**Professional Engagement**

**Source of Evidence 1**

**Describe and demonstrate the structure(s) and process(es) that enable nurses from all settings and roles to actively participate in organizational decision making such as committees, councils, and task forces.**

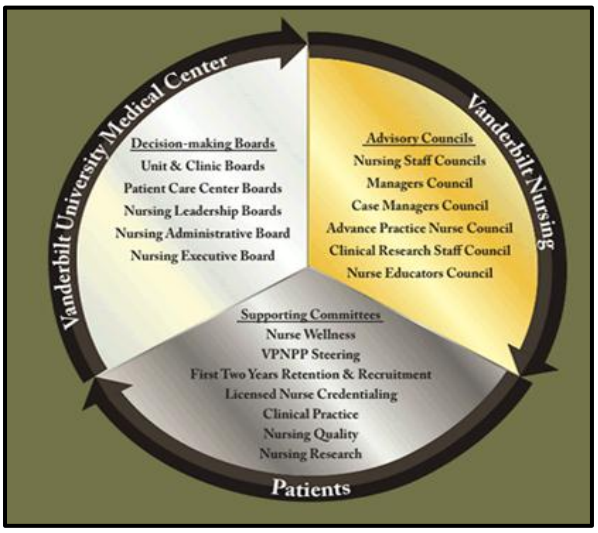
**Overview**

The structures and processes that support Vanderbilt nurses to participate in organizational decision making is our shared governance model which has been in place since the late 1970's. Our model has changed and evolved over the years, but the basic principles of involvement, ownership, accountability, openness and honesty provide the framework for the design and implementation of the model. Decisions are made close to the work and the care provider and have been woven into the fabric of everything we do and the way we continue to do it after all these years. Our complicated matrix leads to a very collaborative process in all the decisions that are made at Vanderbilt. Shared decision making is seen in everything we do from our Credo, to our job descriptions, to the use of targeted selection for hiring our staff to our staff's participation in the nursing governance structure. Our Nursing Bylaws provide the framework for our model of nursing self-regulation, as referenced in the 2010 ANA social policy statement. *(Please refer to the Nursing Bylaws in OO 3)*

Though every large healthcare organization has hierarchy and has formal leaders in place, Vanderbilt has a "heterarchial" shared governance structure, i.e. it is multi-directional, multi-disciplinary, and provides many avenues and opportunities for direct care nurses at all levels. This creates a synergistic partnership between formal leaders and their direct care staff. Our shared governance model consists of three types of committees: decision-making boards, advisory councils and supporting task forces/committees. Our multi-tiered approach to shared governance offers nurses from all settings and roles within the Medical Center opportunities to actively participate in information-sharing and decision-making groups.

See Chart below.

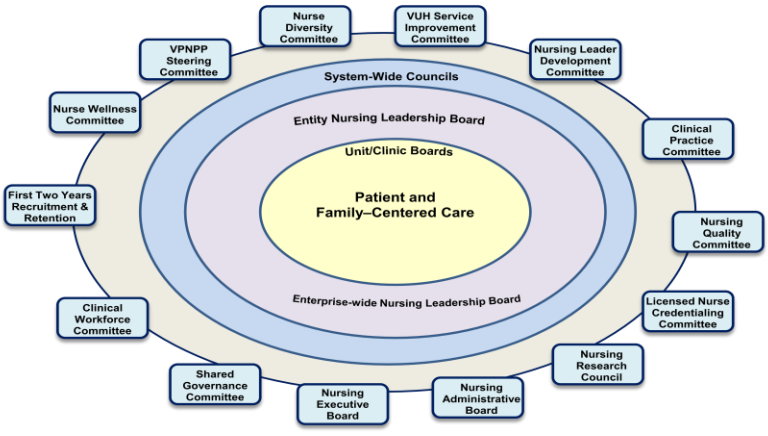
**Chart SE 1 – 1: VUMC Shared Governance Model**




**Communication Flow**

The level of decision-making closest to the point of care (patient) is the unit, clinic or department board. These local boards, co-chaired by two direct care nurses, have direct access to decisions made at the system level by virtue of the partnership established with the manager. For example, every manager goes to manager meetings attended by leaders from across the organization and senior nursing executives. The managers take input, questions, and share results from their local areas out into the organization through these meetings; as well as take discussions, questions and information back to their local area for input and feedback. Communication flows in a variety of multi-directional ways. With appropriately layered board, council and committee membership, communication is tighter and the right stakeholders are engaged.

**Chart SE 1 -2: VUMC Shared Governance Structure**



In the same way, direct care nurses from across the organization attend entity-specific council meetings, co-facilitated by staff nurse peers and their senior entity leaders (VUH CNO, VPH CNO, VMG CNO, and VCH/Children's Hospital CNO). Different levels of nursing leadership, ranging from manager to chief nursing officer attend council meetings depending on the agenda. The direct care nurses serve as active members of these committees bringing information to the large system-wide council meetings from their local level boards and then taking information back to the local level as appropriate. (*Refer to OO 15 for Councils/Committees Membership Information)*

Corporate Medical Center enterprise-wide leaders of functions such as Nursing Research, Family Centered Care, Supply Chain, Systems Support, Nursing Education and Professional Development and others, have a forum to both impart information and education as well as gain feedback and suggestions from the direct care nurses at these staff council meetings. This is an efficient way for enterprise-wide leaders to have direct contact with the staff nurses who deliver the care and service to patients. Many of these leaders go directly to the individual board meetings.

Several committees such as Nurses Week, Service Improvement, Nurse Wellness, First Two Years Retention and Recruitment, to name a few, in addition to having staff nurses as members have also solicited feedback from the staff nurse councils. These councils collectively represent the voices and thoughts of the direct care nurse in all settings within the Medical Center. Throughout the exemplars in this document, we demonstrate direct care nurse input into decision-making at all levels. [*SE1-Exhibit A-1-Inventory of Charters*]

**Challenges**

Sometimes it can be challenging for an organization to find the resources to provide nurses and other clinical caregivers the opportunity to participate in these important councils. We have the additional challenge of being a large complex organization with many off-site locations. Our own experience and insight from literature has demonstrated to us repeatedly that staff involvement is the right thing to do. Vanderbilt nursing has not given up trying to find unique and innovative ways to open channels for participation. Nursing leadership in partnership with the nursing councils has sought easily accessible and navigable technology systems for virtual meetings.

For example, the Director of Shared Governance is working with staff and technology leaders at the One Hundred Oaks (OHO) off-site campus (5 miles away) to use distance communication such as "Skype" or other alternatives for the staff nurses at OHO to be able to

participate in the Vanderbilt Medical Group (VMG) Nursing Staff Council and other meetings. Many staff members physically attend the council meetings as much as possible, but by using technology, participation may be more feasible for all. In fact, because of this work in 2010, an OHO VMG direct care nurse (Dianne McArthur, RN) was elected as a new co-chair to the VMG Nursing Staff Council (NSC). VUMC has recently purchased a webinar system (Webex©) that will provide us with an additional system to conduct meetings and encourage staff nurse participation remotely.

Our structure and philosophy encourages engagement and provides avenues for nurses in every setting to get involved in boards, committees, task forces, and unit councils. Our culture supports direct care nurses in taking ownership for problems by designing solutions to enhance the quality of patient care. In addition, nurses in councils, take responsibility for promoting work life balance through role modeling it for others in their work environment. The very best service cannot be safely delivered to our patients unless our caregivers are healthy, satisfied, and professionally fulfilled.

**Training, Education and Mentoring**

All staff has the opportunity to participate in their local boards and will receive the education and coaching to lead these boards as needed. Staff nurses may also become peer direct care leaders by accepting a nomination to enterprise-wide council (this provides them with a feeling of support from their peers in that selection process).

At the local level, there are two elected staff co-chairs – one a more experienced staff leader and the other in somewhat of an apprentice-learning role. They are mentored by their manager and by the Director of Shared Governance, to lead the Unit/Clinic Board. In addition, there are ongoing shared governance workshops that provide education on:

- Brainstorming and securing engagement among their peers
- Cultivating team leaders to take on certain projects and issues that surface
- Communicating processes and outcomes to the staff at large
- Contributing to a positive team environment in their setting
- Agenda planning and commitment to shared decision making

- Engaging manager mentors to assist the staff in truly engaging and leading the decision-making Process in their councils

**Conclusion**

In our Credo, Vanderbilt expects and supports all staff to express their ideas, to be comfortable with being challenged on those ideas and to be willing to put forth the effort to not only accept but lead change. We believe that sharing one's "voice" is a professional nursing responsibility. Vanderbilt staff nurses and their managers value and foster an environment that welcomes this process of inquiry. Consensus decision-making means exploring all perspectives, having productive discourse, then moving on to a consensus decision that all stakeholders can live with and support. Our shared decision-making culture creates a milieu of transformational leadership styles that respond to nursing care delivery constraints identified by unit boards or system-wide councils. Our leadership teams have the courage and the transparency to go out on a limb to make things happen and the wisdom to support the staff with empowering structures.

Our Shared Governance website is listed first on Dr. Tim Porter O-Grady's small listing of "*exemplary online nursing shared governance sites*" with his remarks "*for those who are interested in further refining their own shared governance journey within the Magnet framework), helpful are the following websites containing information of a practical and applied nature that can assist in facilitating the journey and minimizing the 'noise' embedded in its implementation*". http://tpogassociates.com/blog/ Dr. Porter O'Grady lists only six (6) sites. Our Shared Governance website is the mere tip of the depth of the real work and energy that goes into our sustaining of this culture.
http://www.mc.vanderbilt.edu/root/vumc.php?site=Shared%20Governance

**Table SE 1 – 1:** Examples of Accomplishments from Council Decisions

| | Quality of Care/Service | Work life | Education |
|---|---|---|---|
| **Inpatient Examples** | • Room cleanliness<br>• Evidence-based practice<br>• Vent associated pneumonia & other quality initiatives<br>• Professionalism<br>• Standardizing daily weights<br>• Supply and linen par | • Staff celebrations and kudos<br>• Teamwork<br>• Morale<br>• Scheduling decisions within policy<br>• Breaks<br>• Communication<br>• Trust-building | • Competencies<br>• Preceptorship<br>• Unit specific orientation<br>• Unit website<br>• Unit newsletter<br>• In-services |

| | | | |
|---|---|---|---|
| | levels<br>• Discharge planning<br>• Care partner roles<br>• Equipment upgrades | | |
| **Outpatient Examples** | • Improved clinic flow<br>• Improvements in phlebotomy service<br>• Job description realignments<br>• Crash cart implementation<br>• Dress code standards<br>• Creation of procedure team<br>• Focus on pt satisfaction<br>• Protocol for sickle cell | • Reward & recognition<br>• Space utilization<br>• Shift/work life balance<br>• Recycling<br>• Off-hours security<br>• Scheduling<br>• Focus on communication<br>• "Fun at work" | • Training initiatives with MDs and NPs<br>• Patient/family education materials<br>• Special topics by physicians/residents |

[SE1-Exhibit B-1-VCH NSC Charter, SE1-Exhibit B-2-VCH NSC Minutes 9-2-10, SE1-Exhibits B-3-VUH NSC Charter, SE1-Exhibit B-4-VUH NSC Minutes June 2010]

**Shared Governance Structure Changes**

Originally, we had one entity-wide staff nurse council. As our campus and numbers grew, it became increasingly clear, we needed a change. The nurses on the council recognized that each entity had issues specific to their patient populations and environments. In the Fall of 2007 the original entity-wide staff council decided to create a new level of shared governance. Representatives from every unit, floor, clinic and department gathered, elected officers and formed entity specific nursing staff councils. This new structure was added to our Nursing Bylaws at our 2008 Nursing Bylaws Convention.

