN, RN, PHN, CCRN

Staff RN, CVC ICU, 2 years
RN for 10 Years.

ADN from San Diego City College
BSN from University of Phoenix
Sharp Healthcare - 8 years
UCSD Burn Unit - Burn Tech - 4 years

Patient and Family Centered Care (PFCC) Council

By Patty Graham MS, RN, CCRN, CNS

Patient and Family Centered Care (PFCC) as a concept is difficult to disagree with. Who could possibly say no to it? It seems to rank right up there with Mom, apple pie and lemonade. When incorporating PFCC concepts into clinical practice, however, opportunities for clinical growth become apparent. With this in mind, the PFCC Council was originally created as a multi-disciplinary sub-group of the Clinical Practice Council. Most recently, it has become its own Council and the newest addition to our shared governance structure. This article will outline the core concepts of PFCC; review key literature on the topic; and present the primary mission, vision and objectives of our PFCC council.

Patient and family-centered care is " an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families" (Institute for Family-Centered Care). Though this approach to healthcare is well supported by organizations within healthcare such as the Agency for Healthcare Research and Quality (AHRQ), the Joint Commission (TJC), the American Hospital Association (AHA), the American Association of Critical Care Nurses (AACN), the Society of Critical Care Medicine (SCCM) and many more, it has been difficult to implement. Over the last 25 years there have been a number of key nursing research studies that support this concept. Jacono et al. (1990) examined the perceived needs of family members by both families and staff.

This was the first time in the literature that both sides were viewed at the same time. A key concept in the study was the lack of collaboration between nurses and family members, with families perceiving they were being talked at instead of having something discussed with them. Another study (Ward, 2005) found that in many cases providers used language that was too complex or technical for families/patients to understand. In 1999, Hupcey completed a landmark study which specifically examined the relationship and interaction between families and nurses and the impact this had on family involvement in the ICU. The main themes identified in this study were, "How nurses maintained control, how families remain on guard, endure and find their niche in the ICU" (Hupcey, 1999, p. 253). These themes are constant through the current research today.

Leaders in healthcare have established guidelines for supporting families in the ICU and given us methods to increase the interaction of patients/families with the healthcare team (Davidson, et. al, 2007; Saunders, et. al, 2006).

Therefore, in accordance with the literature and our Professional Practice Model, the vision of the PFCC Council is to inspire, engage and partner with patients, families and healthcare colleagues to transform the care at UC San Diego Health System to realize our model of care centered on patients and families. The mission of this multi-disciplinary council is to educate, inform and empower patients, families, staff and providers to embrace the principles and values of patient and family centered care. A few of our objectives include:
• Enable PFCC education for all levels of healthcare providers and ensure the voice of the patient and family is heard

Patty Graham MS, RN, CCRN, CNS is the recipient of the National AACN Excellence in Education Award, the UCSD Healthcare Marguerite Jackson Award for Professional Nursing Excellence and the SD AACN Mentorship Award. As a practicing ICU CNS, Patty is actively involved in the clinical environment as well as in the APC, PFCC Nursing Council, Code Blue, Critical Care & PFCC Steering Committee. She has published numerous articles and presented at regional, national, and international conferences. Patty is passionate about integrating evidence into clinical practice at the unit as well as at the system-wide level.

All About Me Poster

throughout the healthcare organization
• Assess the extent to which the concepts and principles of PFCC are currently implemented
• Collaborate with patients, families and all UCSD staff and faculty to develop an action plan to establish priorities for implementing PFCC concepts and strategies into the organization's mission, philosophy and definition of quality
• Enable processes to ensure that healthcare providers can reliably meet the needs and preferences of patients including fully informed, shared decision making
• Recommend, revise or create policies, procedures, processes and forms to support PFCC

Our council meets on the 4th Wednesday of every month from 1400-1600 in the EDR classroom. We consist of an enthusiastic, multi-disciplinary group of: nurses from throughout UCSD Healthcare; a social worker; a physical therapist; a case manager; an interpreter; representatives from the Patient Experience Office & from Bannister House; and a way-finding and signage specialist. This diverse group provides a wonderful forum for addressing obstacles as well as opportunities for better partnership with patients and families. Some examples of these opportunities include patient and family involvement in handoff, and use of the All About Me posters. These posters are available on the Forms website in English (D 2036) and Spanish (D2036F) and serve as a tool to facilitate learning about and communicating with our patients. If your inpatient unit is not yet utilizing these All About Me posters, please let us know so we can facilitate the process & education for you.

The PFCC Council has also created a framework to ensure the first person voice of the patient and family is heard. Initially this was accomplished via feedback from patient focus groups led by council members. These groups provided feedback from stroke patients regarding care and pre-discharge education received; and from a broader group on the topic of signage, way-finding, and the frequency with which people get lost . The signage topic was initiated by a patient. In July a group of eleven patients and family members will join our Council as full-fledged members and advisors. We look forward to their involvement and to all that we can learn from them. Amy Yates, the previous co-chair and a true leader for PFCC at UCSD, will be moving to Arizona this month. Her enthusiasm, intelligence and passion will be sorely missed, but all that she has contributed will continue to flourish. Sarah Moore, a 10ICU staff RN, has been nominated to take on Amy's role as co-chair for the council.

For more information on the topic go to: www.familycenteredcare.org.

Family Participation in Hand Off

Journey to Transformational Leadership

By Jan Hebert, MSN, RNC, NE-BC

In 2007, a shared governance structure was launched as a beginning step toward Magnet designation that was ultimately achieved in December, 2011. As part of the shared governance structure, the Leadership Oversight Council was established to empower nurse leaders to make decisions over operational and leadership issues. Transformational leadership was the leadership style selected to help integrate and enculturate shared governance throughout the organization.

Transformational Leadership is a set of leadership behaviors that transforms others by involving them in decision-making, and therefore outcomes (quality, safety, service, efficiency, healthy work environment) of the organization.

The Vision of the Council is to: Shape the future of healthcare through excellence in nursing leadership.

The Mission of this council is to use transformational leadership to:
• Promote efficiency, quality, and service
• Enhance networking of nursing leaders throughout the organization
• Provide peer leadership support
• Lead operational change
• Develop others

The council embarked on an organizational approach to implementing transformational leadership through a formal training program for managers. The Leadership Oversight Council led the selection of an evidence-based model, the Conceptual Model for Developing and Sustaining Leadership from the Registered Nurse Association of Ontario, as the Transformational Leadership model for the framework for the transformational leadership program.

Workforce engagement metrics were defined and have been utilized to measure effectiveness of the training program and engagement of the staff lead by the managers annually. Implementation of training strategies to enhance internalization and implementation of transformational leadership behaviors were designed and chosen by nurse managers. Resources were approved by the Nurse Executive Council. A consultant was selected to develop and provide the training, as well as assist with ongoing support and peer review. A total of 38 nurse managers enrolled in the training program structured around this conceptual model of transformational leadership behaviors.

The educational program included mentoring by organizational directors and leaders both individually and in small groups of 4. Mentors received an orientation session and attended periodic mentor meetings to discuss their experiences with the consultant.

Each manager was asked to implement a performance improvement project that addressed the patient experience and utilized strategies they were learning to engage their staff. The final meeting of the training was a day away with each manager presenting their projects and outcomes with lessons learned.

There has been an ongoing evaluation of the integration of these transformational leadership behaviors in the nursing units under the supervision of the managers trained and their successors through the tracking of staff engagement metrics annually over the last 4 years. We set out to measure a baseline for our nursing leadership against a benchmark for

Jan Hebert, MS, RN, CCRN, CNS, nurse manager for the ISCC, has been a nurse for 33 years. She has been at UC San Diego Medical Center for 24 years, all 24 in the Infant Special Care Unit. She has spent the last 14 years in management.

MLQ Leadership Metrics

UCSD Nurse Leaders 2009
UCSD Nurse Leaders 2012
Universal Database

* = Research Validated Benchmark

Patient Satisfaction

Definitely Yes, Likelihood to Recommend Hospital
Overall Nursing
Nurses explained things in a way you can understand
Staff did everthing they could to help with pain

Staff Engagement

Overall Commitment to Organization
Commitment to Manager
I am involved in decisions that affect my work
Absenteeism (All Employees)
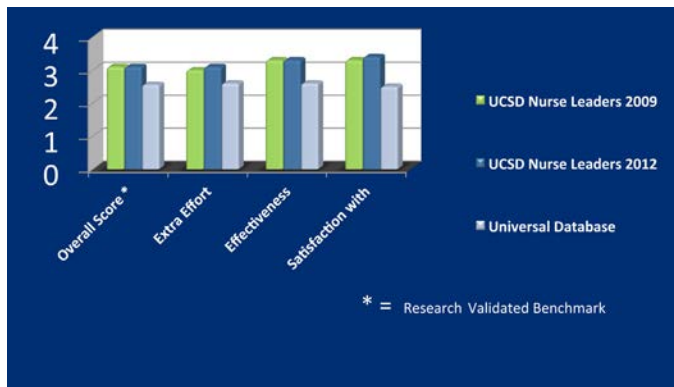
transformational leadership behaviors. We chose the Multifactor Leadership Questionnaire (MLQ), a valid and reliable instrument, to assess an initial group of 38 mid-level nurse managers. The MLQ measures transformational leadership behaviors across five categories: Idealized attributes, idealized behaviors, inspirational motivation, intellectual stimulation, and individual consideration. The behaviors are ranked on a Likert 0 to 4 scale of frequency observed or practiced from "not at all" to "frequently if not always observed". Managers were rated by their supervisor, peers, self and direct reports. Our baseline overall score was 3.1 with a comparative benchmark between 3.0 to 3.75, meaning we rated in the average range of other organizations, but toward the lower end. Our goal ultimately is to exceed the benchmark

so we set out to improve our scores.

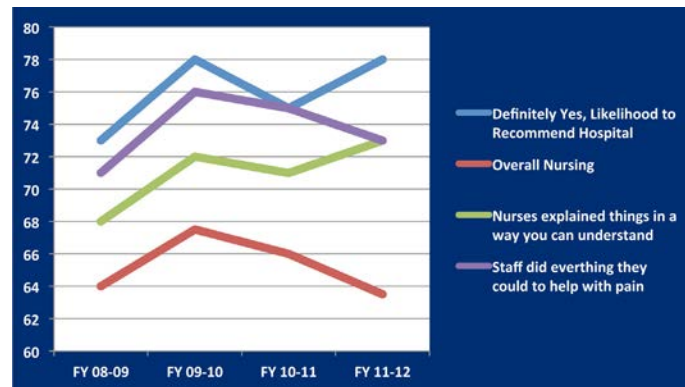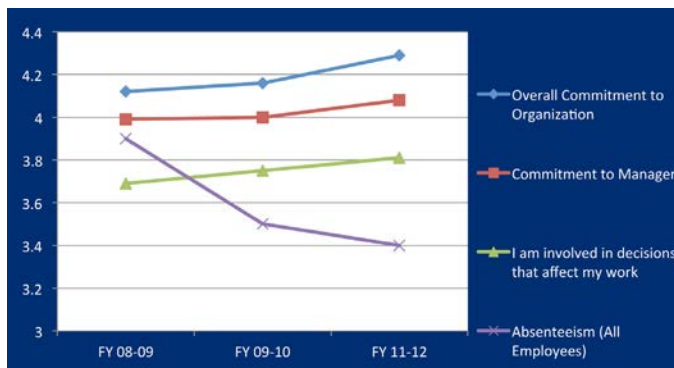The organization improved targeted workforce metrics reflecting transformational leadership as measured by: the Multifactor Leadership Questionnaire (2,3), the number of nurses actively engaged in committees both in their units and organization-wide, the number of nurses qualifying for clinical ladder advancement, increasing certification rates, increasing retention rates, increasing patient satisfaction scores, increasing nursing fill rates, decreasing absenteeism, increasing education leave, and increasing employee satisfaction.

Subsequently, it was decided in FY 12-13 to start to track nurse manager promotions and turnover rates. Overall data results show either holding gains or modest improvements in staff engagement, patient satisfaction, and

MLQ leadership ratings of TL factors. Peer support and networking was cited as most important to the managers as a result of this program. Further development of non-nursing leaders was suggested as well as development of a succession planning program.

As a result of feedback, the Leadership Oversight Council has chosen to focus on specific transformational target behaviors as a next step to promote sustainability. We will be using peer teaching and having our own nurse leaders discuss their experience with implementing transformational leadership strategies. We have changed the structure of leadership meetings to allow for more time to collaborate on topics of interest with peers and nurse leaders in the education and research department.

Supporting relationship building among leaders is a key goal to this strategy.

Empowering nurse managers to design their own programs to promote and measure transformational leadership in the organization has been an effective means of achieving desired workforce outcomes and supporting the Magnet Designation process.

Who Are We?

By Linda Soaft, MSN, NP, CCTC

The Advanced Practice Council (APC) was established in 2006 to give the staff an opportunity to focus on professional autonomy, establish interprofessional collaboration and enhance communication within the multidisciplinary team to provide safe patient care and optimize patient outcomes. The APC was also part of the magnet journey to implement shared decision making about clinical practice. The APC meets monthly and communicates electronically about issues and projects as needed. The APC also provides a supportive milieu for professionals in advanced practice roles to discuss clinical needs and advanced practice issues (Quigley 1991).

The APC is composed of 2 co-chairs and consists of members with Master's or doctorate degrees from various practice settings and represents the interests of all advanced practitioners within UCSD Health System: **certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, nurse educators, nurse practitioners, doctors of nursing practice, physician assistants and other healthcare professionals with advanced degrees employed by the healthcare system. The CNO is also a member.**

DEFINITIONS OF ROLES:

Advanced Practice Nurses are R.N.s with graduate (post-baccalaureate) academic preparation and advanced clinical skills qualifying them as experts in a defined area of knowledge and practice. Graduate academic preparation in nursing is at the master's and doctoral level. Advanced practice roles include:

Nurse Practitioner (NP) – NPs specialize in the primary health care needs of individuals and families. They are skilled health care providers who perform many of the tasks traditionally done by physicians and can conduct complete medical exams, diagnose and treat common acute illnesses and injuries, administer immunizations, manage chronic problems like high blood pressure and diabetes, order lab services and X-rays, prescribe drugs and counsel patients. The NP works in collaboration with physicians and as an independent member of the health care team, working in hospitals, clinics, HMOs, private offices, nursing homes, etc. (American Academy of NPs – www.aanp.org)

Clinical Nurse Specialist (CNS) – CNSs have advanced clinical expertise in a particular specialty (e.g., oncology, cardiovascular nursing, etc.), providing expert patient care or facilitating clinical research to improve patient outcomes. In addition to clinical practice or research, responsibilities may include education and consultation. They provide leadership to other nurses in hospital, ambulatory or home care settings. (National Association of CNS - http://www.nacns.org)

Certified Nurse Midwife (CNM) – CNMs specialize in the practice of obstetrical and gynecological care of relatively healthy women. They practice in hospitals and medical clinics, and may also deliver in birthing centers and at home. CNMs provide care to women from puberty through menopause and may work closely with an obstetrician, who provides consultation and assistance to patients who develop complications.

Linda Soaft, MSN, NP, CCTC, began her career at UCSD as a Case Manager for UCSD Managed Care Department in 1999. She enjoyed working in outpatient case management and in quality assurance but subsequently moved to inpatient case management at the Medical Center.

Graduating from USD Linda became Board Certified as an Adult Nurse Practitioner and was hired by the Liver Transplant team after graduation as a pre-liver transplant coordinator. She achieved her Clinical Coordinator Transplant Certification in transplant the following year. Linda has co-chaired the Advanced Practice Council for the last 2 years and has chaired the subcommittee for the Advance Practice Spring Symposium held during Nurses Week.

(American College of Nurse-Midwives - http://www.midwife.org/)

Certified Registered Nurse Anesthetist (CRNA) – CRNAs are specially trained to administer anesthesia. They work as licensed independent practitioners or require some degree of supervision from the operating physician or surgeon, depending on state law. (American Association of Nurse Anesthetists - http://www.aana.com)

Nurse Administrators/Educators are RNs with master's or doctoral-level academic preparation and advanced clinical skills enabling them to work in hospital administration, nursing policy, research or in nursing education.

Physician Assistants: The physician

assistant came about in the 1960s as a response to the need for more clinicians (there was a shortage of family physicians) and better access to health care. The first PA program was developed by Dr. Eugene Stead, chairman of the Department of Medicine at Duke University, to train PAs for rural areas with dwindling numbers of physicians and nurses. Today the term "physician assistant" has a more precise definition as it applies to a practitioner who is able to practice medicine under the auspices of a licensed physician. Although the physician need not be present during the time the PA performs his or her duties, there must be a method of contact between the supervising physician and the PA at all times. The PA must be competent in the duties he or she is performing and the physician for whom the PA is working must also be licensed and trained to perform the relevant duties. – http://www.medterms.com)

Mission Statement of the APC

• Strive to improve the health of patients and their families through interdisciplinary participation in clinical, educational, research and administrative activities using evidence based practices.
• Support the professional growth and development of the members of the APC and nursing staff at UCSD.
• Provide consultation, leadership and resources for the broader health community.

Function of the APC

The council functions as an integrated team. Members of the APC provide expert care across the organization, publish book chapters, abstracts, practice guidelines and articles annually beyond the walls of our organization, and act as mentors and resources for other healthcare professionals. They consult with patients, family and the interdisciplinary team in the management of burns, palliative care, congestive heart failure, stroke, newborn services and serve as an expert resource for the nursing staff in oncology, cardiology, critical care, trauma, high risk obstetrics, reproductive medicine, orthopedic injuries, pulmonary, pediatric neurological development, lactation, interventional radiology, maternal child, hepatology, liver transplant and clinical research.

Leaders

The members of the APC are proactive on legislative issues that affect patient access to care, such as, healthcare reform. Healthcare reform has set the stage for advanced practitioners to help bridge the healthcare gap in access to care. To help achieve this goal, and to underscore the need for healthcare reform and professional development, the APC has coordinated educational opportunities on contemporary topics for several years now. This year the APC presented "Healthcare Trends: the impact on 2013 and beyond", to the clinical staff during Nurses Week.

This was the 3rd annual symposium in which we have addressed the healthcare reform, advanced nursing education and the importance of advanced practice members to be able to practice to the highest level of their profession and continue collaboration with all staff members. NP's and physicians have worked together since the 1960s. Working together, physicians and NPs have had a positive affect on the health system and the role of collaboration continues to exist between NP and physicians. However, barriers do exist and the physician's lack of knowledge on NP scope of practice sometimes makes it difficult for them to give an NP complete freedom to practice. In spite of the American Medical Association's resistance and opposition, APNs, other health care professionals and consumers will continue to introduce and support bills in state legislatures and in Congress eliminating any and all forms of required physician collaboration or supervision over an APN. The APC as a group are united in supporting the expanded role for NPs which will result in improved access to safe quality care and lower costs. Most recently Senator Ed Hernandez, who chairs the Senate Health Committee, introduced SB 491 to amend the scope of practice to allow and authorize a nurse practitioner to practice autonomously without a standardized procedure or in consultation with a physician or surgeon and would bring California in line with 17 other states that have adopted full practice authority for nurse practitioners. The bill was approved by the Senate Appropriations Committee and then introduced to the full Senate, and was passed on May 28. The bill will proceed to the Assembly for review.

Our members act as mentors and resources for the nursing staff and other healthcare professionals. We also promote advanced practice by reviewing Medical Center Policies and bylaws in order to remove restrictive language that affects or is a barrier to our scope of practice. We are full partners as professionals in the healthcare system strategic redesign and welcome the opportunity to work as a team and lead the way to improve our quality of care and for a seamless healthcare delivery system.

Each one of us has a different story about how we reached our goals either through the traditional educational path or by working in the field and having to balance a professional career and pursue higher education at the same time. Please enjoy the following insightful and moving stories from the perspective of two Advanced Practice Nurses at different stages in their careers and what keeps them in the profession:

Sharing the Experience of Becoming A Nurse Midwife and Nurse Practitioner

by Rebecca C. Garrett-Brown, CNM

Rebecca C. Garrett-Brown, CNM has been in San Diego since graduating from Georgetown University's School of Nursing in 1986 and a CNM (Certified Nurse-Midwife) since 1991, after completing her Master's in Nursing at UCSF (University of San Francisco). She has worked in the home birth setting for 2 years, NMCSD (Naval Medical Center, San Diego) for 20 years and has been back at UCSD Medical Center since October of 2011. She has delivered over 2000 babies and loves taking care of pregnant women and their babies.

I am a Certified Nurse Midwife (CNM). I grew up in Philadelphia and my great aunt was an Obstetrician. She delivered over 4,000 babies and was a role model for me. The first woman doctor; "Elizabeth Blackwell" was my great, great grandmother's cousin and my uncle was a large animal veterinarian, so I come from a long line of medical personnel! When I was 14 years old, a good friend of ours had her baby at Booth Maternity Center in Philadelphia, which was a very successful and popular out-of- hospital birthing center, run by CNMs. I got to see our friend and her newborn baby shortly after delivery and I just thought it was amazing.

I decided that I wanted to become a CNM and applied for early decision to Georgetown University's School of Nursing and was accepted in 1982. My OB instructor was a CNM, so I was able to ask her a lot of questions about the profession. I was lucky enough after graduating to only have to work 3 months in Med/Surg before I could work in the brand new maternity center at Paradise Valley Hospital (PVH) in National City, CA. PVH was a Seventh Day Adventist Hospital and like Georgetown, which was a Catholic Hospital, I liked the philosophy about family centered maternity care. PVH had an ABC (Alternative Birth Center) room that was low tech. After being at PVH for 2 years, I was able to work Per Deim at UCSD Medical Center (in 1988), where they had a huge community based CNM program called the Comprehensive Perinatal Program

(CPP). The RN who oriented me to L&D at UCSD is still here after all these years, which I think speaks volumes about what a wonderful place UCSD is.

After working at UCSD for a year, I applied to UCSF's School of Nursing for Graduate School and was accepted in 1989. At that time, you could spend your 1st year in San Francisco and your 2nd year in San Diego, which was perfect for me. The UCSD CNM Program was moved over to Naval Medical Center, San Diego (NMCSD) in 1998 and so when I graduated in 1991, they asked me to stay on as a Staff CNM and I said "Yes!" Many of the women I cared for came from other countries and I thoroughly enjoyed learning about different cultures and how these women went through labor and delivery. For example, Japanese women are usually very stoic and you have to be prepared that they could deliver without much noise at all. On the other hand, Hispanic women are very vocal and expressive during their labors and births. I even took care of a West Indian woman once who had come from the same little village in Antigua called "Potter's Village" that I had spent 3 years living in as a child, when my mother moved to the British West Indies!

I ended up spending 20 years at NMCSD and attending over 2000 births. When my contract was up, I applied to UCSD to come back as a CNM and I have been back at UCSD since 2011. We do about 1/3rd of the births at UCSD and have the only in-hospital birthing center, west of the Rockies! We have a very low cesarean

section rate, about 15%, which is well below the national average of 32%.

We have less than a 1% episiotomy rate and the highest breastfeeding initiation rate in the nation.

I truly love what I do and I feel so blessed that I have always known what I wanted to be "when I grew up". Nurse midwifery is definitely a calling and I have the honor and privilege of taking care of women during one of the most intimate, transformative and powerful experiences of their lives, it never ceases to amaze me!

CNMs take care of women throughout the life cycle and can

Trauma Nurse Practitioner

by Gabreila Riviello, NP, MSN

provide routine Gynecological care, such as routine pap smears and birth control management. CNMs can fit diaphragms and place IUD's (Intrauterine devices). In many states, CNMs have prescriptive authority and can write prescriptions for medications, including birth control pills. CNMs practice under their state's Nursing Practice Act laws.

Most CNMs work one to two eight hour clinic shifts per week. These visits include new OB visits, routine prenatal care visits, dating ultrasounds, postpartum care visits and Gyn visits. CNMs also work one 12 to 24 hour shift per week at a birthing center or hospital. When you are "on call" taking care of a laboring woman, the CNM evaluates the patient for admission, manages her labor, does the delivery and performs the postpartum exam and discharge. Most CNMs view birth as a normal, natural process and we only intervene if we have to. We are there to support the laboring woman by offering encouragement and recommendations.

CNMs also work closely with doulas. A doula is a non-medically trained woman, who is there to support the laboring woman and her family until the birth happens. Doulas have been shown to decrease the need for anesthesia in labor (ie: an epidural), as well as the need for a cesarean birth. UCSD has a wonderful doula program called; "Hearts and Hands" that offers a laboring woman, free of charge, doula support in labor.

Spring, 1995

My last semester at Vanderbilt University, I am about to complete the Bridge Program at the School of Nursing – a direct entry program leading to the MSN as an Acute Care Nurse Practitioner. I am to write a paper on my ideal job post graduation. The title I choose: Trauma Nurse Practitioner.

January 2004

I am about to begin my first NP job: Trauma Nurse Practitioner at UCSD. After graduating from nursing school in August 1995, I took an ICU RN job in South Carolina and soon thereafter moved to San Diego. I began working in the SICU and trained as a Trauma Resuscitation nurse. I found I loved working with trauma patients. At the end of 2003, the restrictions on medical residents' work hours created new positions for Nurse Practitioners in the acute care setting. One of those was in the trauma department. I was given the opportunity to become the first Trauma NP at UCSD. It was an interesting, and challenging, first 2 years. I spent the majority of my time developing the role and educating physicians, nurses, ancillary staff, and myself on the role of the NP and the laws of the state of California. After two years, two more positions were created and I and my colleagues continued to expand the role. As Trauma NPs and PAs we manage all trauma patients admitted to UCSD in Hillcrest outside of the SICU. We round, write progress notes, create and execute the plan of care for the day. We work closely with physicians, the nursing staff, social work, case management, pharmacy, and physical, occupational and speech therapists on our patient's care. We plan the discharges and write the orders and discharge summaries. We also independently manage the outpatients in the NP/PA-run Trauma Clinic. A large part of our role is in

Gabreila Riviello, NP, MSN

BS in Cybernetics from UCLA, 1991

MSN in Acute Care Nurse Practitioner from Vanderbilt University, 1995

Started at UCSD in the SICU in 1997 Became a Trauma Nurse Practitioner in 2004.

Member of Advanced Practice Council

education. We develop and provide education to NP students, medical students, interns, and residents, as well as to the patients and their families. We serve as resources for hospital staff in the care of trauma patients. Nine years after starting my first, and only, NP position, I look back at that paper and am amazed at the thought process of a young and inexperienced student nurse. The title and some of the future responsibilities are there. Some are naïve and far-fetched. But the desire to care for trauma patients and develop and expand the role of the NP in this field remains.

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Helping Nurses Climb the Ladder of Success

By Dahlia Tayag, MSN, RN, CCRN

Professional Development Council (PDC) is comprised of clinical nurses, nurse educators, and a facilitator from the leadership team. They meet every fourth Monday of the month, from 8am to 10am, in the Administrative Conference Room (ACR), Hillcrest. The initiatives of the PDC ensure achievement of goals as identified in the bylaws:
• To foster professional development and accountability of nursing staff along the continuum
• To retain high quality nursing staff within the organization
• To elevate the level of professional nursing through ongoing education, skills and evidence-based collaborative practice
• To enhance staff satisfaction and improve patient care outcomes

These goals are consistent with the organization's mission to take exceptional care of people through values of Quality, Caring, Integrity, Creativity and Teamwork.

As a Magnet designated institution, UC San Diego Health System emphasizes professional engagement and shared governance. As a result, the Professional Development Council (PDC) was created to facilitate nursing professional development, encourage involvement of nursing staff in the clinical and operational processes, and provide opportunities for clinical and professional advancement. The PDC is committed to providing clinical nurses the opportunity for career advancement through a clinical ladder reclassification process. The council has developed guidelines and processes to support the nurses towards this achievement and for those that meet the promotional criteria. Project and professional portfolio development processes are designed to move the nurse toward a higher level of professional development through learning and leadership.

To make the experience less daunting, CNIII Reclassification Workshops are provided to educate nurses towards project outcomes achievement. CNII to CNIII Reclassification Criteria and Maintenance Criteria were developed through the shared governance process in order to help the nurses on their journey up the ladder of success while remaining in direct patient care roles! The PDC reviews all portfolios and recommends advancement up the clinical ladder based on the pre-established criteria.

The clinical ladder is designed to celebrate nurses who achieve clinical excellence, improve staff satisfaction, increase staff retention, and reduce cost (Drenkard & Swartwout, 2005). Utilizing mentorship, interdisciplinary collaboration, peer review, evidence-based practice, quality improvement, and research; UC San Diego Health System nurses demonstrate exemplary professional practice while continuously striving to provide the best and safest care to the patients, their families, and to the communities they serve. The clinical ladder advancement process recognizes and rewards these achievements at the highest level.

New ideas and suggestions are always welcomed to improve the processes of clinical advancement to better serve the UC San Diego Health System nurses!

Dahlia Tayag, MSN, RN, CCRN
Critical Care RN with over 20 years experience, Clinical Nurse III, PACU Hillcrest. Chair, Professional Development Council, Co Chair Unit Based Council, Member of Competency Committee and Nursing Cabinet Council, CNA - Unit Representative, Professional Practice Council member (Region 2 Southern California Commissioner, National Nurses United Joint Nursing Practice Commission)

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Front, L-R: Norvie Gobaton, Andrea Toledo, Kristi n Davidson, Mary Hackim, Dahlia Tayag, Nelissa Reyes, Rachelle Compton, Eleanor, Yushiyaki, Linda Lobaestal,
Back: L-R: Ardale Pamintuan, Laura Peluso, Manny Brasely
Not in the photo: Wendy Lester, Anna Manulis, Emily Graver, Sheryll Allder, Jocelyn Angel, Julieta Torres

The Voice of UCSD Nurses

By Lori Johnson MSN, RN, OCN

The centerpiece of UC San Diego Health System nursing shared governance model is the Clinical Practice Council. While each council makes a unique and essential contribution to nursing excellence, the Clinical Practice Council combines these elements together to ensure that UC San Diego nurses deliver evidence-based, patient and family-centered care in an environment that empowers nurses to drive change in practice at the point of care.

Why Have a Clinical Practice Council?

Historically, decisions that impact nursing practice have been made by people in high level positions without recent clinical experience, and those decisions have trickled down to the front line care providers who had no voice, no seat at the table. There is an old adage that says, "If you're not at the table, then you're on the menu." Having a shared governance structure and the Clinical Practice Council (CPC) takes direct patient care nurses off the menu and gives us a seat at the table.

The mission of the CPC is to guide clinical practice that values and empowers UCSD nurses by ensuring evidence-based practice, patient and family-centered care, and nursing autonomy. The purpose of the CPC is to promote and provide collaboration and shared decision making across the organization in matters related to nursing practice, patient care, and patient outcomes. The CPC fulfills its mission and purpose through reviewing proposals for changes in practice and consulting on interdisciplinary issues that impact patient care.

Bringing Our Philosophy to Life!