A council was created for each of the four settings, Vanderbilt University Hospital (VUH), Vanderbilt Children's Hospital (VCH), Vanderbilt Psychiatric Hospital (VPH) and Vanderbilt Medical Group (VMG). Charters and mission statements were developed. The Nursing Staff Councils serve in an advisory capacity to Nursing and Administrative Leadership, to propose, evaluate and influence system-wide decisions. The co-chairs of these Councils, known collectively as the Vanderbilt Nursing Staff Cabinet meet with the Vanderbilt University Medical Center (VUMC) Executive CNO quarterly to report progress, discuss and share ideas.

**VMG Staff Council**

Ambulatory care nurses at Vanderbilt have become increasingly more involved in decision-making venues over the past few years. Since the number of clinics has significantly increased, we have made a concentrated effort to involve the ambulatory staff. We have multiple clinics – on and off the main campus. Many of the Vanderbilt Medical Group (VMG) nurses have become peer leaders as a result of participation in the VMG Nursing Staff Council (NSC). The LPN Career Advancement work group and other efforts regarding education, professional development, and clinical orientation started in the VMG NSC.

The VMG NSC decided at its second meeting to survey the nurses to determine what issues they wanted to bring forward for consideration. We had a collective voice and knew that we now were able to bring our knowledge "*from the side of the patient to the boardroom*". The results of the survey were collected and analyzed. It was determined that the top issue was in the area of professional development, including better access to nursing education and greater opportunities for our LPN staff. It was also felt that opportunities for improvement existed in professional communication and compliance with Credo behaviors. Following are some examples of the outcomes of the VMG staff council survey and work:

- A category was added to our occurrence reporting system (VERITAS) to support staff to voice concerns about CREDO behaviors without fear of repercussion. *(details in EP 28)*

- A Director of Clinical Education and Professional Development was hired for VMG

- A Preceptor workgroup was created. This worked to create and develop nursing orientation within the outpatient setting, and also serves to ensure and improve consistency in clinical practice and competency assessment within VMG.

- The VMG NSC works with, and has representation on the Clinic Redesign Committee. This Committee works to improve the clinical setting and processes thereby increasing the throughput of our patients. *(more details in EP 7 EO)*

- LPN Career Advancement Ladder

[*SE1-Exhibit C-1-VMG NSC Proposal*]

Perhaps the area of greatest improvement has been seen in the role of the LPN at Vanderbilt. Our Clinics have a high concentration of LPNs, whereas we have fewer in the inpatient setting. The VMG NSC worked with nursing leadership to address several issues

regarding LPN practice. First and foremost was to include LPNs among the nursing staff within the Vanderbilt Nursing By-Laws. Previously, LPNs were listed as affiliate staff; due to the history of low numbers. A proposal was drafted, presented, and voted into approval at the 2008 Bylaws Convention. There was an enthusiastic round of applause for this outcome. Janice Flatt, an LPN, stood before the floor and expressed how proud she was that after 4 years of nursing at Vanderbilt, she was now officially recognized in her role as a nurse. As members of the regular nursing staff at Vanderbilt, LPNs now have a blue ID badge, they no longer wear white, affiliate staff badges. [*SE1-Exhibit D-1-VUMC Reporter Article-LPN-Nursing Bylaws*]

**"In her own words": *It's More than Just a Color***

"*Who decided to make Vanderbilt nurses' ID badges blue? Was it a random decision, maybe someone's favorite color? Perhaps it was a sunny day and the sky was very blue? However the choice was made, it seems fitting. Psychologists tell us that colors carry symbolism. The color blue symbolizes hope, intelligence, confidence, loyalty, wisdom and truth. It is associated with someone who practices analytical thinking, is practical and takes on tremendous responsibility. It is said that light blue represents health, healing, tranquility, understanding and softness. Dark blue represents knowledge, power, integrity and seriousness. Were these qualities considered when blue was chosen for Vanderbilt's nurses?"*

**Laurie Matravers Ashley, ADN, RN3**
VMG Infusion Center
[*SE1-Exhibit D-2-Laurie Matravers Ashley Letter*]

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One of the proudest moments of the VMG NSC was when Betty Slusher, LPN from PEDS Perioperative Services was awarded the first ever "LPN of the Year". She has served tirelessly as a nurse at Vanderbilt for over 19 years.

Another issue regarding LPN practice was the ability to start IVs in the clinical setting. Tennessee regulations for LPN practice license LPNs to start IVs on patients after adequate training and competency checks. This had been a skill that Vanderbilt has required RN licensure to perform. The VMG NSC petitioned nursing leadership to allow LPNs to perform the skills that they had been licensed to do. An IV therapy class was formed for LPN staff and now they are able to start IVs with venipuncture.

A direct result of this has been seen by our oncology patients. Prior to receiving chemotherapy, our cancer patients must go to the lab and have their blood drawn. Previously, this would require one venipuncture for labs, then another upon arrival to the infusion area for

an IV start. Now our patients can have an IV placed at the same time their blood is drawn, in the lab, by an LPN. Our patients have expressed gratitude for streamlining their care and decreasing their discomfort.

The VMG NSC formed a sub-committee along with representatives from Human Resources, Vanderbilt Professional Nurse Practice Program (VPNPP) and other disciplines within the medical center to create an LPN Career Ladder. This Career Ladder aligns itself with the VPNPP RN Career Ladder enabling nurses to advance within their practice. Many months of hard work by dedicated nursing staff went into the creation of this Career Ladder. It was approved by Vanderbilt's Nursing Leadership and was implemented in the Summer of 2010. As the LPNs work as part of the interdisciplinary team in conjunction with the RNs, these changes serve the teams and the patients well.

This Council has worked vigorously to improve morale and increase the sense of empowerment within the nursing staff. Their work and results have been presented to the 2008 TNA Convention and the 2009 ANA LEAD Conference, via poster presentations. The input of our bedside nurses has proven valuable to improving the level of care given to our patients. At Vanderbilt, our nurses don't sing the blues, we wear it proudly, knowing that in a very small way it symbolizes who we are and what we do every day.

**Professional Engagement**

**Source of Evidence 1 EO**

**Describe and demonstrate two (2) improvements in different practice settings because of nurse involvement in organizational decision-making groups such as committees, councils, and task forces.**

**VUH**

**Purpose/Background**

For many years at Vanderbilt, the Vanderbilt University Hospital (VUH) nurses have set the pace for the other Vanderbilt entity nurses. The technology system upgrades always begin in VUH. For example, Horizon Electronic Documentation (HED), AdminRx, and VandyWorks were first implemented and tested in VUH before rolling out into other areas of clinical practice at Vanderbilt. The VUH nurses have used side-by-side systems more than once to be the first to try new applications. This is done by staff to advance patient care while partnering with nursing leadership to define the areas for needed improvement. Interdisciplinary HED Improvement Committees and Work Redesign groups were formed as task forces to define the system barriers to implementation. HED has been continuously upgraded due to this input from the end-users (direct care nurses).

**Methods/Approach**

One specific example of the work of an interdisciplinary task force is the group that was formed to address the use of AdminRx (bar coded medication administration system) with adult and pediatric oncology patients. VUMC has a large population of both adult and pediatric oncology patients. From the beginning of AdminRx implementation, it was identified that Admin Rx would pose special challenges for the high risk chemotherapy (Chemo) and Bone Marrow Transplant (BMT) populations. These are high risk medication modalities requiring careful coordination and timing of the administration of the medications. Administration is often dependent upon lab values or other clinical measures such as urinary output and urinary pH. There are also medications that must be administered before, during or after chemotherapeutic medications (pre-meds).

This posed unique scheduling challenges for the Admin Rx system since there was not a method to have a schedule generated based upon factors other than the provider-ordered time schedule. The central AdminRx workflow group knew that more research was needed to further identify chemo related issues that had yet to be identified. The Chemo and BMT departments were moved to the end of the implementation schedule and a team identified to assure that all workflow and technical issues could be addressed to ensure that the system would be safely implemented to support chemo and pre-med administration.

The team meeting frequency varied from every two weeks to monthly. Much of the work was done outside regular meeting times with team members testing chemo administration documentation in the test environment and identifying issues in their unit based implementation teams. The testing was interdisciplinary and involved providers entering typical chemo orders, pharmacists processing these orders in the Pharmacy system, HED/AdminRx technical staff observing how the meds were displayed and informatics system support representatives and staff nurses scanning and documenting medications.

Practice scenarios were created and groups of staff nurses administered medications and committee members ("super users") elicited suggestions and issues that were then brought up at the committee. To investigate how other institutions managed chemo related issues, members of the technical team contacted the vendor as well as conducted a conference call with the Ohio Health System to determine how they were handling the identified issues.

To evaluate the impact of changes made by the committee, during the first BMT unit implementation audits were done to evaluate chemo administration and documentation for the first 72 hours (18 administrations). The audit monitored completeness of the pre-procedure checklist, calculation verification, and co-signature completed. The reports were run to check for any warnings that might be received and the staffs were asked to note any problems (i.e. trouble scanning). The results were positive and shared with the committee. The only problem/trend noted was an issue scanning large volume bags of Chemo. The team worked with the Chemo Pharmacy to change the orientation of the label on the bag and this issue was resolved.

How the results of this project were shared:

- Work of the chemo workgroup was shared with the central AdminRx workgroup and steering committee

- Other institutions that have implemented Admin Rx have also consulted

- Committee members re: issues and action plans for BCMA in the chemo patient population

- The work done on the pre-blood/ pre-chemo frequency was shared with another

- Internal work group that was struggling with typical medications ordered for dialysis patients

**Table SE 1 EO – 1: Participants**

| | |
|---|---|
| Carol Eck, RN, MBA | Administrative Director, Oncology Patient Care Center – co leader |
| Gwen Holder, RN, MSN | Assist. Director, Systems Support Services – co-leader |
| Gail Herrman, RN, MSN | Case Manager, Hematology |
| Julia Cartwright, DPh | Director, Chemo Pharmacy |
| Phillip Stewart, DPh | Pharmacy Informatics |
| Barbara Merriweather, RN, MSN | Testing/QA, Informatics |
| Kathy Moss RN, MSN | AdminRx Informatics |
| Sandra McDonald, RT | Project Manager, AdminRx, Informatics |
| Cathy Ollom, RN | Nurse Educator, Cancer Center |
| Christine Crossno, DPH | VCH Pharmacy |
| Janet Lucas, RN, BSN | Asst Manager 11N BMT unit |
| Kristen Berutti CSLP | HED technical/ builder |
| Sheryl Redlin Frazier- RN, MSN | Educator 4E OB/GYN |
| Adele Lewis RN | VCH Staff Nurse |
| Nancy Rudge RN, BSN | HED/ AdminRx, technical manager |
| Anthony Owens RN, BSN | 6$^{th}$ VCH / super user |
| Lana Howard, RN | CRC Staff nurse |
| Michael Jordan RN, MSN | Educator 8 N & S, Medicine |
| Debbie Shinkle RN, MSN | Educator 6A VCH |

**Outcomes**

The table below identifies the issues, solutions identified and the outcomes:

**Table SE 1 EO – 2: AdminRx Chemo medications issues identified**

| ISSUES | SOLUTIONS | OUTCOMES |
|---|---|---|
| **Decimal rounding issues:**<br><br>The AdminRx application recalculates certain chemotherapy medication orders that are processed in the HMM Pharmacy system resulting in a dose based on a slightly different rounding formula. This often results in a decimal place rounding discrepancy between the dose AdminRx thinks the patient should receive and the dose actually delivered. When this happens, with a bar code scan of the medication, the administering nurse gets a warning that the dose scanned does not match the order and the nurse would have to over-ride the ”incorrect dose” warning to administer the medication. This would have led to the nurses developing a habit of overriding warnings which would have negated one of the benefits of bar code medication administration (BCMA). This was a known technical issue but there was not a fix for it from the vendor. | Extensive testing by Pharmacy and informatics testers revealed that this only occurred when the calculation was carried out past 3 decimal points. Chemo Pharmacy reviewed records of all chemo dispensed in the previous 6 months and determined that the likelihood of this happening was very rare. The workgroup decided to proceed with the implementation despite this known issue. The vendor was able to implement a fix for the problem prior to the “go live” implementation with the Children’s hospital chemo areas. | Technical fix applied by vendor prior to implementation. Testing scenarios were run and decimal rounding issues were no longer problematic; monitoring continued post implementation and there were no issues with the decimal rounding or erroneous warnings r/t decimal rounding. |

| | | |
|---|---|---|
| **Inability to sort all chemo related meds together:**<br><br>A system limitation was discovered that identified that medications could not be sorted together. In the manual world there was a separate chemotherapy Medication Administration Record (MAR) that displayed all chemo medications so nurses could see sequencing of medications administered. | The workgroup decided that until this functionality was available the paper MAR would still be used as a reference for scheduling / sequencing of medications. | This will continue to remain high on the priority list. Resolution will probably be achieved with the revisions of Care Organizer (CO). |
| **Scheduling issues:**<br><br>The pharmacy assigns schedules in Admin Rx, however, many of the chemotherapy drug schedules are based upon lab value criteria such as urine pH. Many of the chemo medications have other medicines that must begiven pre-, during or post- chemo so if the timing of the initial dose of chemo is off it will result in the entire schedule for these medications to be off as well. | The workgroup decided that the initial chemo dose would be scheduled for 1800 and the night RN would electronically message the Chemo Pharmacy to alert them when the initial dose of chemo was given and then Pharmacy would change the schedule to reflect that time but future schedule changes would be highly discouraged. If a chemo medication had to be rescheduled the medication would have to be returned to the chemo pharmacy for re-labeling with the appropriate schedule information. The paper MAR would also serve to prevent scheduling issues. | First 24h schedule is not correct in Admin Rx and staff must rely on paper chemo MAR – This issue was worse for VCH since pediatric patients have to meet criteria ( urine pH & specific gravity) and the RN needs to send the schedule change but usually occurs after the Chemo Pharmacy closes for the night so the change is not made until the next day after the schedules have already been generated.<br><br>Options have been discussed to improve this process but implementation has not occurred as yet. |
| **Locating Chemo related documentation:**<br><br>Staff had to go to various sections of the electronic documentation system (HED) to locate data related to chemotherapy and there was | A Chemo tab was develop in HED that would pull information from various other tabs as well as serve as a place to document all chemo related information except for the actual medication administration. | Night staff cannot see next day's schedule of meds.<br><br>This hinders the nurses' ability to request schedule changes that assure medications are adequately spaced out. When there were paper MARs that |

| | | |
|---|---|---|
| not an electronic method to document that the pre-chemo checklist was completed. | A pre-procedure checklist was used, a place for verification of calculations was denoted and staff were educated on how to co-sign chemo administration in AdminRx since two RNs had to verify each dose. | were generated at 0200, night shift was able to complete this process. Staff need a way to see a virtual MAR- HMM has this information but the nurses are not able to view this information. Admin Rx/CO does not import this information until the HMM batch jobs run which means that it 0530 or later before the next day's schedules are visible. |
| **One time medication orders:**<br><br>Displayed as "discontinued" 1 minute after the due date/time causing confusion (re: if the medication should be given or not). In addition, the one-time medications were not displaying on the overdue list and would fall off the to do list too soon. | Technical adjustments were made to extend the duration of one time medication orders and also to have one-time medications displayed on the to-do list and overdue medication list. | Technical changes made so that 1time orders display on care organizer X 24h and show up as overdue after 60 min. Ongoing monitoring revealed this is no longer an issue. |
| **Multiple syringes for a single dose:**<br><br>Some chemo medications are dispensed as 2 syringes – when the second syringe is scanned, staff incorrectly get a "medication discontinued" error. | Pharmacy staff were educated on new technique to process these types of orders that would not result in error message for staff – also worked on labeling to ensure that a message displayed indicating number of syringes needed for the dose. | Post go live, change in work process made and bar coded label attached to a ziplock bag that contains all the syringes. Label indicates number of syringes and nurses scans it. Use of ziplock bag also prevents syringes from getting separated. 2 RNs must verify the meds, the order in addition to scanning bar code. There has been a decrease in the errors related to missing med dose secondary to multiple syringes. |
| **Chemo queue:**<br><br>Chemo orders entered after the Chemo pharmacy closes are not processed by the | Nursing staff educated on verification of orders process that would assure that chemo medications would not be missed ( i.e. writing on | An "After hours chemo policy" restricts processing of chemo orders by non chemo phm staff and explicitly states process for preparation in an emergency. |

| | | |
|---|---|---|
| central pharmacy and the potential exists for medications to get missed or delayed. | paper MAR until entered by Chemo Pharmacy); workflow changes were made in central pharmacy to generate a printout when a chemo order was entered after chemo pharmacy was closed and chemo pharmacy staff were trained to check queue first thing every morning. | Chemo pharmacy staff audit a report that contains all the chemo order entered for past 24hs to assure all orders are processed. This report also could serve as a way to identify any problem trends ( ie certain providers ordering chemo after hours, central pharmacy processing/preparing orders in appropriately etc.) Ongoing monitoring reveals this is not an issue. |
| **Pre-Chemo/ Pre-blood medications did not have a schedule:**<br><br>These were displayed in the "prn" section of the to do list. It was feared that the staff would miss these important pre-medications. | The decision was made to have charge nurse from the chemo unit administer chemotherapy on non chemo unit patients and make all attempts to transfer the patient to the chemo unit as soon as possible. The decision was also made to make the Chemo tab in HED available for all units. | Education provided during implementation to check for preblood meds in the prn section. Since implementation there have been no incidents of missed pre meds. |

The results of this project were shared with the central Admin Rx workgroup and steering committee. Other institutions that have implemented Admin Rx have also consulted the group related to these issues and have used the action plans that we developed for BCMA in the chemotherapy patient population. The work done on the pre-blood/ pre-chemo frequency was shared with another internal work group that was struggling with dialysis related medications. [*SE1EO-Exhibit A-1-Chemo Workflow Work Group Minutes*]

**Children's Hospital**

**Background/Approach**

An example of direct care nurses coming together to solve an issue is demonstrated by the Equipment and Supply Task Force that was formed in VCH. This group was formed based on issues that had been brought forth by direct care nurses to the Children's Nursing Staff Council.

Direct care nurses expressed concerns about having equipment when they needed it. Specifically, there were challenges in obtaining functioning transport monitors, dopplers, suction regulators, thermometers, beds and cribs. Nurses were spending a significant amount of time looking for equipment and when it was found it was either broken, in disrepair or dirty.

**Methods/Approach**

The Equipment & Supply Task Force was formed and included representation from supply chain, nursing, biomedical engineering, environmental services and other members of the multidisciplinary team.

The VCH Administrative Coordinators collected information pre- and post intervention work on this project to be able to assess change and improvements. One of the first steps was to take inventory of the issues/concerns/problems and develop potential solutions.