One of the first orders of business for the CPC was to draft the UCSD Nursing Philosophy. This turned out to be a several month long process that started in November of 2007, with the final version unveiled during the Nurse Week awards ceremony in May of 2008. A small task force penned the first draft, which was sent to all staff nurses via e-mail with a call to action. The task force envisioned staff nurses from all over the UCSD system responding with input and edits. The result was four replies…clearly another tactic was needed.

The second strategy involved large versions (2 ft. x 3 ft.) of the document posted on nursing units with a marker attached and a request for nurses to read and mark changes directly on the document. We also asked CPC representatives to present the draft at staff meetings. This approach hit the mark! Nurses crossed out phrases and wrote in new ones; they added concepts, and generally made clear the collective philosophy of our UCSD nursing community. They also suggested changing the format of the document.

The final step was taken during 2009 Nurse Week. Two different formats of the same document were printed on large poster board, and nurses were asked to vote on their preferred format at the Nurse Week breakfast. The result is the UCSD Nursing Philosophy as it

Lori Johnson MSN, RN, OCN, has been the Clinical Nurse Educator for Moores UCSD Cancer Center since 2009. Ms. Johnson joined UCSD as a nurse's aide in 1996. She then earned her Bachelor of Science in Nursing from San Diego State University in 1998, and her Master of Science in Nursing Education from Walden University in 2012. She has been involved in the UCSD Magnet journey since January 2007 when she took on the role of Chair for the Clinical Practice Council. Ms. Johnson handed off the Chair position in December of 2009, and then returned as Chair in June of 2001 for another two-year term. She is a member of the Oncology Nursing Society (ONS) and the American Holistic Nurses Association (AHNA). Her professional interests include psychosocial care of patients and families, holistic nursing, and integrative healthcare.

stands today. It is the shared expression of what nursing means to us as a community. You can find the UCSD Nursing Philosophy on the UCSD Nursing web site. You may also notice it posted at almost every elevator.

UCSD Professional Practice Model for Nursing Practice

The second major outcome of the Clinical Practice Council (CPC) was the formation of our Professional Practice Model for nursing practice. Again, a task force laid the groundwork by searching the literature and examining various practice models and nursing theories to find one that matched our newly established Nursing Philosophy. This model outlines the principles that guide nursing practice at UCSD at every level from the direct patient care nurse to the unit nursing manager to the Chief Nursing Officer. No matter what your position this model provides the foundation for your work.

Every UCSD nurse should be familiar with the starfish logo by now. You may have seen it during new employee orientation, on nurses' badges, on posters throughout our facilities. So what is it all about? Sure, each arm of the starfish has a blurb next to it depicting the five elements of the model- Professional Values; Compensation for Professional Achievement; Management Approach; Patient Care Delivery Systems and Outcomes; and Professional Relationships- but how do these things relate to our work from day to day? And what about Patient and Family-Centered Care that is at the center of the starfish? Let's look at these elements in terms of how we can recognize each of them in our day-to-day practice.

Professional Values

Our professional values are based on the four tenets of professional nursing: 1) patient advocacy; 2) lifelong learning; 3) shared decision making; and 4) peer review. In addition to these principles, the American Nurses' Association (ANA) Scope and Standards, along with the California Nurse Practice Act, provide the foundation for our practice.

Patient advocacy is arguably the most important thing we do as nurses. When we contact a physician requesting orders to improve pain management we are advocating on an individual level.

When nurses bring a proposal to the Clinical Practice Council they are advocating for a practice change that will benefit our patients and families.

Compensation for Professional Achievement

Are you a Clinical Nurse II (CN-II) interested in being promoted to CN-III? Do you hold a certification in your chosen specialty? If so, you know firsthand that UCSD recognizes and rewards your achievements. Every nurse at UCSD has the opportunity to advance through the system based on professional achievements. By working to grow professionally you make a contribution to nursing excellence. In return the UCSD clinical ladder, along with certification pay, provide compensation for your achievement.

Management Approach

In the years before UCSD adopted nursing shared governance we all followed the rules that were laid down by management. With our shared governance and Professional Practice Model nurses at all levels of the organization gained a voice and we are all now able to share in decision-making. Through shared decision-making we have a management approach that is horizontal [more equal partnerships], not vertical [orders handed down].

Patient Care Deliver Systems and Outcomes

The best way to see how this element of the Professional Practice Model comes to life is to read the articles in this journal on unit-based councils. There you will find how different units are exemplifying patient care delivery systems and outcomes at the point of care. A patient care delivery system may be a team approach or involve primary nursing, or may be a combination of strategies to ensure excellence in patient care. The delivery system in your area is simply a description of how you operate. The outcomes can be found in our nursing dashboard. Outstanding skin care that results in reducing pressure injuries to a rare occurrence is just one example. What other examples do you see in your area?

Professional Relationships

Last but not least, our professional relationships are evident throughout our work. We engage in professional

The following are some of the practice changes that have been endorsed by CPC. This list is not all-inclusive, rather it is a sample of the work reviewed and promoted by our Clinical Practice Council .

· RN-MD Paging Standards (developed by a team of MDs and CPC RNs)
· Revisions to the Patient Assessment Data Base (PADB)
· Standardized procedure for transporting IMU patients within the hospital
· Limb Alert bracelets to protect patients from undue harm
· Safe patient handling equipment
· IV bolus from smart pumps
· High risk medications ordered only within established protocols
· CAUTI prevention - urine specimen collection process
· 3:00 Wipe Down of all clinical areas
· CUROS caps for CLABSI prevention
· Rewriting of standardized insulin orders
· Key vs. code for PCA access
· CHG daily bathing for all hospitalized patients
· Changes to standardized enteral tube feeding times for patients with diabetes
· Annual review of all updates to nursing guidelines

relationships every time we consult with a physician, pharmacist, administrator, social worker, food service, environment care service, or the EPIC help desk, just to name a few. If you have worked on a project in an interdisciplinary team you have engaged in professional relationships.

What About Other Clinical Practice Council Outcomes?

In the first seven years of nursing shared governance at UCSD the Clinical Practice Council (CPC) has reviewed numerous proposals for changes in nursing practice. Some of these have been born out of CN-III promotion projects; others have come from physicians, pharmacy services, and nursing management.

When a proposal is presented to CPC, it is examined in terms of the following questions. What is best for patients and families? What is the evidence basis? How will this affect nursing in terms of workload, workflow,

autonomy? Who are the other stakeholders, and how will this affect them? Have all stakeholders been involved in the planning process? How will this be rolled out, and how will training and education take place? Who will be responsible for the different aspects of this proposal? Asking these questions ensures that changes in practice are well thought out, and that shared decision-making is preserved.

Following discussion of all aspects of each proposal, CPC may endorse the proposal with recommendations or as presented.

How To Get Involved

The goal of the Clinical Practice Council is to have representation from all clinical areas, both inpatient and outpatient. The Council meets from 8:30 to 10:30 a.m. on the fourth Thursday of every month, with the exception of November when the meeting is held the third Thursday and December when there is no meeting. Meetings rotate

between Hillcrest [even months] and La Jolla [odd months] to meet the needs of nurses at both sites. All UCSD staff members are welcome to attend meetings as a guest, and nurses who do so can then determine whether this Council is a good fit. If you are interested in attending a meeting or joining this Council please contact the current Chair, Toni Birch Moseley RN at tbirch@ucsd.edu, or Co-Chair, Shannon (Sigurdson) Hall RN at ssigurdson@ ucsd.edu.

Enhancing the Quality of Patient Education Through the Development of a Patient Education Council

by Ayelet Ruppin-Pham MN, RN

Patient education has always been an important nursing skill. More and more research shows the importance of patient education to a patient's health. Readmission rates are greatly decreased the more engaged a patient is in their healthcare, and costs go down if a patient is properly educated. Research also shows that over eighty percent of the United States' population has poor health literacy, or the ability to understand health information. With all of our challenges in keeping our patients healthy and out of the hospital, it is increasingly clear that we, as nurses, must have the skills and resources to effectively teach our patients.

Patient education is embedded into our daily nursing practice at all levels of care. From educating the patient about the risks of having surgery, to teaching how to test blood sugar or why a patient has to take a new medication, the nurse is responsible for giving the patient and their family a whole host of information. We say nurses are teachers, but in nursing school we do not teach nurses how to be an effective teacher. Patient education is a skill just the same as taking vital signs or doing a head to toe assessment.

In 2010, we did an assessment of all of the patient education resources and handouts available in the entire Health System. The results were grim: while most staff recognized the need to provide our patients with information, we did not have an organized system to know what resources were available to our patients or where to get them. Our ambulatory areas had fifty different brochures and handouts, and our inpatient areas had just a handful. We did not have any resources other than reading material (some of which had been copied from a copy ten times over). In short, while we had many staff at the Health System who were passionate about educating our patients, we were short on resources and organization.

Also in 2010, our Acute Care floors in Hillcrest were embarking on a journey towards improving discharge education through the use of teach-back. Part of a quality improvement project, this teach-back project spurred increasing interest in improving patient education, and a small group of patient education champions came together from 6 East and 6 West to meet monthly. From this group, we determined that patient education standardization was needed throughout the health system, not just on a unit-by-unit basis.

The Patient Education Council in its current incarnation was formed on January, 2012. An interdisciplinary group from its inception, its members include representatives from pharmacy, respiratory therapy, ambulatory services, forms management, marketing, and of course, nursing. The mission of the Patient Education Council is to promote best practice, culturally competent patient education that empowers patients and families to actively engage in their health processes in the hospital and at home. To accomplish this mission, our goals include creating a formalized review and approval process for patient education material, improving patient education documentation, and encouraging teach-back at every patient encounter. In addition to these goals, we have been working on promoting the use of Emmi patient education videos throughout the hospital, to great success.

Ayelet Ruppin-Pham, MN, RN, is the Patient Education Coordinator for the UC San Diego Health System. In addition to her role as chair of the Patient Education Committee, she also oversees the development of Patient Handouts, assists with management of the Emmi program. Coordinates other patient education resources staff may need to help provide quality education to our patients. She has been with the Health System since 2009. Her background includes a Master's in Nursing in Community Health from the University of Washington.

Future projects for the council include educating staff on our newly developed clinical practice guidelines for Patient Education, continuing to train staff on using Emmi videos, mentoring nurses who pursue patient education projects and teaming up with our quality and clinical practice groups to help improve outcomes through the delivery of effective patient education.

We encourage anyone who has a passion for educating patients to join our council – we need dedicated nurses with great ideas! The Patient Education Council meets the third Thursday of every month in the Hillcrest 3rd floor classroom from 8:30-9:30AM. Interested patient education champions can contact Ayelet Ruppin-Pham, council chair and Patient Education Coordinator at aruppin@ucsd.edu.

Emmi Teach Back Questions: Warfarin

Nurses: These teach back questions are guides to assess your patient's learning. This information corresponds to the content in PH115 and the EMMI Module for Warfarin. This is not a patient handout.

Teach Back Question	Answer Guide
1. What is warfarin?	Warfarin (also called coumadin) is a blood thinner or anticoagulant ("anti" means against and "coagulation" means clotting.) It slows down the clotting process of blood. It is used to treat or prevent clots in your blood vessels, lungs or heart.
2. How do you take warfarin?	Warfarin is a pill that you usually take once a day. You should take it at the same time every day. It is very important to never skip a dose or take a double dose. If you are unsure when to take a pill or how often, it is best to ask your doctor instead of guessing
3. Why do you need to have blood tests on warfarin?	The blood test is called an INR. INR tells your doctor how long it takes your blood to clot. You do not want your blood to clot too much or too little. The blood test is called an INR. INR tells your doctor how long it takes your blood to clot. You do not want your blood to clot too much or too little. The INR is used to see if you are taking the right amount of warfarin to reach your target range.
4. What should your diet be on warfarin?	Your diet needs to be consistent. You do not need to change what foods you are eating or how much. Make sure to eat a consistent amount of Vitamin K. Vitamin K balances your warfarin dose. Vitamin K is found in high amounts in green leafy vegetables. You don't have to stop eating foods with vitamin K or eat a larger amount than before, eat your normal and regular amount of vitamin K. Alcohol can affect how warfarin works. Do not drink more than 1 alcohol drink per day such as one beer or one glass of wine.
5. How does warfarin interact other medications?	Warfarin can change the way other medicines work and other medicines can also change the way warfarin works. Tell your doctor or pharmacist about the other medications you are taking.
6. Can you tell me three signs of major bleeding? What would you do if you had any of these signs?	Changes in the color of urine or stool. Vomit that looks red or like coffee grounds Coughing up red secretions Severe headache or stomach ache A lot of bleeding from the gums, nose or menstrual bleeding Call the Anticoagulation Clinic or your doctor or go to the emergency room immediately.
7. What will you do after discharge?	Notify all healthcare providers that you are taking warfarin. It is very important you attend all your follow up appointments. Make sure to have your INR checked within 5-7 days of discharge either at a clinic or with your primary care provider.
What questions do you have?	

Emmi

Since partnering with Emmi in 2009, usage has dramatically increased from less than 200 videos assigned monthly to over 1000 in June 2013! Emmi videos let us offer education beyond just written handouts, and helps ensure our patients understand the risks and benefits of surgeries, or new medications, or what to expect when they stay in the hospital. The web-based video system is very user-friendly, with all education delivered at a low health literacy level so all patients can feel confident that they understand information without too much medical jargon.

The picture shows a picture from one of the Emmi videos, with an explanation of what makes these videos useful to our patients.

The Road to Excellence

By Dianne Warmuth, MSN, RN, CNS

The mission of the Quality Council is to support evidence-based practice and research utilization to continually improve patient care. Excellent patient care and outcomes are achieved by consistent implementation of quality interventions at the bedside. This is achieved by one nurse mindfully interacting with one patient at a given time.

Nursing sensitive quality indicators are reported nationally by hospitals. Consumers can compare outcomes with similar hospitals, in our case, teaching facilities of about the same size. Providing these outcomes allows consumers of healthcare to choose the facility that meets their needs. It provides transparency to the consumer about how care is delivered and places nursing care at UC San Diego in the public's eye.

Some of the clinical outcomes regarding safety include:
• Hospital acquired pressure ulcers (HAPU)
• Falls with injury
• Central line-associated blood stream infections (CLABSI)
• Catheter-associated urinary tract infections (CAUTIs)
• Restraint usage
• Ventilator associated pneumonia (VAP)

Quality is also measured through patient satisfaction surveys with questions such as, "Did the nurse do everything she or he could to relieve my pain?" and "Did the nurse treat me with dignity and respect?"

The Quality Council has been involved in many of these quality initiatives and is currently focused on initiatives to decrease the number of Catheter-Associated Urinary Tract Infections (CAUTIs). The Quality Council reviews CAUTI infection rates quarterly and has determined that UC San Diego's rates are higher than the national benchmark. It is the Council's goal to reduce CAUTI rates below the national benchmark through education and training of our staff on the utilization of best practices. Prevalence studies and education have been applied to the proper indications for the use of catheters as well as the early removal of catheters. Most recently, the focus of the Quality Council has been a roll-out of a catheter maintenance bundle. This bundle includes:
• Performance of hand hygiene before and after each patient contact
• Daily review of the need for the catheter using approved indications
• Removal of the catheter as soon as possible
• Not breaking the catheter seal unless medically indicated
• Daily assessment for the correct placement of the securement device
• Daily performance of meatal hygiene with soap and water or personal cleanser
• Regular emptying of the drainage bag using a clean measuring container dedicated for each patient. The drainage bag should not exceed ½ full and should be emptied prior to transport.
• Maintenance of unobstructed urine flow and bag below the level of the bladder at all times; avoiding dependent loops in tubing or placing bag on the floor.