**Table SE 1 EO – 3: Equipment and Supply Issues identified**

| ISSUE | SOLUTION | OUTCOME |
|---|---|---|
| Challenges in obtaining functioning equipment: | Standardized process for broken equipment tracking (red tag process)<br><br>Centralization of the purchasing and replacement of equipment<br><br>Confirmed process and accountability for cleaning and management of equipment | Identified the responsible party for cleaning, tracking and repairing various pieces of equipment used in Children's Hospital. Once responsible party was identified a quick reference guide was developed for members to share with their areas of practice. |
| - transport monitors | Centralized distribution of transport monitors<br><br>Purchased additional transport monitors after completing an inventory and tracking usage | Advocated for the purchase of 24 batteries that would help make our current bedside monitors transport monitors. Twelve of the batteries were placed on the bedside monitors on 6C so that the patients would not have to be transferred to a transport monitor when going to procedures. |

| | | |
|---|---|---|
| - dopplers | | Assessed current inventory, evaluated overall number needed and equipment was purchased and distributed to departments. |
| - suction regulators | Secured new suction regulators and developed color coded system for each unit – to ensure that regulators stay on the specific unit | Assessed current inventory and advocated for purchase of additional suction regulators. All regulators in Children's Hospital were replaced with each floor having a different color regulator to facilitate tracking. |
| - thermometers | Created an amnesty day for the return of broken and misplaced electronic thermometers | Elevated the trend of broken thermometers throughout Children's Hospital. Advocated for an Amnesty Day in Children's Hospital, where all thermometers were taken to Clinical Engineering for repair. Common trend was noted in broken probes on thermometers, additional probes were placed in the Service Centers so that staff can replace 24/7. |
| - beds and cribs | Process to tracking cribs and beds was developed.<br><br>Identification of a threshold for leasing additional cribs and beds during peak census and surge periods | Developed a trigger point with EVS to notify the Administrative Coordinator when we get to a "Near" critical level on beds and cribs. |

**Table SE 1 EO – 4: Participants**

| TASK FORCE MEMBERS | AREA REPRESENTED | ROLE |
|---|---|---|
| Autumn Bailey Mayfield, RN, MSN | Peds ED | Member |
| Sharon Boyd | Environmental Services | Member |
| Angel Carter, RN, BSN | 6C | Member |
| Karey Coleman, RN 2, BSN | NICU / Staff Council | Member |
| Tia Coleman, RN, BSN | 8th Floor | Member |
| Angela Derksen, RN, BSN, CRRN | Periop | Member |
| Migdalia Garcia | Equipment | Member |
| Lisa Germano, RN 2, BSN | 6 C | Member |
| Richard Hearn, RN 2, CEN | Peds ED | Member |
| Jessica Inkster, RN, BSN | Peds ED | Member |
| Kelly Kiser, RN | Float Pool | Member |
| Karin League, RN, MSN | Periop | Member |
| Brian Randolph | Equipment | Member |
| Todd Reimer | Clinical Engineering | Member |
| Laurel Roberts, RN, BSN | Acute Care, Manager | Member |
| Alisha Schmidt | Equipment | Co- Chair |
| Susan Short, RN2 | NICU | Member |
| Barb Shultz, RN, BSN, ENPC | Peds ED, Manager | Co- Chair |
| Gloria Smith | Patient Transport | Member |
| Leanne Snell, RN, BSN | Administrative Coordinators, VCH | Member |
| Karen Sterbutzel | Equipment and Materials Management | Co- Chair |

**Outcomes/Impact**

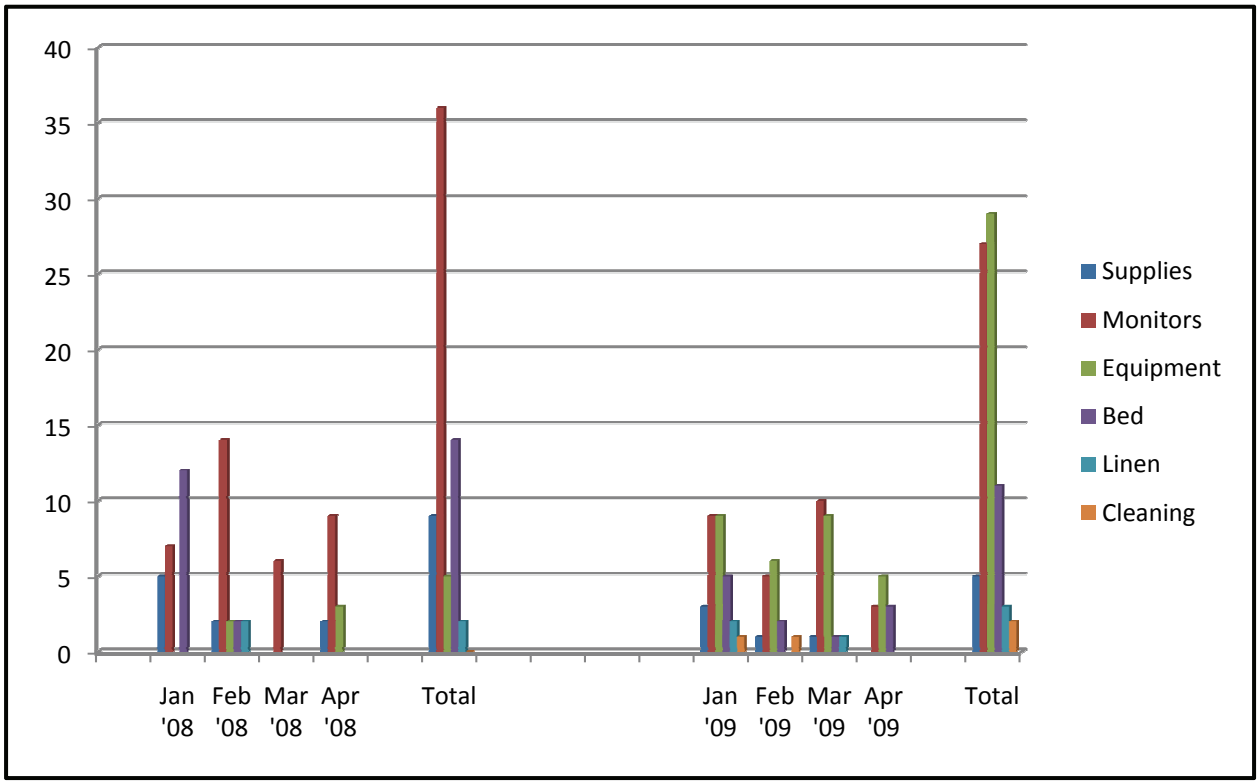
Outcomes for solving specific issues are listed in Table 2 above, additional information below.

See below for results from reports collected by Children's Hospital Administrative Coordinators the 4 months prior to the implementation of the Equipment Task Force and the same 4 months the following year which was post implementation of strategies developed by the Equipment Task Force. Conclusions from the data include:

1. The number of monitor, supply and bed issues that were reported to the Administrative Coordinator post task force work was less than prior to task force work. These were the focused areas of the task force.

2. The types of issues reported to the Administrative Coordinator expanded from 5 areas to 6 areas which is due to the education that was put out by the team to report all issues to the Administrative Coordinator
3. The overall number of reports to the Administrative Coordinator did go up post task force and this is expected due to the emphasis that the committee put on elevating these issues versus just "dealing with them".

**Graph SE 1 EO – 1: Administrative Coordinator Reports**




Additional accomplishments of this task force include the following:

- Developed standardization around the return of equipment throughout Children's Hospital
    - All equipment being returned is placed in dirty utility room and picked up on rounds by equipment technicians
    - EVS pulls all monitors and equipment out of rooms at time of discharge clean in Acute Care areas
- Developed standardization around communication of equipment replacements

- Developed standardization around communication of back orders
    - Materials Management Team attends bed meetings to communicate critical back order items
    - Back order notification card is placed in supply bin of backorder item identifying replacement of back order
- Education of Task Force Members on broken equipment process
- Developed new broken equipment tag to help track equipment that is being repaired
- Developed relationships with key leaders of ancillary departments that will help facility resolving equipment issues in a more efficient time frame

Direct care nurses at Children's Hospital now have access to clean and functioning equipment when needed. The work was completed through the interdisciplinary Equipment and Supply Task Force with periodic reports back to the Staff Council and in Children's Hospital Charge Nurse retreats. Todd Reimer from Clinical Engineering also shared the tool that was developed in the Be the Best Service Improvement Task Force. [*SE1EO-Exhibit B-1-VCH Equipment Task Force Presentation, SE1EO-Exhibit B-2-VCH Equipment Task Force Presentation*]

**VCH - Reducing Adverse Drug Events**

**Background/Purpose**

Adverse drug events (ADEs) have been a significant problem in healthcare across the nation. The Institute of Medicine's report, *To Error is Human* estimates that adverse drug events occur in almost 6-10 percent of hospitalized patients translating into $17 to $29 billion in increased costs, more than half of which are health care related. Additionally, in Child Health Corporation of American (CHCA) hospitals an estimated 11 ADEs occur per 1000 patient days, making ADEs the leading cause of harm for pediatric patients.

As a focus on patient safety, Monroe Carell Jr. Children's Hospital at Vanderbilt participated in a CHCA collaborative focused on reducing medication related harm by reducing the overall occurrence of ADEs.

The purpose of the CHCA Collaborative was to reduce medication-related harm for all medications, with a special focus on high-risk medications such as narcotics, anticoagulants,

insulin, and TPN. The aim of the project was to reduce the overall adverse drug events (ADEs) by 50% during the given timeframe.

Children's Hospital's aim was to reduce overall ADE rate by 25%. The goal was to accomplish this by focusing change strategies on narcotics and anticoagulants because the baseline data had shown the greatest room for improvement with these high risk medications. [*SE1EO-Exhibit C-1-CHCA Charter*]

**Methods/Approach**

This collaborative project tested 3 change strategies to achieve the goal. Measures of success (i.e., ADE rates) were developed by an expert panel of representatives from CHCA hospitals. Primary outcomes for Vanderbilt Children's Hospital included:

- Overall ADEs per 1000 patient days
- Opioid ADEs per 1000 patient days
- Anticoagulant ADEs per 1000 patient days

Baseline data were collected from April to June, 2008. The change strategies were implemented from July 2008 through June 2009. Several change strategies were used to address improvements in adverse drug events at Children's Hospital. They include "*In the Zone*", *Medication Drip Double Checks*, and *Computerized Physician Order Entry (CPOE)*. Each change strategy is described in more detail below.

Additional hospital-specific measures were developed to monitor and improve the processes related to medication administration.

**Table SE 1 EO – 5: Strategies for Decreasing ADEs in VCH**

| | STRATEGY | OUTCOMES |
|---|---|---|
| **In the Zone** | Creating a safe physical environment (medication room)<br><br>Survey was administered to RNs, NPs, and Care Partners via Survey Monkey™. The intent of the survey was to determine the amount of interruptions staff experience on a regular basis. Responses from the survey were collected over a two week timeframe | Actions taken as a result of the survey included branding the "In the Zone" concept by using caution tape in the "zone" areas, signage, and communication techniques<br><br>Nurse Champions were identified to lead the implementation of "In the Zone" |

| | | |
|---|---|---|
| | Creating a culture of safety for staff when ordering, preparing, or administering medications and/or EBM | Rounds were made on staff for feedback. This also provided a mechanism for the staff to give input on additional improvement opportunities<br><br>When staff members are in the protected "In the Zone" area, they are not distracted by interruptions from other staff, patients, or families |
| **Medication Drip Double Checks** | The need for a hands-on double check process was identified by staff as a way to prevent errors.<br><br>Data was collected by completing audits twice per month on all patients on medication drips in the PCCU to determine the frequency of incorrect medication drips | Medication drips were considered correct if they met ALL of the following requirements:<br>- all infusing medications on pump<br>- guardrails used<br>- drug names correct<br>- concentration correct<br>- rate correct<br>- all lines labeled<br>- all lines dated<br>- all lines not expired<br>- all bags not expired<br>- pump double check completed and documented.<br><br>A drip was considered incorrect if any one of the requirements were not met. |
| **Computerized Physician Order Entry (CPOE)** | Included improvement efforts specific to Anticoagulation. Anticoagulation efforts focused on the standardization of Heparin ordering protocols with emphasis on the urgency for entry into the CPOE system<br><br>Pharmacy and ECMO staff have also worked together to create an anticoagulation protocol specific to ECMO patient | |

**Table SE 1 EO – 6: Participants**

| NAME | TITLE | ROLE |
|---|---|---|
| Jenny Slayton RN, MSN | Administrative Director, PMI; Quality Consultant, Patient Safety | Primary Contact/Team Leader |
| Stacey Hoagg, BS | Quality and Improvement Specialist | Primary Contact/Team Leader |
| Amanda Bawcom, RN, BSN | Assistant Manager, Acute Care | Team Member |
| Connie Ford, RN, CPON, BSN, MHA | Director, Hem/Onc | Team Member |
| Ellen Gregory RN | Assistant Manager, NICU | Team Member |
| Lisa Howard RN, BSN, CCRN | Assistant Manager, Acute Care | Team Member |
| Kate Copeland RN, BSN | Assistant Manager, ED | Team Member |
| Tanika Wilson RN, BSN | Assistant Manager. PCCU | Team Member |
| Jenny Jastrzembski, Dph, BCPS | Assistant Director, Pharmacy | Team Member |
| Jen Domm, MD | Assistant Professor, Hematology | Team Member |
| Mark Riederer, MD | Assistant Professor, General Pediatrics | Team Member |
| Barbara Joers, MHSA, CHE | Chief Operating Officer | Senior Leader |
| Lydia Colley, RN, BSN | Registered Nurse, PCCU | Team Member |
| Laura Filingo, RN, BSN | Registered Nurse, Acute Care | Team Member |
| Bobbie Ramer. RN, BSN | Registered Nurse, Acute Care | Team Member |

**Outcomes**

The goals set by CHCA and VCH were met over the 12 month implementation period. The aggregated data from the 12 participating CHCA hospitals showed a 42% reduction in overall ADEs. Aggregate data analysis has shown that the overall ADE rate was reduced by 42%, with a total of 12,910 ADEs averted. VCH exceeded their goal for overall ADEs and opioid ADEs (details below).

The response rates for the surveys were 81.4 percent for Hem/Onc and 46.4 percent in the NICU. The survey results revealed that 78 percent of the staff were interrupted while preparing medications/EBM. The majority of the interruptions were reported from two groups: 1) RNs, Care Partners (CP), Medical Receptionists (MR), techs, students (29.8%) and 2) patients and families (34.7%). The frequency of interruptions occurred 1-2 (48.7%) and 3-4 (24.7%) times per shift. Staff also expressed that 54% of the issues that interrupts them are moderately

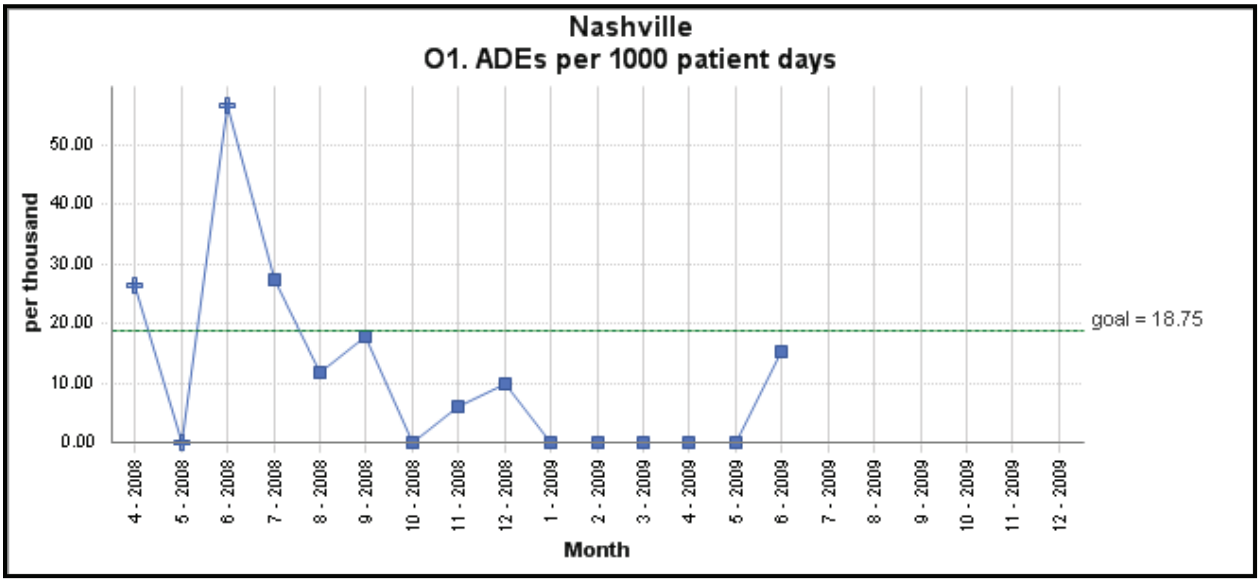
significant and 50.7 percent of the interruptions are from personal interaction from staff or patients and family.

Therefore, the development of the concept, "In the Zone" has been successfully implemented in the Hem/Onc and NICU units. The process has also been spread to the inpatient surgical unit. After brainstorming with frontline staff at a monthly staff meeting, it was determined that patient and family member interruptions were the major cause of distraction in this unit. As a result, they implemented family-oriented "In the Zone" tools (e.g. educational handouts and signs) that had initially been created for the Hem/Once unit. After meeting with ED champion nurses, work has begun to implement "In the Zone" in trauma rooms during resuscitations. This includes defining the scribe's responsibility to complete a second double check for all medications and to maintain a quiet atmosphere in the room. Nursing staff will be educated about how best to communicate with physicians if they are uncomfortable with a medication (e.g., "My reference materials state….."). [*SE1EO-Exhibit D-1-Poster in the Zone*]

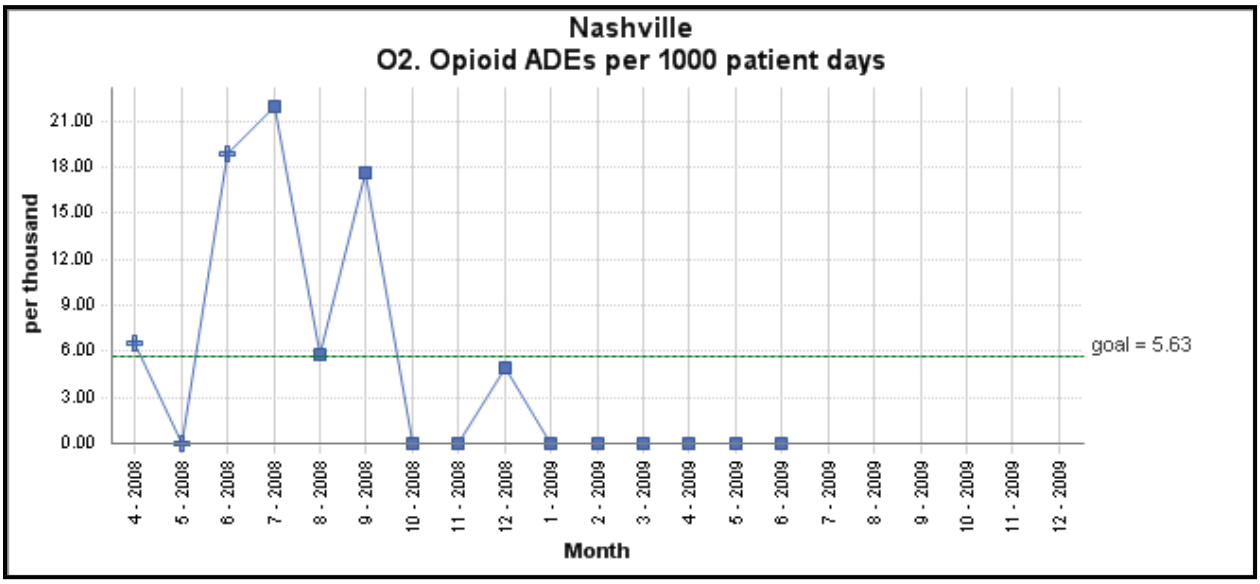
This practice change that includes a medication drip double check process continues to be successful in the PCCU and NICU. The process has also been adopted by the Pediatric Hematology/Oncology (Hem/Onc) unit, including the new process of entering data into the electronic database. The PCCU quality nurse worked with the Hem/Onc quality nurse to develop the best audit process for each unit. The nurse educator in the Hem/Onc unit will use the audit results to target education efforts for all staff. In addition, the inpatient Hem/Onc unit has begun work to improve the handoff process with the outpatient Hem/Onc clinic. Through this work, the inpatient Hem/Onc quality nurse will educate the outpatient clinic on the medication drip double check process. We anticipate this will increase compliance with all components of the medication drip double check process before patients are admitted to the Hem/Onc service.

The measurement used was the medication drip double check in the PCCU. The numerator was the number of correct medication drips and the denominator was the number of audited patients on a medication drip. Our baseline data (July-September 2008) demonstrated a 72.1% accuracy rate. The final 3 data points (April-June 2009) demonstrated an improvement to an 81.2% accuracy rate. Complete results can be viewed in the graphs below.

**Graph SE 1 EO – 2: ADEs per 1000 patient days (April 2008 – June 2009)**




**Graph SE 1 EO – 3: Opioid ADEs per 1000 patient days (April 2008 – June 2009)**




Overall, we were able to meet and exceed our goal for ADE/Narcotic ADE per 1000 patient days. At the start of the initiative, the ADE per 1000 patient days was approximately 26.32 with a goal to decrease to 18.75. After implementation of improvements, our ADE was 15.15 as of June 2009. Moreover, the Narcotic ADE per 1000 patient days was 6.58 prior to the initiative with a goal to decrease this number to 5.63. As of June 2009, there were 0 Narcotic ADEs.