Although the components of the bundle may seem basic, it is important

Dianne Warmuth, MSN, RN, CNS, is a Critical Care Clinical Nurse Specialist at UC San Diego Medical Center since 2005. She earned her BSN from Fresno State University and her MSN from California State University Long Beach. She is a member of the American Association of Critical Care Nurses (AACN). Her professional interests and clinical experience include trauma and transplant nursing. She is currently the Clinical Nurse Specialist for the PCU's at UC San Diego Hillcrest. She is the Chairperson for Nursing Quality Council and her current evidence-based practice focuses are in the areas of CAUTI/CLABSI prevention, patient/family needs and transplant education.

to implement all of the evidence-based interventions with every catheter, every shift, or more frequently, depending on the intervention. Along with learning the components of the maintenance bundle, staff was taught where to document interventions in EPIC. UC San Diego's Evidence-Based Nursing Genitourinary Guideline of Care was also revised and reviewed with staff. This is available for reference. The Competency Committee, educators/clinical nurse specialists, along with

FOLEY PREVALENCE/CARE/DOCUMENTATION APRIL 2013
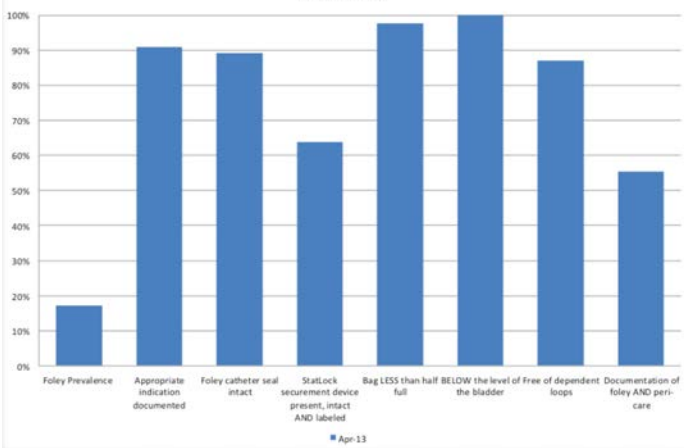
CAUTI Rates per 1000 Foley Days
Adult ICU: Q1 2012 - Q1 2013

Unit	Q1-12			Q2-12			Q3-12			Q4-12			Q1-13			NHSN 50%	*IDR %
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate		
BICU	2	358	5.6	4	354	11.3	3	327	9.2	2	295	6.8	3	352	8.5	4.1	90
CCU	4	619	6.5	4	589	6.8	6	607	9.9	8	712	11.2	4	705	5.8	2.6	92
SICU	10	795	12.6	9	692	13.0	9	657	13.7	10	689	14.5	5	681	7.3	2.6	96
CVC_CCU3A	3	567	5.3	3	490	6.1	0	498	0	2	538	3.7	3	502	6.0	2.2	94
TICU	4	676	5.9	4	552	7.2	2	469	4.3	2	488	4.1	1	531	1.9	2.2	56
Total	23	3015	12.9	24	2677	9	20	2558	7.8	24	2722	8.7	16	2771	5.8		

- IDR % (Incident Density Ratio) is the percentage of ICUs in NHSN of that description that have a lower CAUTI rate.
- Example: IDR% of 90 for BICU means that 90% of BICU in NHSN have a lower CAUTI rate. (done by FM/ DW)

UC San Diego HEALTH SYSTEM

California Confidential Evidence Code 1157

unit managers provided the staff training. A shortened audio slide show discussing the maintenance bundle and CAUTI prevention was created and disseminated as part of the education.

The Quality Council has also reviewed EPIC documentation and suggested changes to support the "catheter maintenance bundle" to make it easier for nursing to document and audit Foley catheter care. Although Foley catheters are a common intervention nursing may see as benign compared to other medical interventions, there "is a potential" for a significant, yet easily preventable infection for patients who have been catheterized.

Infection rates are currently monitored by the Infection Prevention/ Clinical Epidemiology Unit for the ICU's at Thornton, Hillcrest and the Cardiovascular Center as an outcome measure for the CAUTI bundle interventions. The data is collected and disseminated to managers of units so they can share it with their staff on a quarterly basis. It is also posted on the infection control website.

Hopefully in the future, data will be available for the acute care areas as well. Auditing at the bedside has also been performed to track compliance with the bundle. The data can be used to reinforce interventions as needed. The graph above shows the CAUTI rates for the ICU in comparison to the National Benchmark. You can see that despite improvement in the rates, they are still above the national benchmark as of this publication. Overall, the total rates are improving as a result of the effort enacted by the Quality Council with ongoing work to continue to improve this.

Caring for hospitalized patients is complex, requiring the knowledge of a professional nurse. Nurses perform many interventions for patients on an hourly or even minute to minute basis. The key to excellent quality outcomes relies on nursing mindfully interacting with a patient and consistently ensuring quality interventions are performed. This practice ensures that the best safety outcomes can be attained.

References:

Hanchett, M. Preventing CAUTI: A patient centered approach. Prevention Strategist, Autumn 2012 (42-50).

Gould, C. Umsceid, C. Kuntz and the Healthcare Infection Control Practices Advisory Committee (HICPAC) Guideline for the prevention of catheter-associated urinary tract infections. Department of Health and Human Services Centers for Disease Control and Prevention 2009.

The Starfish Story

A young girl was walking along a beach upon which thousands of starfish had been washed up during a terrible storm. When she came to each starfish, she would pick it up, and throw it back into the ocean. People would watch her with amusement. She had been doing this for some time when an old man approached her and said, "Little girl, why are you doing this? Look at this beach! You can't save all these starfish. You can't begin to make a difference!" The girl seemed crushed, suddenly deflated. But after a few moments, she bent down, picked up another starfish, and hurled it as far as she could into the ocean. Then she looked at the man and replied, "Well, I made a difference to that one!"
The old man looked at the girl inquisitively and thought about what she had done, and inspired, he joined the little girl in throwing starfish back into the sea. Soon others joined, and all the starfish were saved.

–adapted from the Star Thrower by Loren C. Eiseley.

THE PURSUIT OF EXCELLENCE:
The Journey to Nursing Certification

By Sal Chiappe RN, OCN

> "The quality of a person's life is in direct proportion to their commitment to excellence, regardless of their chosen field of endeavor." – **VINCE LOMBARDI**

Coach Lombardi was a cultivator of excellence; to excel at what you do should be a priority we bring to the workplace every day. The Journey to Nursing Certification is both voluntary and time consuming; the rewards are many such as:
• Professional recognition
• Financial compensation
• Job mobility
• Career advancement

Medscape com reports that "86% of nursing employers would hire a certified nurse over a non-certified nurse if all qualifications were the same"

Nurse certification is a relatively new idea that did not begin until 1974, but in the span of almost 40 years it has exploded to include at least 79 Nursing Certification Boards. These boards cover everything from AIDS Certified RN to Lamaze Certified Childbirth Educator (LCCE), a veritable alphabet of nursing certifications.

As an Oncology Certified Nurse OCN at the UCSD Moores' Cancer Center, I am surrounded by some of the best nurses I have ever worked with; they bring a wealth of experience that if added up would amount to hundreds of years. One of the partners of nursing excellence is the nursing experience that my colleagues bring to the Cancer Center; they encourage the newer nurses in Oncology not only to pursue Nurse Certification in Oncology but to excel in their profession. These qualities provide the mentoring and the guidance that my newer co-workers both seek and desire. As a nurse with 27 years of experience I can say honestly that I am still learning about my profession. Nursing, like a lot of areas of medicine, has evolved into a specialty profession, as evidenced by the amount of Nursing Certification Boards now in existence.

When I went to nursing school in the 80's before the home computer became a fact of life, nursing was more centered at the bedside. Now nurses have more opportunities to showcase their skills and to obtain certification for their area of practiced proficiency.

Part of the journey to certification includes belonging to organizations in your specialty, partaking in conferences and journal clubs. These are venues where professional growth takes place; part of that professional growth includes stepping up to the plate and obtaining that certification when you are ready.

The first time I took the exam for OCN I failed, I had only been at the Cancer Center a short time and in retrospect I should have waited. Failure can be the road to success because in failure you double your efforts to succeed the next time. I passed on the second attempt at the exam a few years later because I had experienced more and was able to apply it to the whole of Oncology. Life is full of goals and one of those goals as a nurse should be Nurse Certification. I know that on
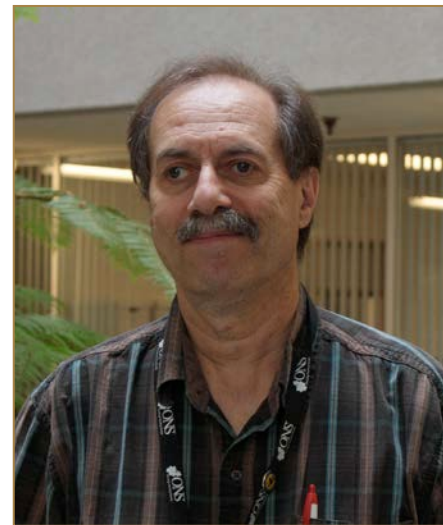
Sal Chiappe RN, OCN,
Nurse Case Manager UCSD Moore's Cancer Center
Nurse for 28 years
Happily married with 4 children
Hobbies- Astronomy, writing Poetry
Favorite Sports team-New York Yankees

several occasions I have been asked what the letters on my ID badge stand for. When I explain what OCN means my patients like what it represents. Recognition by your peers and your patients gives you a sense of fulfillment and contentment in the job you do; working with people every day who are cancer patients is both challenging and rewarding. Bringing the best skill set we can every day to our patients is what they need and deserve.

Once a year the UCSD Image of Nursing Council takes time out to honor all Nurses who have obtained certification, the nurses are given a Certificate of Recognition to recognize that accomplishment. This recognition

Number of Certified Nurses at UC San Diego (2012 data)
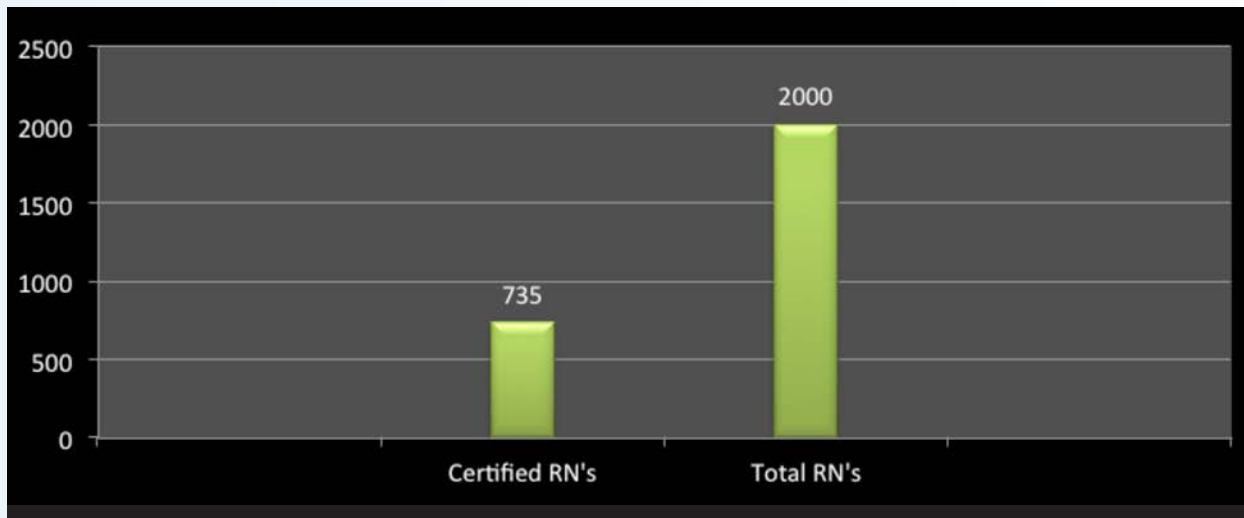
Percentage of Certified UC San Diego RN's by Area
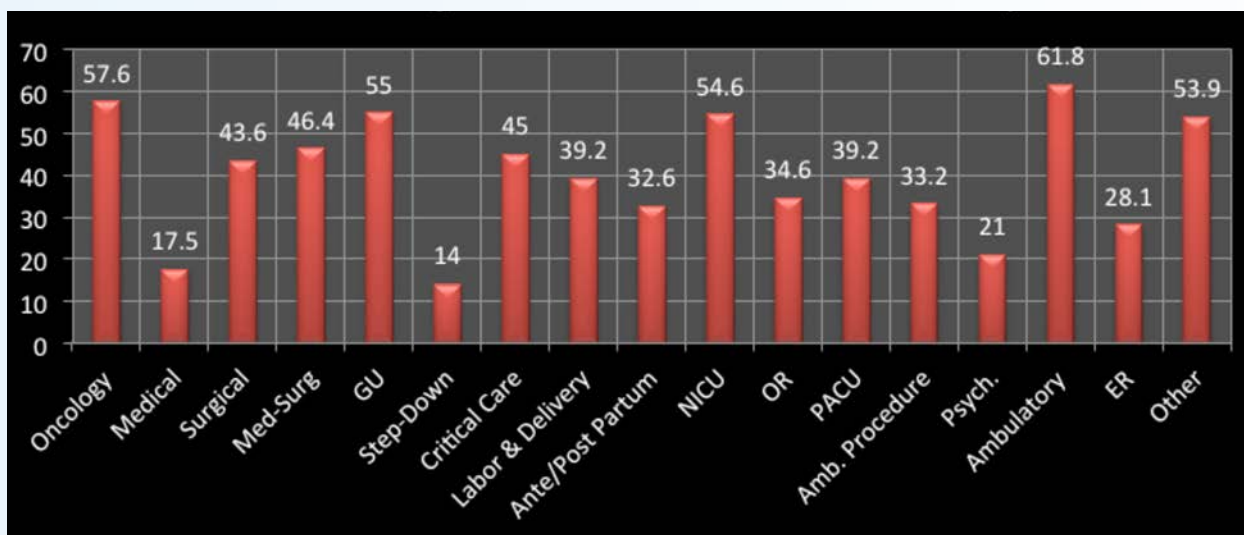
speaks to the professionalism and leadership in achieving and maintaining national board certification in a nursing specialty. At present, 37% of all the RN's at UCSD have obtained certification on our road to excellence.

Besides recognizing our certified nurses, the Image Council has played an invaluable role in enhancing the image of nursing at UCSD in many other ways. We are proud of our nurses and we want to promote that image locally and within the community.

To that end, our mission includes:
• To insure a positive and professional nurse image at UC San Diego Health System

• To provide an opportunity to showcase positive accomplishments for our nursing staff via the nursing journal, web site and professional recognition events
• To continue to elevate the recognition status of the professionally accomplished and engaged UC San Diego nurse

As a founding member of the Image of Nursing Council I have been privileged to work with some of the most innovative people I have ever met in the field of nursing. The Image Council from its inception has delivered this mission. This council has pioneered the following items:
• Founded the UCSD Nursing website

• Founded the UCSD Journal of Nursing
• Annual Nurse of the Year selection
• Annual celebration of Certified Nurses
• Magnet Pinning Ceremony
• Community outreach projects at San Diego County schools career days
• Annual Nurses week Celebration in May

"The secret of joy in work is contained in one word - excellence. To know how to do something well is to enjoy it." **– PEARL BUCK**

Advancing Nursing Knowledge

By Laura G. Dibsie MSN, RN, CCRN

When Shared Governance was in its formative stages at UC San Diego, there were many people invited to participate in the process and contribute to the future of Nursing in the organization. Staff in the Nursing Education, Development and Research (EDR) Department felt strongly about the ways they could bring their experience, knowledge, and expertise to Shared Governance. EDR was asked to spearhead a Research Council and to take responsibility for facilitating the incorporation of evidence-based practice into the Department of Nursing.