**CHCA Report**

Measurements for data collection were created by an expert panel of all CHCA hospitals. Data was compared on an aggregate level with other CHCA hospitals for a national view of improvement results. Data analysis has shown that the overall ADE rate was reduced by 42%, with a total of 12,910 ADE's averted. The aggregate data is currently being further analyzed and will be distributed to all participating hospitals in the near future.

Monroe Carell Jr. Children's Hospital at Vanderbilt was one of only two teams to receive a final score of 5.0, signifying an organizational achievement of outstanding sustainable results. In this CHCA collaborative, this project was used to determine improvements that could be implemented to reduce errors related to adverse drug events. Each CHCA hospital reported data on measurements, outcomes, and strategies used to implement improvements. Outcome data for Children's Hospital was shared with other CHCA Owner Hospitals through a series of learning sessions, and webcasts in hopes that all organizations can learn from the improvements made in a variety of different and diverse settings. [*SE1EO-Exhibit E-1-Minutes 4-20-09 in the Zone, SE1EO-Exhibit E-2-CCCBD Presentation in the Zone*]

**Professional Engagement**

**Source of Evidence 2**

**Describe and demonstrate the structure(s) and processe(s) that enable nurses at all levels to participate in professional nursing organizations at the local, state, and national levels, include international participation, if any.**

Nurses at VUMC contribute to the profession of nursing by being involved in organizations in varying capacities at the local, state, national and international level. (*Table in OO7)* We support their participation by:

- Giving them professional leave time to attend board or committee meetings
- Working with their schedules to provide flexibility and patient care coverage

They also receive institutional support to assist with the development of poster presentations through the Departments of Nursing Research and/or Nursing Education and Professional Development. VUMC provides space for meetings such as the local affiliate of the National Nurses in Staff Development Organization (SEEDS - Southeast Educators for the Development of Staff) and for the local District 3 (Middle Tennessee) meetings of the Tennessee Nurses' Association (TNA).

The table in Organizational Overview question 7 provides examples from across the Medical Center of the nursing staff involvement in one or more professional organizations. A variety of professional organizations are represented, many based on specialty. Vanderbilt nurses are either serving or have recently served in various roles such as president, vice president, secretary, and committee chair. In these roles Vanderbilt nurses have been leading work that has impacted nursing practice and the care of a wide variety of patient demographics.

Our clinical policy, CL 20-06.15, (*located in OO 8*) entitled, "Travel/Workshop Funds" was written in 2002 to provide guidelines for the use of budgeted funds to support travel, educational workshops, and national certification through entities such as the ANCC (American Nurse Credentialing Center) or related specialty-based certification entities. The policy states that, "*Vanderbilt University Medical Center (VUMC) is strongly committed to its threefold mission of education, research, and clinical care. Funds available for travel, workshop attendance, and national certification are viewed as mechanisms that can be utilized to enrich*

*the growth and development of staff within the institution. Funds are made available to promote, support, recognize, and reward staff as they self-actualize and grow within their established role. Inherent to this philosophy is a recognition that staff will typically develop across a continuum of practice performance ranging from novice (beginner) to expert (mastery)*."

Funds are allocated annually to each nursing unit for these purposes. The leadership team works with the unit board to determine how these funds will be allocated each year. For example, if a national conference is being held in Nashville, the department may decide to send more staff because there will not be any travel expenses that year, whereas, other years the unit may decide to sponsor a nurse's entire travel because they had an abstract accepted for a poster or oral presentation. (*See policy OP 40.10.03 Travel Reimbursement in OO 8*)

**Professional Engagement**

**Source of Evidence 2 EO**

**Describe and demonstrate two (2) improvements in different practice settings because of nurse involvement in a professional nursing organization(s).**

**Example of professional Nursing organization involvement**

**VCH**

**Background**

Katie Koss, RN, BSN, CPEN, CPN is an Assistant Nurse Manager in the Pediatric Emergency Department and she is a member of the Emergency Nurses' Association (ENA). Katie reviewed the Emergency Nurses' Association's published results of a nation-wide survey regarding staff perception of safety and security in emergency departments and brought the results to the attention of VCH emergency department leadership.

According to OSHA, more than 9,000 nurses and healthcare workers are attacked each day. OSHA also reports that the risk of job-related violence is presently higher in healthcare than in any other field. The New York Times reported in 2008 that one of the most dangerous settings for assault on a nurse is the emergency department. One study in the *Journal of Emergency Nursing* (2007), states that ED nurses report the highest rates of assault in the workplace. 100% of ED nurses reported verbal assault in the past year and 82.1% of ED nurses reported physical assault in the past year. The most common causes of assault by a patient or family member as reported in the *Journal of Emergency Nursing* include enforcement of hospital policies (58.1%), anger related to the patient's condition or situation (57%), anger related to long wait times (47.7%), and anger related to the health care system in general (46.5%).

The ENA completed a study in 2007 entitled, "Workplace Violence against Registered Nurses in the Emergency Department." Of the nurses that responded, approximately half felt that violence is simply part of their daily practice. The healthcare industry leads all other sectors in the incidence of non-fatal workplace assaults at a rate of nearly four times that of the overall private sector injury rate. Healthcare workers are more likely to be attacked at work than prison guards or police.

**Methods/Approach**

With all of these statistics, the Peds ED staffs felt that addressing the perception of safety and security in their department was critical. They had been discussing security and safety in the Peds ED since early 2009. However, the first staff survey was sent out in August, 2009 with a follow up survey completed in May, 2010. The Peds ED used the ENA survey and asked the staff to anonymously report their feelings of safety and security in the department.

They compared their results (50% of the staff responded) to the national report. Afterward, they met with the Vanderbilt University Police Department and completed a security walk through the ED, highlighting physical areas that needed attention. They were encouraged to implement a number of changes and education to the staff and began meeting more frequently with police personnel.

**Table SE 2 EO – 1: Participants**

| Name | Area |
|---|---|
| Barbara Shultz RN, BSN,ENPC | Director of Emergency Services |
| Kate Copeland, RN, BSN, CPN | Manager, Pediatric Emergency Department |
| Katie Koss, RN, BSN, CPN, ENPC | Assistant Manager, Pediatric Emergency Department |
| Major Andrew Atwood | Major of VUMC Precinct |
| Charles DeFrance, Jr. | Coordinator, Security Services |

**Outcomes/Impact**

The changes that were made in the department based on the staff survey included:

- Three additional panic buttons were added, for a total of five panic buttons in the department

- Extensive education provided on dealing with potential violence and how to avoid

- Monthly in-services scheduled for staff in conjunction with VUPD re: personal safety, de-escalation of violence, narcotic diversion, etc.

- Badge access reader to entrance of administrative hallway

- Live camera feeds in two places for the waiting room, ambulance bay, and helipad

- Reflective mirror added at registration and back hall so staff could more easily visualize corners or hard to see areas in the department

- More frequent rounding of VUPD officers in the department

After approximately eight months, the staffs were surveyed again using the same measurement tool. The results showed significant improvements in staff perception of safety and security. They continue to meet with counterparts in VUPD to highlight additional items and educational needs for the staff. Safety in the Peds ED has become a priority for the leadership team.

This information was shared with the staff in a variety of ways; via email and in board meetings. Rounding was done on the results with both the charge nurse group and the staff members. Results were also shared with VUPD. [*SE2EO-Exhibit A-1-ABS Minutes 8-13-2009, SE2EO-Exhibit A-2-Ambulance Bay Security Presentation*]

**Table SE 2 EO – 2: Summary Results of ENA Survey compared to VCH (Pre-and Post-Implementation)**

| ISSUE | VCH PRE-IMPLEMENTATION September 2009 | ENA | VCH POST-IMPLEMENTATION May 2010 |
|---|---|---|---|
| Experience in healthcare | 4% <1 year<br>44% 1-5 years<br>28% 5-10 years<br>24% > 10 years | | 6% <1 year<br>42% 1-5 years<br>27% 5-10 years<br>25% > 10 years |
| Experience in emergency medicine | 14% < 1 year<br>56% 1-5 years<br>11% 5-10 years<br>20% >10 years | | 27% < 1 year<br>37% 1-5 years<br>13% 5-10 years<br>23% >10 years |
| Experience in VCH PED | 25% <1 year<br>65% 1-5 years<br>6% 5-10 years | | 29% < 1 year<br>50% 1-5 years<br>6% 5-10 years |

| | | | |
|---|---|---|---|
| | 4% >10 years | | 15% > 10 years |
| Gender | 89% female<br>11% male | 84% female,<br>16% male | 92% female<br>8% male |
| Role in department | 3% Patient transport<br>10% medical receptionist<br>15% care partner<br>68% bedside nurse/paramedic<br>3% charge nurse/educator<br>1% Management | 60% staff nurse<br>16% charge nurse<br>11% ED manager<br>3% educator<br>10% other | 2% patient transport<br>12% medical receptionist<br>13% care partner<br>67% bedside nurse/paramedic<br>6% charge nurse/educator/management |
| Shift that is worked | 38% Day shift<br>40% night shift<br>22% Midshift | | 44% Day Shift<br>33% night shift<br>23% midshift |
| How often do you experience physical abuse in the PED? (including intentional hitting, kicking, pinching, pushing, scratching, spitting):<br>o Each Shift | 1% | 4% | 8% |
| o Weekly | 28% | 20% | 10% |
| o Monthly | 26% | 23% | 38% |
| o Yearly | 18% | | 17% |
| o Never | 26% | | 27% |
| How often do you experience verbal abuse either by the patient or their family in the PED? (including being called names, sexual innuendos, intimidated, sworn at, threatened, yelled at):<br>o Each shift | 3% | 27% | 6% |
| o Weekly | 31% | 41% | 27% |
| o Monthly | 33% | 18% | 33% |
| o Yearly | 15% | | 13% |
| o Never | 18% | | 21% |
| How do you feel that the level of violence in the PED has changed in the past year? (Increase, no change, decreased): | 42% increase<br>9% decrease<br>49% no change | 65% increase<br>4% decrease<br>31% no | 19% increase<br>25% decrease<br>56% no change |

| | | change | |
|---|---|---|---|
| How safe do you feel in VCH ED? (Rank 1-10, 1=least. 10=greatest): | Avg 7.0 | Avg 4.6 | Avg 7.3 |
| What is your perception of the effectiveness of security available in the VCH ED? (Rank 1-10, 1=least 10=greatest) | Avg 6.1 | Avg 4.7 | Avg 7.0 |
| How effective do you feel that the panic button/silent alert works for the department? (Rank 1-10, 1=least. 10=greatest) | Avg 4.8 | | Avg 7.2 |
| How prepared are you to handle violence in the PED given your education/ training? (Rank 1-10, 1=least. 10=greatest): | Avg 5.5 | Avg 5.4 | Avg 6.6 |