It did not take long to realize that Nursing Research and Evidence-Based Practice (EBP) was at the root of many aspects of Nursing Shared Governance. The original Shared Governance model, with its overlapping circles of influence, was soon modified to have a foundation beneath the entire model of Nursing Research and Evidence-Based Practice, thus reflecting that all the work within each of the Councils should and could, have research as its base. The Nursing Research and EBP Council are viewed to be a source of support and a resource for information necessary to make enlightened decisions.

The Council was charged with important work:
• To ensure that staff learned about evidence-based nursing practice and recognized it within their practice
• To provide education to staff about EBP and nursing research
• To review and work with staff pursuing CNIII projects
• To support nursing research within the Department of Nursing.

The following Mission Statement was written by the Council members:

The UC San Diego Nursing Research and Evidence-Based Practice Council exists to ignite the spirit of inquiry and create, nurture, and sustain a culture of nursing practice based on evidence.

We endeavor to improve patient outcomes by promoting, facilitating, and conducting nursing research studies, as well as develop Evidence-Based Nursing Practice changes that assure quality patient outcomes and cost-effective patient care. Every staff nurse will understand Evidence-Based Nursing Practice concepts and recognize the practical application in the clinical setting.

The Nursing Research and EBP Council is a part of the UC San Diego Nursing Shared Governance structure. The Council provides support to all Councils and Committees within the Department of Nursing and Shared Governance structure.

Since then, and under the leadership of Dr. Caroline Brown, policies and nursing clinical practice guidelines have been closely linked to the latest nursing evidence. Additionally, the UC San Diego Nursing Evidence-Based Practice Model was developed and is utilized by Nursing as our model for EBP and change. Under Dr. Brown's leadership, UC San Diego collaborated with nursing leaders within the community and formed the San Diego Evidence Based Practice Institute (EBPI). In this 7-month course staff nurse fellows, along with their advanced practice mentors, learn about each stage of an EBP change project and receive education and resources to take an idea from 'asking a question' through implementation and adoption of the change.

Staff nurses interested in advancing to a Clinical Nurse III are strongly encouraged to bring a project idea to the Council for support and feedback on their project ideas. The Council

Laura G. Dibsie MSN, RN, CCRN is the Clinical Nurse Specialist assigned to the Surgical ICU and Trauma Unit since 2001.

Chair of the Nursing Research and Evidence- Based Practice Council. Chair of the Skin Committee. She graduated with her BSN from University of Southern California and completed her MSN at University of San Diego.

will help to narrow the project scope, suggest steps for initiating the project, direct the nurses to resources, and help determine appropriate outcomes for monitoring success. In the last two years, the Council has partnered with the Professional Development Council to offer workshops to CNIII candidates and review the criteria, frequently asked questions, possible project types and examples of completed projects.

This allows many more candidates to hear the information and encourages participants to provide peer review to other attendees while interacting with members of both Councils and eliminating the mystery of the advancement process.

On May 29, the Nursing Research

and EBP Council hosted the 5th Annual Nursing Research and EBP Council Conference – Nursing Innovations and Inquiry. This year the event was held at the Liberty Station Event Center in Point Loma and offered a stimulating agenda made up of UC San Diego staff and a key note speaker from Long Beach Memorial and Miller Children's Hospital, Dr. Peggy Kalowes.

The Council was pleased to host 100 nurses at this event and provide a forum for staff to share their projects in poster displays and podium presentations. A wide range of topics were included with representation by staff from throughout the organization and community. We were thrilled to introduce Dr. Judy Davidson as the new Nursing Research and EBP Liaison. We are excited to welcome her back to UC San Diego and work with her on projects and other Council activities.

One final and important responsibility of the Nursing Research Council is to manage a database of nursing projects in progress in the organization. We were very fortunate to have the assistance of an innovative IT team and Linda Lobbestael from the EDR Department to help develop and incorporate an interactive database form into the new EDR website. If you have started, are currently working on, or have completed a project or study, we want to get some information from you. Please give it a try and get us your information by going to the EDR website (edr.ucsd.edu) and find the communication form under Nursing Research and EBP tab – Research Council.

All staff is invited to join the Council or attend any meeting they choose. Meetings are on the second Friday of every month, 12:30 – 14:00 in the AVRC Conference room at the Hillcrest campus.

Nursing Research and EBP Council Conference Planning

Committee: Odette Ada, Debbie Ashton, Frann Teplick, Amy Yates, Catharina Madani, Karen Elizabeth Mitchell, Karen Vejvoda, Laura Vento, Laura Dibsie, Noriko Morita

Staff RN Project Presentations

An Assessment of existing teaching modalities used in diabetic discharge education in the post-transplant patient and the addition of web based technology called EMMI to improve patient discharge readiness – Chau Nguyen

UC San Diego Nurse confidence in providing Diabetes Education in the inpatient setting – Diane Pearson & Ayelet Ruppin-Pham

Video monitoring improving patient safety and efficiencies in increased observation – Laura Vento

Implementing patient-centered bedside report: A patient-centered approach – Faye Rivera

Borders, Barriers and Bridges: Sharing Best Practices Outside the U.S. – Marlon Saria

Keynote Address: Advancing Innovation and EBP in a Magnet Organization – Dr. Peggy Kalowes

Infection Prevention Panel Presentation and Questions

Trial for Port Protectors on Patients with Central Lines – Aran Tavakoli

New Look at Infection Control in NICU – Michele Carson

Implementation of a Patient Education Process on Infection Prevention in Hospitalized Hematology/Oncology/BMT Service Patients – Chauncy Noble

Apheresis Preventative Strategies to Reduce CLABSI – Sherlita Aguilar

Sharp Hospital Staff RN presentation:

Implementing Daily CHG Bathing protocol in the ICU

Validating the Hopkins Fall Risk Assessment for Home Health – Sandra Hnizdo and Raquel Archuleta, Scripps

The Cost of Caring: Effects of Compassion Fatigue among Emergency Department Staff at UC San Diego Health System, Hillcrest – Karen Elizabeth Mitchell

Relationship Between Pre-Operative Anxiety and Post-Operative Delirium in ICU Patients Post Pulmonary Thromboendarterectomy (PTE) surgery – Cassia Chevillon and Mary Hellyar Improving

Care of the Patients Receiving Chemotherapy and Biotherapy by a Non-Chemotherapy Provider Nurse – Anthony Velasco

POSTER PRESENTATIONS

Partnering with Patients to Improve Pain Patient Satisfaction Scores - Naomi Orysiek

Increasing Patient Satisfaction with Nurse's Sensitivity and Responsiveness to Pain: A Patient Centered Approach - Vladimir Camarce

Improved Pain Management Communication Promotes Positive Outcomes - Erin Long , Anne Stuard

The integration of the 5 C's in developing a structured, web-based diabetic patient education program - Chau Nguyen

Implementing a Pain Communication Tool to Improve Patient Satisfaction - Kylie Hoang

Registered Nurses Doing Discharge Call Backs for all Joint Patients to Increase Patient Satisfaction Scores - Nelissa Reyes

University of California San Diego (UCSD) Health System 8th Floor Nurse Certification Rate 75%

– Sharing our Success Story - Eleanor Yoshisaki Yusi

Capnography monitoring and education to reduce adverse respiratory depression events - Julie Zimmerman, Melissa Meadows, Megan Adams, Sue Talask-Jordon

Implementing daily 4% CHG bathing on the Blood and Marrow Transplant Unit - Aran Tavakoli

Improved Triage Process in Labor & Delivery - Elisa Papadoupoulos, Felicity Esquinas, Pat Inzano, Frann Teplick

New look at infection control in the NICU - Michele Carson

Huddle up to improve communication, teamwork, nurse satisfaction - Mary Hellyar, Cassia Chevillon

Protection for patients with limb restrictions - Louise Barr, Kathleen Kuttler

Code Sepsis in Emergency Department - Linda Ojeda

Nurse Education on Heart Mate II patient education: An educational Intervention - Sabrina Fernandez

Apheresis preventative strategies to reduce central line associated blood stream infection (CLABSI) - Sherlita Aguilar, Odette Ada, Majella Vaughn, David Ward, MD

Implementation of a patient education process on infection prevention in Hospitalized hematology-oncology/BMT service patients - Aran Tavakoli, Chaney Noble

Blood transfusion during hemodialysis-development of an evidence-based procedure - Debbie Ashton

Performance Improvement in Procedural Areas

By Laura Peluso, BSN, RN

The Procedural Quality Council is a multidisciplinary council with representation that includes; Cardiac Catheterization Lab, Gastroenterology, Special Procedures from Thornton, Interventional Pulmonology, Interventional Radiology and Electrophysiology.

The primary focus of this council is to identify practice improvement issues that share a common theme throughout the various departments. Previous completed projects included addressing the special needs of sleep apnea patients when receiving moderate sedation and/or general anesthesia for various procedures and their requirements post procedure. This included a patient questionnaire which helped identify those with diagnosed sleep apnea and more importantly those who did not have a diagnosis of sleep apnea but were considered to be at greater risk for post procedure complications due to sleep apnea. This information was collected for a committee assessing the sleep apnea risks at UCSD.

Another project looked at time management issues. Scheduling conflicts and patient care delays affect all procedural areas. We developed a tool that included tracking times from the scheduled time to patient's arrival time, patient ready time and start of procedure time as well as out of room and discharge times. In Interventional Pulmonology (IP), we also had 16 possible reasons for those delays, including patient arriving late, complicated patient, staffing issues, MD issues, scheduling errors, etc. Each procedural area added their own list of time management glitches and it is a tool that we still use in IP.

We reviewed the recommendations for use of capnography for moderate sedation by various professional organizations. We found that this technology was not in great use by outside facilities. After the council discussed the various types of measurement tools it was decided that the cost of capnography outweighed the benefits.

Last year the council decided on a yearly skills day for each area which was to meet the needs of each individual department. We also surveyed the nurses and found a need for more education regarding radiation exposure. We developed a one hour educational presentation for radiation safety for nurses, to be presented at skills day which was also presented at the nurse management meeting

Current performance improvement projects include:
• Partnering with the Epic team to develop Epic Optime for use in the procedural areas.
• Peer review of nursing care in the various areas.
• Review of central line use and the development of an educational tool for procedural clinical staff.

This is a unique group that has the benefit of collaboration with professionals in different specialties but face many similar challenges. By working as one council we develop professional growth and improve the multidisciplinary relationships among departments.

Laura Peluso, BSN, RN has been a nurse at UCSD Medical Center for over 20 years. She found a home in the Interventional Pulmonology Unit, where she has spent most of her career.

Shared Governance in PACU

by Cresilda Newsom, MSN, RN, CCRN, CPAN

Post anesthesia care unit (PACU) is always changing and PACU nurses must update and maintain practice controls to achieve safe and quality care for our patients. With nurses caring for patients ranging in age from infants to geriatrics, from orthopedic to neurosurgical, trauma to burn patients, there are many challenges for the post anesthesia care unit nurse. PACU nurses make critical decisions daily that affect patient outcomes, influence the healthcare organization and reflect on nursing competency. Engaging bedside nurses is essential for the success of a busy unit like PACU and for improving the quality of UCSD health care system as a whole.

Why a Unit-Based Council in PACU?

Development of a Unit Based Council (UBC) in PACU was established to facilitate change by implementing evidence-based practice to improve clinical outcomes, increase patient and staff satisfaction, and to promote positive change as it pertains to PACU nurse practice. It is our UBC's goal to achieve the quality outcomes we desire by implementing evidence based practice. Having a UBC in PACU is critical for planning, improving and maintaining quality patient care throughout the PACU department. By empowering PACU nurses to use their clinical knowledge and expertise to develop, direct, and sustain their own professional practice, UBC provides a structure for decision making at the unit level. It also provides an opportunity for our nurses to participate in unit-wide activities including pain management,

> "The ability to convert ideas to things is the secret to outward success."
>
> **HENRY WARD BEECHER**

chart audits, surgical outpatient phone surveys, peer reviews, as well as conducting studies on perioperative patient volumes, staffing, and how it affects patient safety. Our UBC has also allowed our nurses to network and develop collaborative partnerships among other units, departments, and other disciplines. Below is a chart illustrating quality improvements in the perioperative care areas as a result of the work done by the UBC:

Unit-Based Council Success

The power of unit-level shared governance council is highlighted in PACU by producing profound impacts on patient/family outcomes and staff engagement. Shared governance has been viewed as facilitating quality patient care, aiding in retaining nursing staff, and assisting in reducing costs (Barden, Griffin, Donahue, & Fitzpatrick, 2011). Structures such as shared governance and unit based councils allow nursing staff to influence decisions that matter. Shared governance gives frontline nursing staff greater latitude in decision-making related to how their work is organized.


Cresilda T. Newsom, MSN, RN, CCRN, CPAN, received her BSN from Grand Canyon University and her MSN from South University. Cresilda started her career as an RN in ICU in 1997 and transitioned to PACU in 2004. She started her journey with UCSD as a PACU nurse in December 2011. She received her certifications both as a critical care nurse through AACN and as a certified post anesthesia care nurse through ASPAN. Cresilda is currently pursuing her Doctorate in Nursing Practice (DNP) through Samuel Merritt University to further her education.