**Chart SE 2 EO – 1: September 2009 - How do you feel the level of violence has changed in the PEDS ED in the last year?**

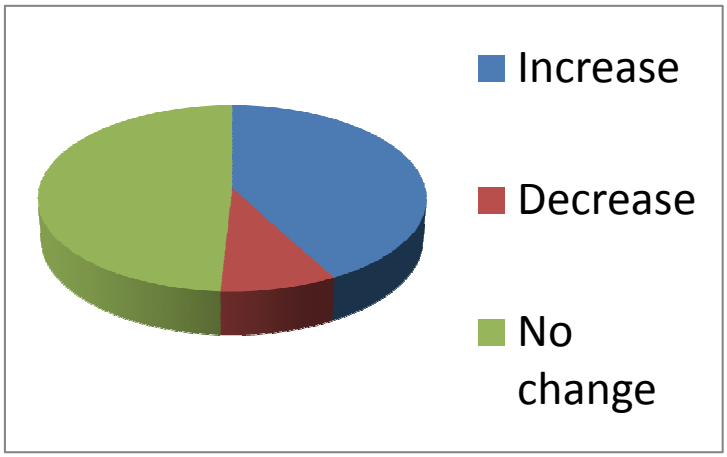
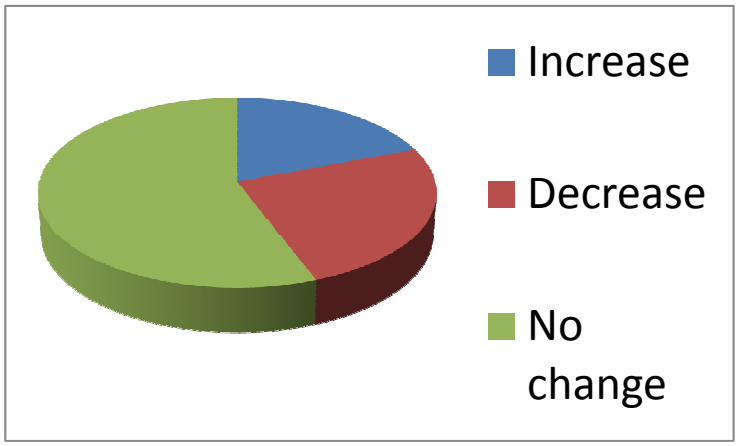
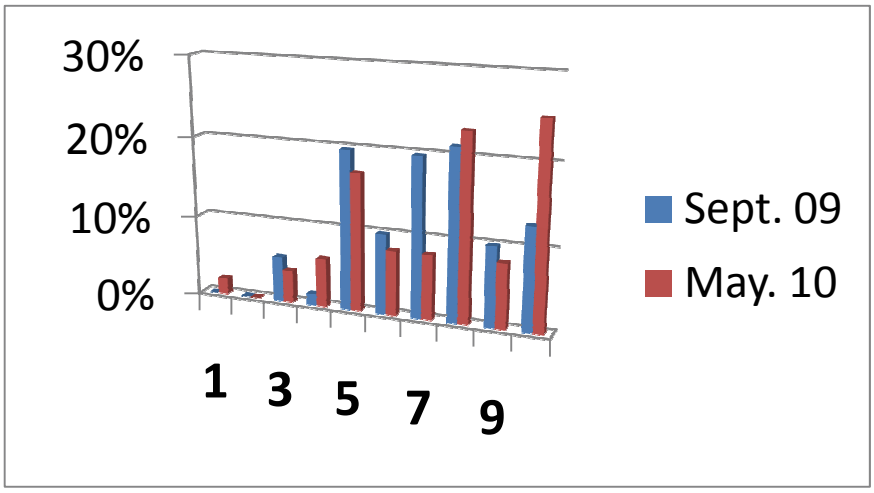


**Chart SE 2 EO – 2: May 2010 - How do you feel the level of violence has changed in the PED in the last year?**

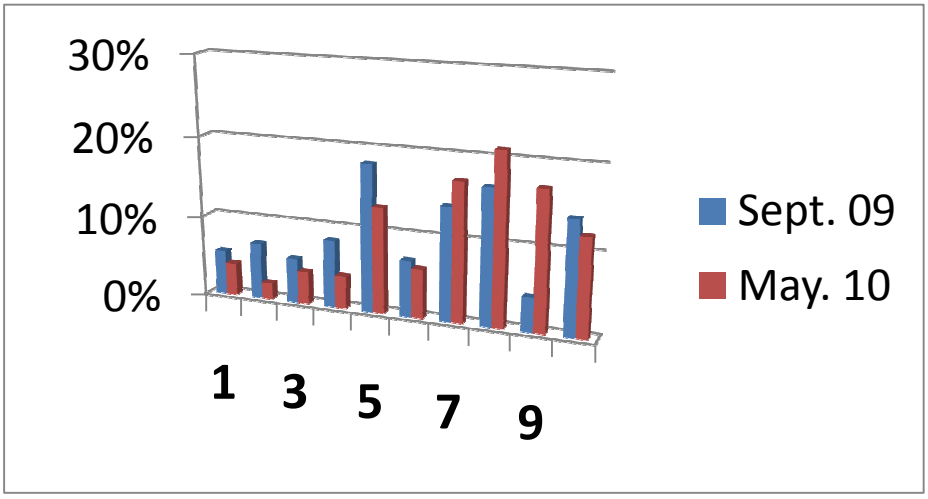



**Graph SE 2 EO – 1: How safe do you feel in the PEDs ED?**



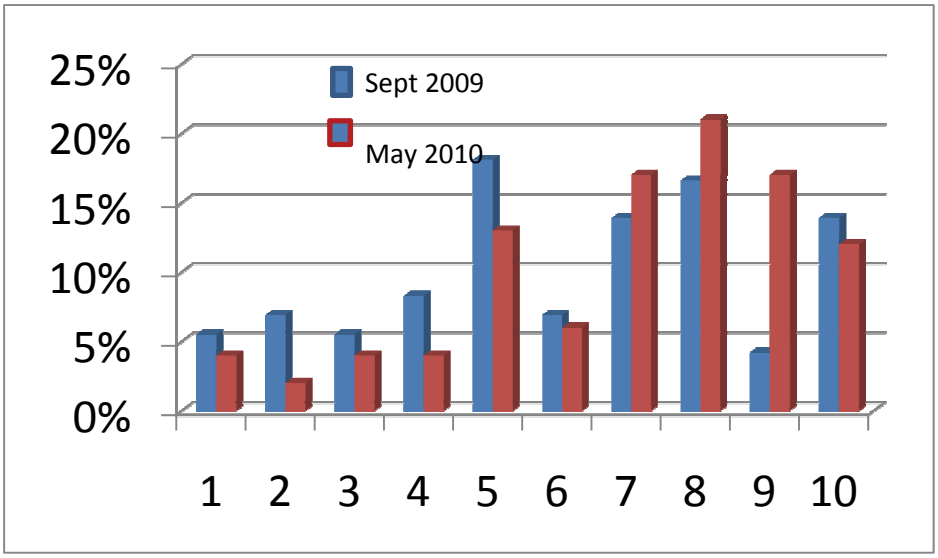

**(Rank 1-10, 1=least safe, 10=extremely safe)**

**Graph SE 2 EO – 2: What is your perception of the effectiveness of security available in the VCH ED?**



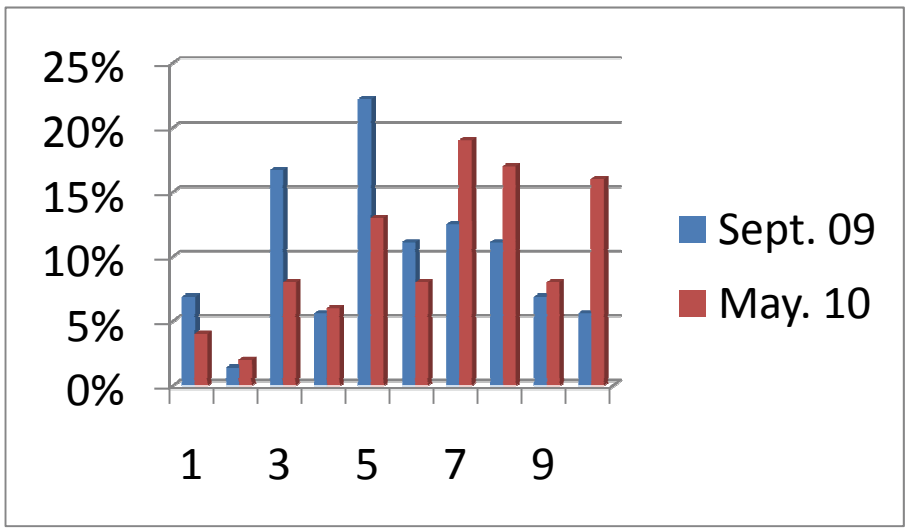

**(Rank 1-10, 1=least safe, 10=extremely safe)**

**Graph SE 2 EO – 3: How effective do you feel that the panic button/silent alert works for the department?**




**(Rank 1-10, 1=least effective, 10=most effective)**

**Graph SE 2 EO – 4: How prepared are you to handle violence in the PED given your education/training?**




**(Rank 1-10, 1=least effective, 10=most effective)**

**VMG Example**

**Purpose/Background**

A subgroup of nurses from the Unit Board of the Cancer Clinic was established to address the process and safety challenges of having complete, accurate chemotherapy orders available before patients arrive for their chemotherapy treatments. Members of the task force (see Participant List below) represented the nurses in the Cancer Clinic, the Manager and a Charge Nurse Representative from the Infusion Center, a Charge Nurse from the Cool Springs Oncology Clinic, an Oncology Pharmacist, the Quality Consultant, and the Nurse Educator. Additional physician liaisons were added. It was identified that numerous clarifications on orders were required, delaying patient throughput and creating a potential for chemotherapy errors and patient harm. This work was based on the review of the oncology nursing standards by the nurses' participating in the Oncology Nursing Society (ONS) and the National Comprehensive Cancer Network (NCCN).