Having a UBC in PACU has given us an opportunity to know each other better and look at solutions to improve our department rather than focusing on the negatives. It has indeed involved nursing staff in the ownership of our unit.
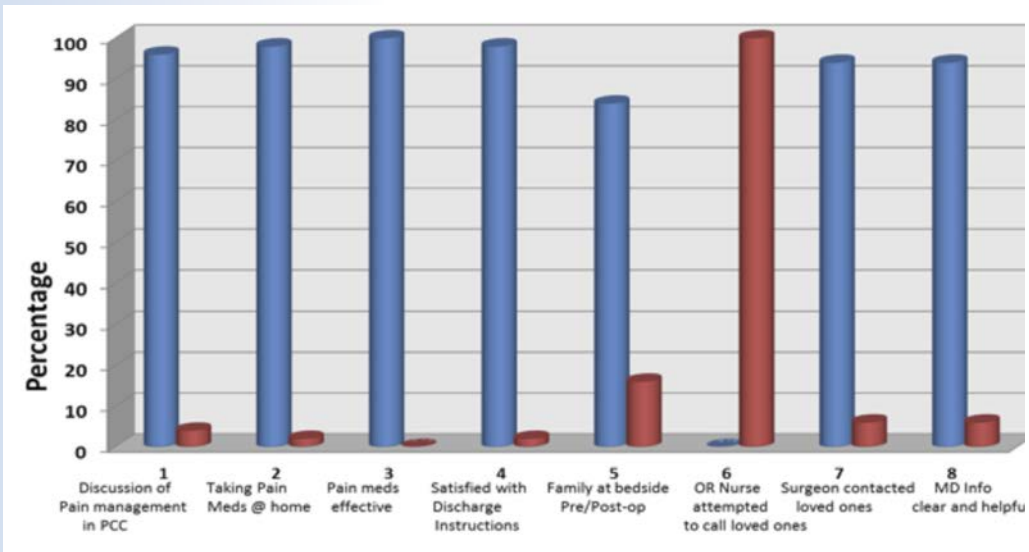
Reference:

Barden, A., Griffin, M., Donahue, M., & Fitzpatrick, J. (2011). Shared governance and empowerment in registered nurses working in a hospital setting. Nursing Administration Quarterly, 35(3), 212–218.
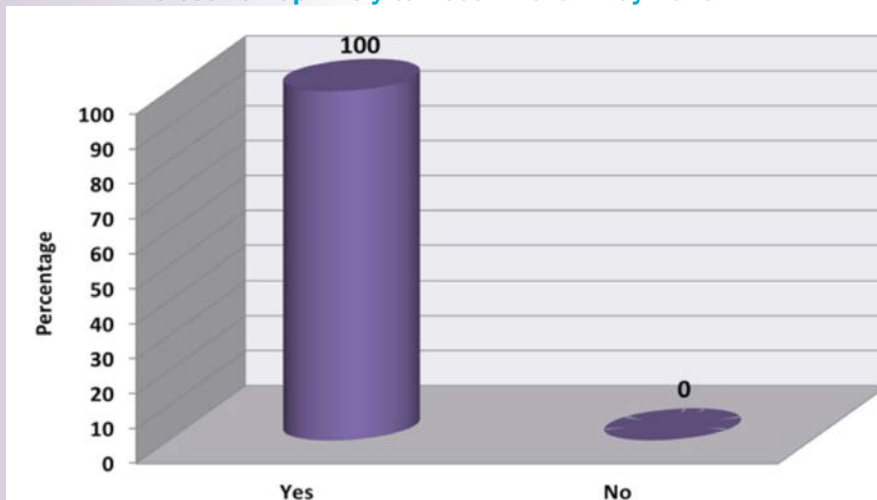
Hillcrest Peri-Op Satisfaction Survey Results - May 2013 N:64
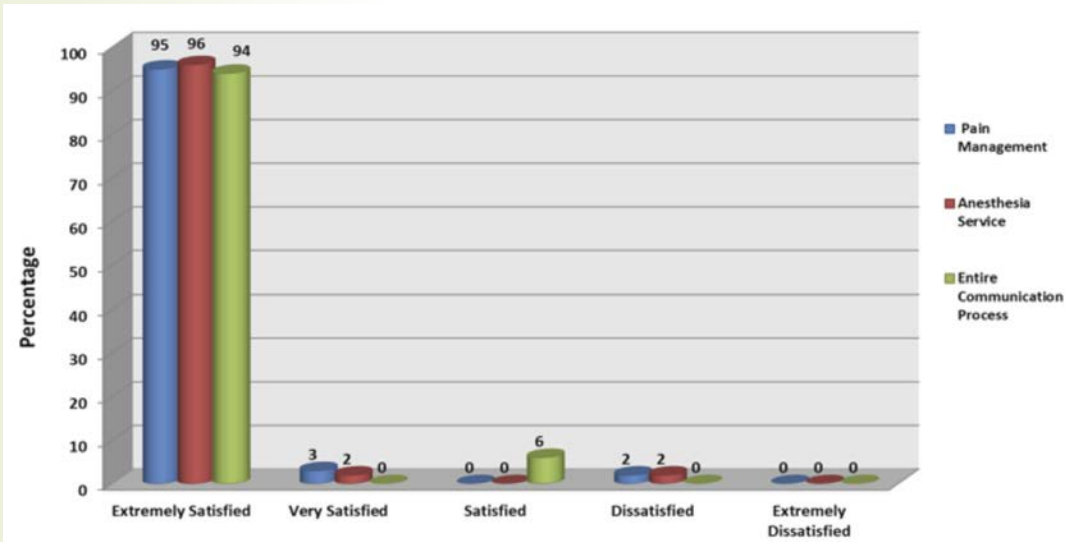
Hillcrest Peri-Op Survey Results - May 2013 N:64

Hillcrest Peri-Op Likely to Recommend - May 2013

Nurse-Driven ICU Palliative Care Triggers

by Catherina Madani, MSN, RN, and C Chevillon, MSN(c), RN, CCRN

Catherina Madani, MSN, RN, first started working in Thornton's ICU in 1999. She is currently the co-chair of the Palliative Care Committee, a member of the research council and a 3rd year PhD student at USD.

Cassia Chevillon MSN(c), BSN, RN, CCRN is the Clinical Nurse Educator for the Sulpizio Cardiovascular Center and Thornton Intensive Care Unit. Ms. Chevillon has been with UCSD since 2008. She earned her Bachelors of Science in Nursing from Hawaii Pacific University, and is currently pursuing her Master of Science in Nursing and Clinical Nurse Specialty from Point Loma Nazarene University where she is a member of the Sigma Theta Tau Honor Society. She is also a member of the American Association of Critical Care Nurses (AACN). Her professional interests include caring for the cardiovascular patient population, palliative care, and end of life care.

Background and Significance

Palliative care offers a means of providing patient and family centered care in hospital settings by placing emphasis on communication of patients' knowledge and understanding of prognosis and expectations of care; providing family support and education on mitigating symptom burden and transitional care planning. Several models for palliative care delivery in intensive care settings have been implemented and reported with varied success. Barriers experienced include possessing an open versus closed intensive care unit (ICU) model with several teams managing patient care, surgical intensive care units (SICU) compared to medical ones, and utilization of only one approach versus a combination of consultation and integrative palliative care delivery models. Even with examples of improved integration of palliative care services in an ICU setting there is ample room for further evidence of success. To date there has been no research looking at the impact of nurse-driven palliative care triggers in a medical-surgical ICU setting.

Our Unit and Trigger List Development

The UC San Diego Health System Thornton Intensive Care Unit (TICU) is a 12-bed medical-surgical ICU that specializes in oncology, bone marrow transplant, and neurovascular, cardiothoracic and vascular surgeries before the opening of the Sulpizio Cardiovascular Center in 2011.

Afterwards, the TICU experienced a significant shift in its population towards medical and surgical oncology patients, many of which have terminal conditions with prolonged and complicated ICU stays.

In anticipation of this shift change, the ICU leadership, which included the medical director, nurse manager, unit educator, along with several clinical nurses, reached out to the Howell Service to co-develop a palliative care educational plan and palliative care consult triggers with the goal of expanding palliative care utilization in TICU. Another goal was that palliative care education and trigger implementation would provide tangible tools to empower the ICU clinical nurses to advocate for patient and family centered care and possibly reduce moral distress.

The trigger list was established with true interdisciplinary collaboration including clinical, management and educational nursing staff, nurse practitioners, physicians, and social workers. Based on published data, along with unit specific cultural considerations eight PC triggers were selected:
• Family request
• Death expected within ICU stay
• ICU stay > 10 days
• Diagnosis with median survival <6 months
• Advanced malignancy
• Permanent severe cognitive impairment
• Conflict in goals of care
• Poorly controlled symptoms despite current treatment.

These triggers were initially

approved in the TICU and CCU, and disseminated through e-mail, badge cards, meetings and palliative care classes and conducted by clinical nurses in conjunction with the Palliative Care Service.

Implementation and Outcomes of Trigger List

ICU patients are evaluated daily by the bedside or charge nurse to determine if they meet one or more palliative care (PC) triggers.

Recommendations for a palliative care consult are communicated with the primary team, and documented in the data collection tool created by the team. The majority of the TICU staff has attended UCSD's palliative care class that provides background information on how to approach the primary team for a consult as well as provides two role play situations wherein the class works through the process of how to approach a physician for a consult. This is done with the medical director of the Howell Service and another physician. The activity is conducted in an interactive and lively manner, which encourages the audience to share their experiences of what has worked and not worked for them. Emphasis is placed on the process of a culture change within a unit and how it takes time and energy.

In looking at our preliminary data, we found that 93% of our patients met at least one trigger. The frequency of each trigger being met individually from highest to lowest is as follows:
• Advanced malignancy
• ICU stay > 10 days

• Diagnosis with median survival <6 months
• Poorly controlled symptoms despite current treatment
• Death expected within ICU stay
• Conflict in goals of care
• Permanent severe cognitive impairment
• Family request

The number of palliative care triggers resulting in consults has increased steadily after the establishment of the triggers and educational classes. To date our committee has held eight classes with more than 450 interprofessional attendees from within and outside UCSD. We will continue to offer classes on an annual basis and are looking for representatives from each unit to attend our hospital-wide meetings to share their experiences and needs regarding palliative care.

TICU Palliative Care Consults trends from January 2010 through May 2013.
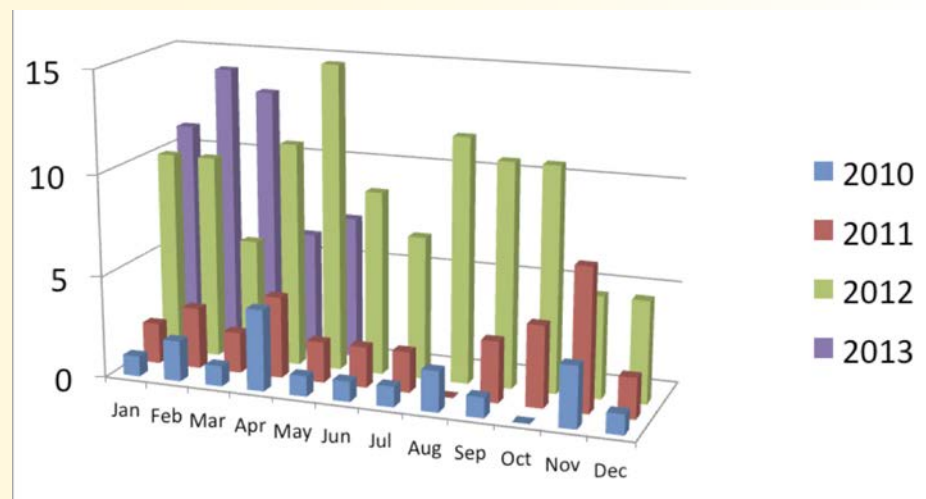
10 CCU - Making a Critical Difference

By Dorothy Scyoc, BSN, RN, CCRN, CMC

The CCU Quality Council (QC) consists of bedside nurses, management, and a clinical nurse specialist. This group meets monthly to analyze data, discuss opportunities for improvement, and to implement clinical change on our unit. We discuss current projects and ideas for new ones. The meeting is also a venue for interdisciplinary presentations from other hospital committees. We invite other disciplines (i.e. pharmacy, MDs, etc.) to attend the meetings when the committee feels that additional education is warranted. Many great quality improvement projects have originated from these meetings. A few of our accomplishments include:

1. A decrease in unit based CRRT Errors:

The CNS brought CRRT errors to the QC for group discussion and brainstorming. It was identified that errors were made by experienced CRRT RNs. A discussion with experienced RNs on the QC revealed they did not feel as comfortable as they would like with CRRT. They requested a CRRT for the Experienced CRRT RN class. Eileen Lischer, BSN, RN, MA, CNN, taught these 4 hour classes over the course of the year. Since these classes were implemented there has been a 17% reduction in CRRT errors in the CCU compared to the previous fiscal year.

2. Staff empowerment in teaching and coordinating Skills-A-Thons:

After looking at data, and holding a discussion at QC about observed unit needs, the QC regularly determines the content and format for the CCU skills days. Of significance, it is the QC members who are coached to teach these skills stations. Having QC members in this role ensures a broader base of expertise in the unit.

3. Staff empowerment in helping to achieve Comprehensive Stroke Center Certification

In the Fall of 2012, our UC San Diego Hillcrest facility was recognized by The Joint Commission as one of the first five Comprehensive Stroke Centers in the country. This was accomplished in part via a tight partnership between the CCU QC and Dr. Navaz Karanjia, Medical Director of Neuro-Critical Care. Dr. Karanjia and her team offered multiple clinical and classroom educational opportunities for a sub-group of the QC to increase their expertise in caring for this patient population. This sub-group of CCU staff RNs is recognized as the neuro champions in the unit. They work with the QC to mentor and educate their peers, serve as clinical resource, do professional presentations, complete chart audits, and report outcomes.

Through these efforts, CCU has been transformed into a dual specialty unit caring for both complex stroke and medical intensive care unit patients.

4. Staff empowerment in improving Code Blue and Rapid Response Team Processes

CCU staff RNs actively participate in Code Blue Committee, in ART and BART education and in the Center for Resuscitation Science. The data and outcomes from these efforts are presented by CCU staff RNs, Sheri Reiakivam and Ruth Chapell at the Code Blue RN meeting. CCU is proud to align itself with the nationally recognized outcomes from this group.

In addition to accomplishments listed above, there are a number of other peer review based CCU QC projects in

Dorothy Scyoc, BSN, RN, CCRN, CMC started as a new grad on the IMU about 6.5 years ago, and has not left UCSD since. She transferred to the CCU about 5 years ago and loves what she does! She has her bachelors in Human Biology and Nursing, and has plans to go back to receive a masters as a CNS.

process. Presented with data indicating elevated central line associated blood stream infection (CLABSI) rates, staff nurse, Gina Zarella, provided education to the QC and other staff members on the topic. An action item list was created with CNS input that addressed central line insertion and line maintenance quality indicators. Staff nurse, Danielle Williams has taken this topic on as an FLA project. Other action items include: linkage with the house-wide CLABSI group; inclusion of the topic in the CCU skills day, and close bedside monitoring of central line insertion and maintenance procedures by QC members.

Improvement of staff compliance with personal protective equipment use in isolation rooms is another project taken on by the council. Staff RNs Megan Kelly and Heather Warla are engaged in a house-wide CNIII project focused on this topic. Staff RN Mayra Parra has taken on the project of patient and family education in regards to PPE as a CNIII topic. As these projects move forward our CCU QC will serve as the vehicle for rolling out education and subsequent monitoring of outcomes.

The unit rates for catheter associated urinary tract infection (CAUTI) and ventilator associated conditions (VAC) are another area of focus. Christina Justice, a QC member who also sits on the house-wide competency committee, linked the house-wide initiative on CAUTI to the unit based goal of improving outcomes.

Through this linkage Christina provided education to our QC and facilitated the completion of the CCU competency sign-off for CAUTI. Staff RN Raquel Alvarez utilized the QC as a forum to present evidenced based education on ventilator associated condition practices to improve VAC outcomes.

Our quality council encourages staff empowerment and peer review to improve patient outcomes. Strong relationships with multi-disciplinary teams and linkage with the house-wide Shared Governance Councils have helped us to accomplish this goal.

11E Unit Council: Reducing Falls

By Michael Baumgardner, MSN, RN

While making a causal stroll down the hallway of a critical care unit it is easy to notice a lot of commotion. There are multiple medical teams on rounds, physical, occupational and speech therapists working with patients, pharmacy techs delivering medications, families requesting updates on their loved ones and something that is so common it can get lost to the novice onlooker, but not to nurses– the endless ringing of bells. There are alerts to tube feeding malfunctions, alaris pump complications, bedside ECG monitors and each has a distinct intonation. It is amazing how only after a few shifts that most nurses are able to distinguish what a particular bell is alerting them to check without even looking.

In May 2012, the Shared Governance Committee on 11 PCU was asked by management to consider ways to reduce falls on the unit by 25%. On any given day the unit can have forty-three patients, many of whom, due to diagnoses, medications, IV therapies, and telemetry monitoring are high fall risks. The committee quickly understood that meeting this goal would require the entire unit's assistance. A task force was established to meet monthly to review all falls in order to learn how to prevent similar situations from occurring.

During the course of the year many good suggestions came from the staff on ways to reduce falls in our patient population. Many of the ideas were easy to include such as new fall risk signage, discussion of patients with a fall risk at handoff, including CCPs in educating the patients on their fall risk and a post fall "huddle" to discuss immediately what led to the fall. There was much success with these interventions but the occasional fall still took place. Then it was decided to use something that nurses know well – bells.

While the bed alarms were already being used, and alerted staff to check on the patient, there were still incidents of falls. After the first quarter of the year the task force made the suggestion to increase the sensitivity of the bed alarm on all patients who are high fall risk.

Now a nurse can be sitting at the nursing station, walking down the hallway or in another room and immediately know that a patient needs attention. Often on arriving at the room the nurse will find the patient sitting on the side of the bed or laying back down waiting for the nurse and comment, "I am sorry I forgot to call for help". A quick reorientation to the situation and education on the fall risk and the patient's needs are met.

Our fall rate dropped from a peak of 3.57 falls /1000 patient days in Jan-Mar, 2012 to a low of 2.50falls/1000 patient days in Oct-Dec 2012. It is satisfying to our staff, patients and families to know that implementing this simple change has helped our unit work towards its goal of promoting patient safety.

Michael Baumgardner, MSN, RN, is a graduate of the University of San Diego Hahn School of Nursing where he received his MSN in 2011. Upon graduating he was hired as a bedside nurse on 7,9,11 PCU at UCSD Hillcrest. He has served as co-chair of his unit's Shared Governance Committee for the last two years. Prior to entering the nursing profession Michael worked as a Spiritual Counselor for San Diego Hospice and the Institute of Palliative Care and as a Catholic Priest for the Diocese of San Diego. He is dedicated to improving patient safety and satisfaction as a leader on the PCU, that recently reduced its fall rate by 25%. Currently he is working on a CN III project that will result in standardization of patient handoff between nurses."

A PATIENT-CENTERED BEDSIDE REPORT:
in the Medical Surgical Division

by Laura Vento, MSN, RN, CNL

Laura Vento, MSN, RN, CNL, is the Assistant Nurse Manager of Medical Surgical Quality. Laura joined UC San Diego Health System with an MSN from University of Virginia, having a previous bachelor's degree in Health Sciences from James Madison University. She is certified as a Clinical Nurse Leader.

Evidence-based practice (EBP) is an increasingly familiar theme among nurses. Integrating these best practices at the bedside continues to pose numerous challenges. Barriers to participating in EBP include: the nurse does not feel empowered, a perceived lack of time to change practice and a lack of awareness of research. Utilizing unit-based practice councils (UBPC) as a structure to foster a spirit of inquiry and navigate an evidence-based practice model was one strategy used to implement bedside report among six inpatient units in the Medical-Surgical division.

In 2011, the division-wide EBP journey began with individual UBPC library trips and consultations with the UC San Diego nursing research librarian, Mary Wickline. The first unit to undertake this was 5 West, a trauma progressive care unit. Their focus of research was shift handoff communication.

Faye Rivera, the 5 West UBPC chairperson reports, "At that time, we were transitioning from a telemetry unit to a trauma progressive care unit. Our hand-offs were not standardized and with more critically ill patients being admitted to the unit, we sometimes missed important information."

Practice council members attended a presentation by Dr. Caroline Brown, discussing EBP basics and how to appraise nursing research. This expert support fostered nurses' confidence and engagement in their project.

Faye recalls, "Based on our research and interviews of patients and co-workers, we decided we needed to create a standardized structure and process to bedside report. We started with the "Situation, Background, Assessment, Recommendation (SBAR)" communication format, and then added other elements specific to our unit."

At the beginning, change was not easy. With the full support of the UBPC, members championed the project, modeled and encouraged staff to go to the bedside and use the standardized tool. After a short evolution period, nurses embraced bedside report.

Faye found "There were many patient safety issues that were caught at bedside report. A medication error was caught and a patient's IV drip rate was corrected. That's when nurses realized the benefits from a structured bedside report."

The project yielded positive outcomes, including increases in patient satisfaction survey responses in the

Bedside Report Action Items Timeline

Action	Unit	Time Frame
Administer Nursing Satisfaction pre-implementation Quiz	5w, 8th floor	by Jan 6
	10e, 11w	unitl Jan 20
	6e, 6w	until Feb 3
With Project Manager finalize audit form (using universal audits plus anything unit specific ex. Pain, white boards, ect.)	5w, 8th floor	by Dec 31
	10e, 11w	by Jan 6
	6e, 6w	by Jan 20
With Project Manager create nurse education of bedside report rollout	5w, 8th floor	by Dec 31
	10e, 11w	by Jan 6
	6e, 6w	by Jan 20
Roll out nursing education	5w, 8th floor	Dec 23-Jan 6
	10e, 11w	Jan 7- Jan 20
	6e, 6w	Jan 21- Feb 3
Bedside report rollout with leadership support	5w, 8th floor	Jan 7- Jan 20
	10e, 11w	Jan 21- Feb 1
	6e, 6w	Feb 4- Feb 15
Weekly peer audits x1 month	5w, 8th floor	Jan 21- Feb 21
	10e, 11w	Feb 2- March 2
	6e, 6w	Feb 16-March 16
Monthly peer audits	5w, 8th floor	starting March
	10e, 11w	starting March
	6e, 6w	starting April

areas of "nurses overall," "nurse kept you informed," and "skill of the nurse."

Nursing satisfaction with handoff also improved. The most dramatic improvements reported by nurses were nurse accountability and time of report. The nurses of 5 West presented their findings at the 2012 UC San Diego Research and EBP Conference.

This project attracted the attention of bedside nurses and med-surg leadership. The leadership team conducted a division-wide observation study to assess shift report. This study revealed bedside report was occurring sporadically or not at all on the five other med-surg units. When report was given at the bedside, the patients were rarely involved. To integrate the positive outcomes of 5 West's project, a divisional bedside report initiative was created leveraging the UBPCs in the same way 5 West had.

One UBPC member was nominated from each council to serve as the bedside report project manager. They reviewed the current literature and developed standardized tools for bedside report using 5 West's as a template. Adopting evidence-based practices at the unit level required the integration of current evidence, clinical expertise, and patient and caregiver perspectives. UBPCs served as forums for discussing and incorporating caregiver perspectives. Members trialed the tool and customized it with unit specific patient needs.

For example, Darleen Parjarillo, bedside report champion for the 8th floor orthopedic unit, added the joint replacement clinical pathway to their tool. This is critical information in shift report for this unit. The individualization of the bedside report templates in UBPCs optimized the process for each unit. Additionally, a greater sense of ownership was created.

Basic elements of bedside report were incorporated into each unit's template to ensure a level of standardization among units. As nurses float among units the processes of bedside report would be the same with unit specific details. To audit bedside report on all med-surg units, the task force elected six universal processes of beside report to audit.

Faye replies, "For auditing, we decided on elements of bedside report that would be done on all units, like opening Epic (our electronic medical record) at the bedside. We included asking the patient what their goal is for the shift. We also added an audit question "Was this a 3-way report between both nurses and the patient?" to ensure we were actively involving the patient."

The task force developed an implementation plan that included bedside champions and management. This plan focused on coaching and modeling bedside report for two weeks on each unit during both day and night shift change. After the initial two weeks of the project rollout, peer-to-peer audits were conducted weekly for one month.

Initial outcomes are promising. Five of six units have increased patient satisfaction scores in "nurses kept you informed" in the first month of implementation. Incidence of nurses clocking out late is trending down as nurses become accustomed to the new standardized handoff process. Nurse satisfaction will be reassessed at 6 months.

Many patient safety issues have been caught at bedside report. Patient falls have been prevented, incorrect "no blood draw/blood pressure" limb identification was caught, and inadvertently clamped IV antibiotics

have been restarted in a timely manner.

Nurses have expressed surprise at hearing patient's priorities for the shift were as simple as having their hair washed or sitting in a chair when they ate dinner. Asking this question has helped develop the patient-nurse relationship, building trust and accountability.

Faye presented 5 West's adoption of bedside report and its influence on other units at the 2013 Nursing Innovation and Inquiry Conference. In her "lessons learned" slide, Faye credited shared governance structures and leadership at all levels for facilitating innovation evidence-based practice at the bedside. UBPCs also have provided a structure for project managers to report out process and outcome measures, address barriers and promote sustainability.
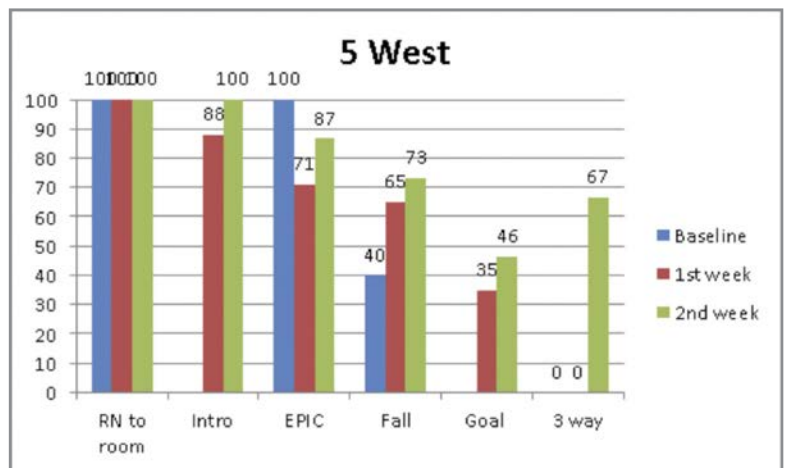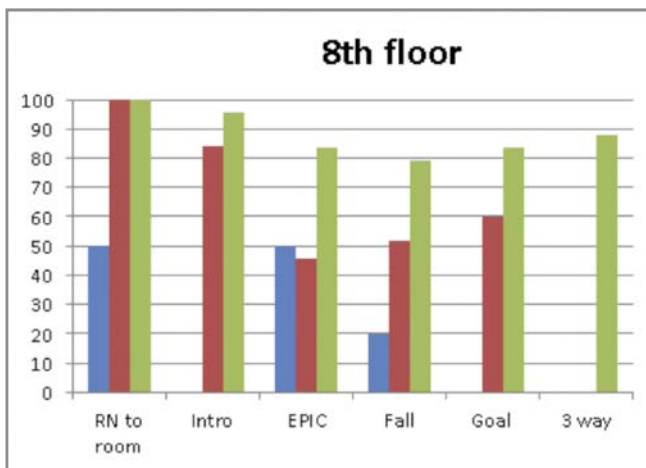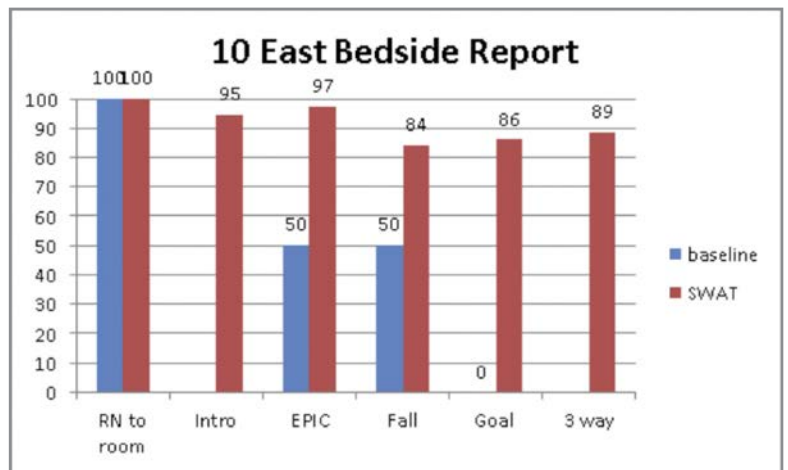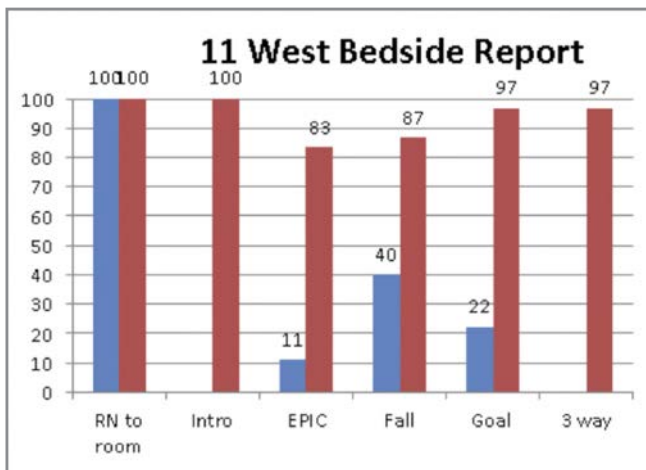
Neonatal Intensive Care Unit (NICU) Shared Governance Council- Meeting Communication Challenges to Empower a Unit

by Jackie Iseri, MSN,RN

With nearly 140 nurses, NICU is the largest unit of the UCSD Medical Center organization. There are currently 17 unit-based teams:

- Bereavement
- Clinical Practice
- Communication
- Developmental
- Documentation
- Family-Centered Care
- Family Education
- Infection Control
- Lactation
- Night In-Service
- PICC
- Picnic
- Policies and Procedures
- Shared governance
- Skin
- Staffing
- Volunteers

Jackie Iseri, MSN, RN , has worked as a nurse in the Neonatal ICU at UCSD Medical Center for two years. She received her B.S. in Human Development from UC Davis and her RN and MSN from the University of San Diego. Jackie received a "Rookie of the Year" award in 2012 and currently serves as a co-chair for the NICU Shared Governance and unit representative in the Nursing Cabinet. She is currently working toward receiving her certification and CNIII.

Although the NICU's large staff allows for a significant number and wide range of teams, the unit faces the challenge of monitoring and coordinating their efforts. The NICU Shared Governance Council hopes that the improvement of communication among teams will lead to a reduction in redundant work and improved quality and service outcomes.

With the start of the Magnet Journey in 2007, there was a strong movement to implement shared governance throughout the organization. Given the unit's challenges of communication and coordination, implementing a council focused on overseeing these needs quickly became a hopeful solution. The council was formed with a mission to guide both quality and service initiatives in the unit by acting as a hub for communication among teams as well as between teams and nursing management. The NICU was familiar with this type of council given its long-standing Core Group that includes involvement from nursing leadership, physicians, neonatal nurse practitioners, and all other ancillary personnel. In an attempt to emulate the Core Group model, the first Shared Governance council consisted of a chair from each unit-based team. The goal was to develop a monthly report on team activities so that they could be reported to the Nurse Executive Council, where accomplishments from each unit were highlighted.

Teams shared their PDSAs and action plans, but meetings were not interactive and information was not being brought back to the other nurses. Communication continued to be a challenge with such a large council and eventually lack of attendance became a concern. The unit's level of progress remained as it was prior to the implementation of a Shared Governance

Council. There were several successful projects, but a lack of shared work and coordination. In a second attempt to improve communication, the unit held its first annual retreat in 2011. The meeting was attended by two co-chairs from each team, nursing management, and the divisional manager. The retreat was designed with two main goals. The first goal was to share organizational and divisional strategic plans, including information surrounding structure, operations, regulatory requirements and budgetary issues. The second goal was to encourage the participation of attendees in prioritizing and designing the NICU's action plans for the upcoming fiscal year. The retreat received positive feedback from those who participated, so the event continues annually.

While the retreat provided a single opportunity to align management and team goals, the lack of attendance and efficiency at Shared Governance meetings remained a challenge. In 2012, iShare was becoming popular throughout the organization and presented as a tool that could be utilized to improve communication. The website provided an opportunity to restructure the Shared Governance Council. Only those members who wished to participate in Shared Governance as a council member rather than a team representative would remain. Instead of attending monthly meetings, teams became responsible for uploading bylaws, attendance sheets, minutes, PDSAs, 90-day action plans, and dashboard data to iShare. Shared Governance members became responsible for auditing iShare compliance each month. In addition to the availability of iShare and council restructure, the communication team's development of a monthly newsletter improved information sharing among the unit. The newsletter includes information from the entire neonatal division, including nursing management, respiratory therapy, pharmacy, lactation, and occupational therapy.

Although the NICU Shared Governance Council will undoubtedly continue to undergo changes, the current utilization of iShare, annual retreat, and monthly meetings for council members have proven to be steps toward the goal of improving communication among the teams. The Shared Governance Council remains hopeful that the persistent search for solutions to communication challenges will be met with the better fulfillment of its purpose to empower staff and coordinate the improvement of quality care and patient satisfaction.

Reflections from 10E New Graduates

by Monica Neslage, MSN, RN, Nicole Miram, MSN, RN and Lee Moreira, BSN, RN

It is often said, "It's not the destination that matters but the journey;" for what makes you who you are but the people and experiences you encounter along the way. It is also said, "When life hands you lemons, make lemonade;" because if you can't find the good in everything, you will be perpetually miserable. In many ways, you could say these proverbs personify the life of a nurse. Being a new grad on a unit like 10 East two years ago exemplified the meaningfulness in these proverbs even more. It was during this time that 10 East was going through a whole new identity change of new management, new staff, and a shift in patient population. Now, two years later, three new graduate nurses share their experience of being brand new nurses at UCSD, how shared governance grounded them on a solid foundation, and the pearls of wisdom they've learned along the way.

EMOTIONAL ROLLERCOASTER

Monica recalls the flood of emotions after being offered the job at UCSD: "Starting as a new graduate RN at UCSD Medical Center, I experienced all phases of emotions from panic and shock followed by excitement and anticipation. As far as first jobs go, I felt that I had hit the jackpot obtaining a position on a telemetry unit, an area of nursing I was always interested in."

Lee describes that inner voice that can often be overwhelming: "I remember when I started as a new grad in July 2011; I had mixed feelings and emotions. I had butterflies in my stomach on the first day and was so anxious, doubting myself and if I was capable. I worried about getting the acceptance of the others nurses and co-workers on the unit."

Nicole adds, "When I was offered a job at UCSD on the telemetry floor, I could barely fathom how lucky I was; the job almost seemed too good to be true. As my start date approached, I could only envision a job that I would soon find out couldn't be further from what I expected."

WALKING INTO THE UNKNOWN

Monica: "The unknown is always a little frightening, and as most first days go, I saw so much, learned so many new things, met so many new people, that it all went by in a blur. One thing I am thankful for is being hired along with two other new graduates at the same time. We developed a group mentality that I really came to depend on, sort of like "You've got my back and I've got your back.""

Nicole: "My first day at 10 east is hard to truly recall. It was a blur of fear, excitement, and countless unknowns. As my time as a new grad sped by, I came to find that 10 east was nothing of the 'telemetry' unit that I expected.

It was a melting pot of patients with a myriad of diagnoses. I became immersed in a patient population that spread across the whole spectrum of medical conditions, and was forced to quickly learn how to time manage, assess, document, and monitor. This whole process seemed daunting, and I would be lying if I said it wasn't."

Monica: "Working on 10 East, I started to learn very quickly of the difficult patient population and types of chronic diseases I would be dealing with on a regular basis. Our unit was becoming exposed to many new and unfamiliar types of patients from end stage liver disease to what seemed to

Monica Neslage, MSN, RN, received her Master's in Nursing from California State University, Dominguez Hills in 2011. She also holds a Bachelor of Science in Health and Human Services with an emphasis in Public Health and is trained in motivational interviewing. Monica was hired as a new grad on 10 East in January of 2012.

Nicole Miram, MSN, RN, received her Masters of Science in Nursing with a focus on Leadership Management from Sonoma State University in 2011. Prior to that she received a Bachelor of Science in Exercise Biology from UC Davis. Aside from having a certification for Clinical Nurse Leader, Nicole is also a certified Public Health Nurse. Nicole came to the 10 East team as a new grad in September 2012.

Lee Moreira, BSN, RN, received her Bachelor of Science in Nursing from Azusa Pacific University in 2011. She holds an additional Bachelor of Science in Business Administration which she received from Universidade Paulista, San Paulo Brazil. Lee is also a certified Public Health Nurse, speaks fluent Spanish, volunteers in the Post Anesthesia Care Unit with Thousands of Smiles, and is the Vice President of the San Diego National Association of Hispanic Nurses. Lee came to 10 East as a new grad in January 2012 and immediately joined the UBPC. She is currently working towards her CNIII, focusing on stroke education and patient follow up.

be an increase in psychiatric and mood disorder-type patients. Learning to interact with these patients proved to be quite demanding and tough at the start."

A GOOD PRECEPTOR IS WORTH THEIR WEIGHT IN GOLD

"On my first day, I was immediately greeted by my preceptor who I would quickly come to know as an incredible bedside nurse, a selfless coworker, and a very dear friend. Her energy and compassion were, and still are, unparalleled. She had the ability to make me feel accepted, confident, comfortable, and supported. Which for a new grad are probably the most important things you can hope for.

With my preceptor, I got them all, wrapped up in a mentor and friend."

Lee: "I had an amazing preceptor. She is the foundation upon which I built my practice and is largely responsible for the nurse that I am today. She had the passion, patience, knowledge, and great sense of humor needed to both guide me and put me at ease. She helped build my confidence, improve my knowledge, and made me work independently in a short period of time. I cannot thank her enough for all she did for me."

Monica: "I had the opportunity of having two preceptors to learn from. With the Sculpizio CVC opening in August 2011, my first preceptor went along with it so I was paired up with another experienced RN on the unit. I felt very lucky to have gotten along so well with both of them, as well as to have learned from their two very different teaching styles. In the end, I know my first preceptor's 'throw the cub into the lion's den' approach forced me to break out of my shy, timid little shell. On the other hand, I still cherish my second preceptor's compassionate, empathic, and cautious methods at the bedside. Both helped to form my outlook and the way I interact with patients every day I work."

FINDING YOUR VOICE

Monica: "One of the most valuable opportunities I had as a new grad was joining the Unit Based Practice Council (UBPC). As a shy and timid person, the UBPC gave me a way to communicate in an arena that didn't make me feel isolated. It also introduced me to valuable resources and helped me to focus the chaos of information in my brain. The great thing about our UBPC is that it was solution-focused. As tough as things may have been going on 10 East, we always knew we could bring our issues to the table for discussion and management support."

Lee: "Being a part of the UBPC has been an amazing experience. From the first day I sat down across the table from my co-workers at our first meeting, I felt like part of the team. Our UBPC has been a great platform

for positive change and has allowed me to be a part of that change. I mean, let's face it, no one wants to listen to a new grad. The UBPC, however, gave me a place to voice my ideas where they would be both heard and supported."

Nicole: "I was very thankful for the 10 East UBPC because it allowed me to get involved in the unit right away. I liked that I didn't have to work there for years first. Being on the UBPC has inspired me as a nurse and given me the knowledge and confidence to pursue quality improvement projects, not just with the group but on my own as well."

ATTITUDE IS EVERYTHING

Monica: "I still look at our unit's transition as a positive, as opposed to a negative, because of all the new skills I have acquired over the past two years. Despite being exposed to new types of patients, there are still a lot of difficulties that came along with the transitioning unit. Those difficulties include a loss of experienced RNs on the unit, which I noticed more than others, I think, due to having so many needs and questions during my first year. Even so, this negative was replaced with a positive because so many new RN's were hired and I felt that I was a part of a unit that was focused on teaching and precepting. It felt like everyone was learning, even the seasoned RNs because of the new types of patients we admitted."

Nicole: "What my experiences with my preceptor, managers, and co-workers have taught me, is that while our work does define who we are; it is also we, who define our work. There are days that can drown you, and the only way I was able to keep from sinking was to utilize the support, teamwork, and care of those I am lucky enough to be surrounded by at my job. I love being a nurse, and even in my most miserable and challenging moments, I can grasp at least one thing that keeps me subtly grateful. It is the hospital I work for and the people I work with who keep me going, keep me grounded, and constantly perpetuate my love for nursing on 10 East."

2013 Nursing Excellence Clinical Awards

The following awardees are recognized as our 2013 Award Winners:

Clinical Nurse Awards are supported by the David & Alice Miller Nursing Award Endowed Fund.		
Award Recipient	Unit	MAGNET Component
Melvin Ersando, BSN, RN	6 West Med Surg	Transformational Leadership
Dahlia Tayag, MSN, RN, CCRN	Post Anesthesia Care Unit	Structural Empowerment
Hayley Kuhn, BSN, RN, TNCC	Post Anesthesia Care Unit	Exemplary Professional Practice
Laura Boerner, BSN, BS, RN, CEN	Sulpizio CVC Emergency Department	New Knowledge, Innovations and Improvements
Faye Rivera, BSN, RN, PCCN	5 West PCU	Empirical Outcomes
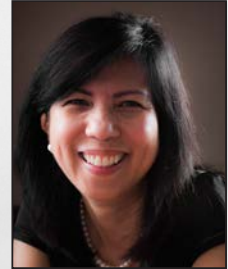
Overall Clinical Nurse of the Year: Dahlia Tayag, MSN, RN, CCRN

Nurse Consultant Awards are supported by the Patrons of Nursing Shared Governance Fund.		
Award Recipient	Unit	MAGNET Component
Cheryl Cross, MSN, RN, PHN	Education, Development and Research	Transformational Leadership
Jennifer Garner, MSN, RN, CCRN	Surgical ICU	Structural Empowerment
Cassia Chevillon, MSN(c), RN, CCRN	Education, Development and Research & SCVC ICU	Exemplary Professional Practice
Peggy Castor, RN, RNC-NC	Neonatal ICU	Empirical Outcomes

Overall Nurse Consultant of the Year: Cheryl Cross, MSN, RN, PHN

Advanced Practice Nurse Awards are supported by the Sonya Healy Nursing Management Award Fund.		
Award Recipient	Unit	MAGNET Component
Laura Dibsie, MSN, RN, CCRN, CNS	Education, Development and Research	Structural Empowerment
Patricia Graham, MSN, RN, CCRN, CNS	Education, Development and Research	Empirical Outcomes

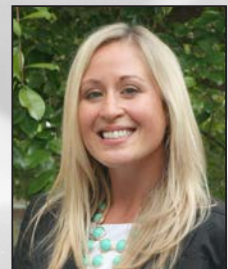**Overall Advanced Practice Nurse of the Year: Patricia Graham, MSN, RN, CCRN, CNS**

Nurse Leader Awards are supported by the Sonya Healy Nursing Management Award Fund.		
Award Recipient	Unit	MAGNET Component
Mary Hellyar, MSN, RN, CCRN	Thornton ICU	Transformational Leadership
Cristina Cazares-Machado, BS, MSNc, RN	6 East Med Surg	Structural Empowerment
Leah Yoshisaki Yusi, BSN, MPH, RN, ONC	8th Floor Med Surg	Exemplary Professional Practice
Laura Vento, MSN, RN, CNL	6 East Med Surg	New Knowledge, Innovations and Improvements
Esther Lee, MBA, RN	Peri-Anesthesia	Empirical Outcomes

Overall Nurse Leader of the Year: Laura Vento, BS, MSN, RN, CNL

The Marguerite Jackson Scholarship for Doctoral Education

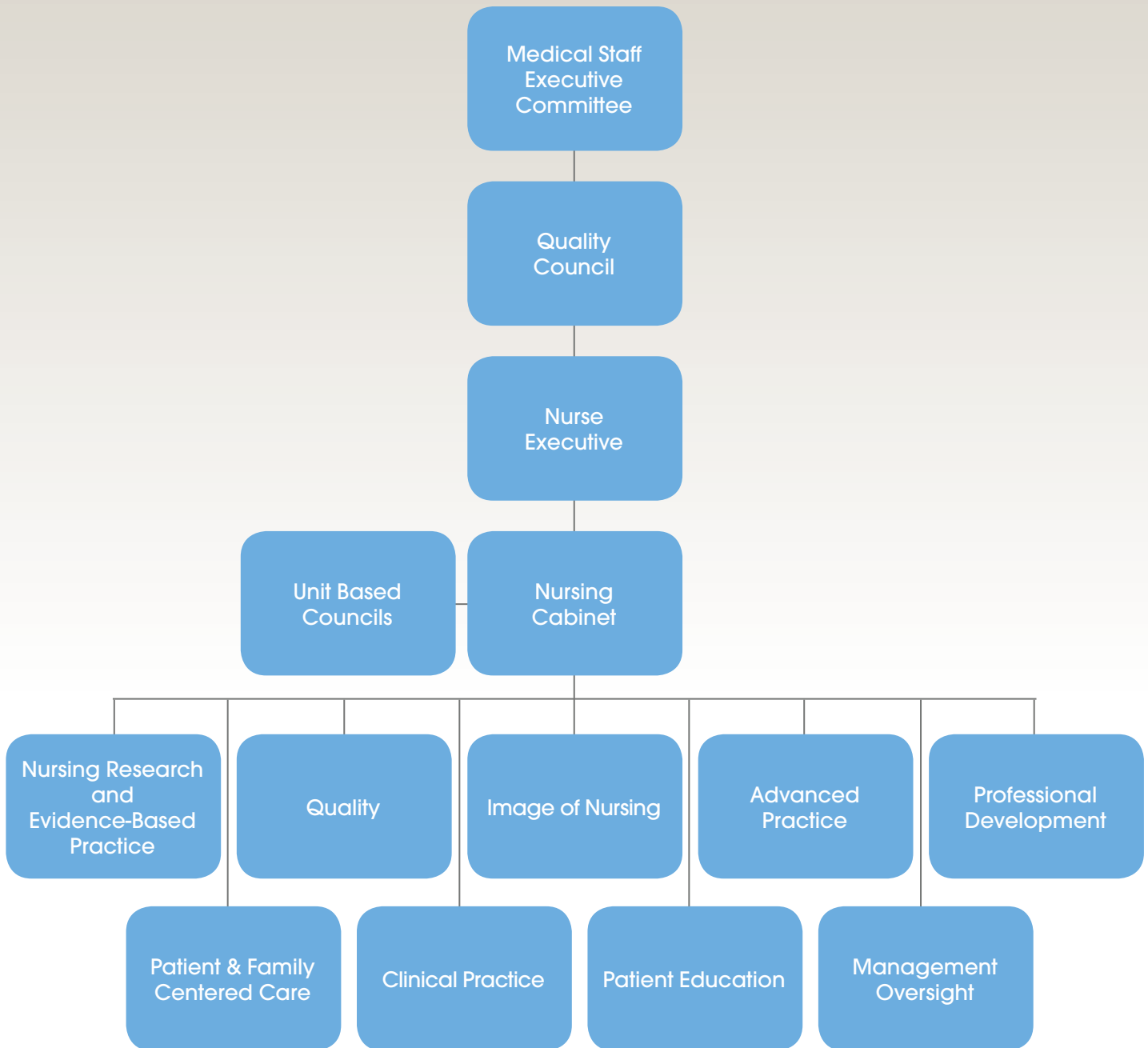Provides education funds to a nurse enrolled in a formal doctoral education program.

Scholarship recipient: Jillian Jewett, RN, BSN
Burn ICU

The Marguerite Jackson Award for Professional Nursing Excellence

Provides funds to a nurse who exemplifies professionalism as evidenced by their level of education, certification, and professional activities.

Award recipient: Aran Tavakoli, MSN, RN, AOCNS
Education, Development and Research

Dahlia Tayag, MSN, RN, CCRN

Cheryl Cross, MSN, RN, PHN

Patricia Graham, MSN, RN, CCRN, CNS

Laura Vento, BS, MSN, RN, CNL

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