**Methods/Approach**

Timeline of activities of multidisciplinary work on chemotherapy orders and safety improvements included:

**Table SE 2 EO - 3: Timeline of Activities**

| | |
|---|---|
| **Late 2008** | Unit Board established the need for a subgroup to address the chemotherapy processes, and begin with revision of the standardized order sets, accessible and printable from the Vanderbilt Ingram Cancer Center Intranet. |
| **Jan/Feb 2009** | Unit board begins monthly meetings. Chemotherapy order templates were reviewed and recommendations for format and inclusion of data and NCCN GCSF guidelines were considered. |
| **March/April 2009** | Committee recommendations were taken by Quality Consultant to Medical Director of Oncology, David Johnson, for consideration. Inclusion of ASCO/ONS and NCCN guidelines was supported and a MD representative, Dr. Keedy, was designated. |
| **June/July 2009** | Webmaster contacted for options for online access and process for replacing old templates with revised orders. |
| **Sept/Oct 2009** | Finalized 110 order sets designed for 7 cancer types. Go live implementation was October 26, 2009. Decision to meet 2-4 times per year to evaluate practice in relationship to all of ONS /ASCO guidelines |
| **Feb 2010** | Mia Levy,MD, Chief of Medical Informatics for Cancer Center lays the groundwork for electronic medication and chemo order entry for Fall 2010 after meeting with Stakeholders concerning chemotherapy, including Oncology clinic nurses, Hematology clinic nurses, Infusion Center nurses, Pharmacists, Gyn Oncologists, Medical Oncologist, and Hematologists. These meetings gathered information about what was working well, what was not working, and what changes are needed regarding chemotherapy safety practices and processes. |

**Table SE 2 EO - 4: Participants**

| | |
|---|---|
| Leah Atwell, RN, OCN. * | Manager, Infusion Center, *ONS Chemo Instructor* |
| Debra (Kay) Armstrong, RN, OCN.* | Staff Nurse, *Clinic NCCN task force member* |
| Tracy Coyne, RN, MSN. * | Quality Consultant |
| Linda Dial, RN, MN, AOCN.* | Nurse Educator, *ONS Chemo Instructor* |
| Janet Gage, RN. | Charge Nurse, Infusion Center |
| Ann Hankenson, RN,BSN,OCN.* | Staff Nurse, Clinic |
| Debbie Preston,RN,BSN,OCN. * | Interim Manger, Clinic |
| Elizabeth Bates, RN, BSN,OCN. | Staff Nurse, Clinic |
| Barbara Stewart, RN 3, BSN, OCN,* | Staff Nurse, Clinic |
| Melissa Curran, RN, BSN | Charge Nurse, Cool Springs |
| Beverly Puckett, RN 3, BSN,OCN. | Staff Nurse, Clinic |
| Vicki Keedy, MD | Physician Advocate |
| David Johnson, MD. | Medical Director of Cancer Center |
| Mart Goemann, RPH | Oncology Pharmacist |
| Anna Belle Leiberson | Informatics |

** Denotes active member in ONS, Professional Oncology Nursing Society and Middle Tennessee ONS local chapter*

**Outcomes/Impact**

**Quantitative Results:**

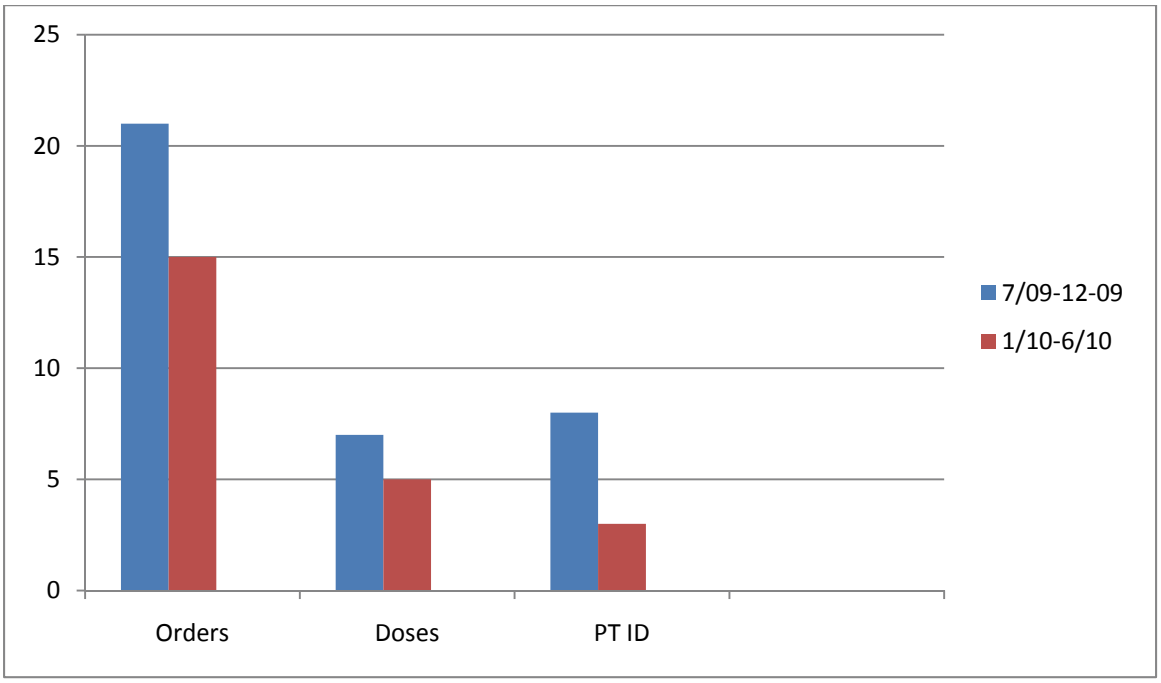
1. One hundred ten (110) order sets for 7 types of cancers were updated.

2. Standardized order sets, intranet accessible, have replaced old order sets across the VUMC Cancer Center including the Hematology Clinic, Cancer Center, Infusion Center, and Cool Springs Oncology.

    - Chemotherapy order errors reported in the VERITAS Incident Management System were reduced. Comparing the errors reported from July 2009 through December, 2009 and January 2010 through June 2010, the following reduction in errors was reported:

- Incorrect orders: reduced 30%
- Incorrect doses: reduced 30%
- Incorrect patient identifiers: reduced 60%

**Graph SE 2 EO – 5: Error Comparisons**




Overall, updated order sets contribute to fewer handwritten changes, illegible or inconsistent orders and improved patient safety. The order sets and electronic order entry were goals derived from review of nursing and medical standards as a result of professional affiliation with ONS and NCCN.

**Qualitative results:**

- *Teamwork*: Through collaborative team efforts, staff nurses have demonstrated that they feel more empowered to ensure safe and efficient nursing practice due to better patient safety and increased satisfaction from fewer patient delays and shorter wait times. Following the positive impact of these types of professional activities and changes, one of the team members proceeded to develop a leadership project through the Center for Frontline Leadership that included the establishment of guidelines to resolve other process problems affecting operations and patient safety for patients in

the Chemotherapy Infusion Center. Additional redesign work and leadership efforts occurring concurrently may also have contributed to this outcome.

- *Improved communications and relationships*: Reduced interdepartmental nurse conflicts and tension have been observed among the nurses. Routine collaborative "joint meetings" have been positively attended and relationships have been enhanced for teamwork as a result of intentional collaborative work teams. Both the Infusion Center and Clinic Unit boards have a representative member from the other board, which was initiated during the Chemotherapy Order Committee meetings.

- *Ongoing Quality Initiatives*: Improved processes have been initiated as a result of the ground work begun in the Chemotherapy Orders Committee and follow up stakeholders meetings have been initiated to address the next steps for safety orders - electronic order entry. For example, the interviews revealed the need for improved clinic nurse orientation to chemotherapy order completion and time sensitive processes. While many of the orders are being completed by nurses with greater clarity and accuracy, it has been recognized that completion of the physician orders regarding laboratory parameters remains an opportunity for improvement.

Some of the impact of the Chemotherapy Orders committee was a direct result of the product produced; however, indirectly the open conversations and attention to chemotherapy safety and improvements may be attributed indirectly from the work begun. For instance, the issue of safety measures for oral chemotherapy was first brought to the awareness of the committee while reviewing the ASCO/ONS standards for updating the chemotherapy order sets (all intravenous chemotherapy orders). Subsequent journal club discussion and a proposal for improved oral chemotherapy safety processes and patient education have evolved and expanded the safety concepts to home prescriptions. A proposal for impacting this aspect has been recently presented. What is impressive about this work is how a seed planted to resolve one aspect of a problem has given birth to a tree with many branches, with ongoing commitment to engage in innovative solutions that are participative and collaborative among the healthcare team. [*SE2EO-Exhibit B-1-Chemo Workgroup Minutes 7-27-09*]

**Commitment to Professional Development**

**Source of Evidence 3**

**Describe and demonstrate how the organization sets expectations and supports nurses at all levels who seek additional formal education e.g. baccalaureate, masters, or nursing doctoral degrees.**

Our Philosophy of Nursing is the guiding force of our commitment to professional development. "*We believe that the future of the profession rests upon developing collaborative models between nursing service and nursing education. Nursing accepts the responsibility for facilitating education of patients, families, nursing peers, colleagues from other disciplines and students of the various health professions. Each nurse serves as a role model of quality professional practice*."

**Leader Expectations**

One of our Be the Best committees, Leadership Development, reviewed the job description for our nursing managers and created a matrix outlining the key functions and job expectations in 2006. In continuation of that work, the committee began reviewing the matrix again in 2009 to establish the performance rating criteria for each category of "meets expectations," "exceeds expectations," and "outstanding." These categories reflect Benner's (1984) novice to expert development theory with "meets expectations" correlating with "competent," "exceeds expectations," correlating with "proficient," and "outstanding" correlating with "expert." [*SE3-Exhibit A-1-Manager Rating Scale]*

Nursing leadership has set the expectation that nurse managers will have a minimum of a Masters degree and administrative directors are working with their nurse managers to develop specific educational action plans to achieve the goal of 100% of our inpatient nurse managers being Masters prepared by 2013. The nurse managers can take advantage of our Human Resources tuition reimbursement policy as well as our Nursing Tuition Assistance Benefit policy. *(Policy in OO 8)* Currently, a little over 50% of our Nurse Managers are masters prepared.

We are fortunate to have the Vanderbilt School of Nursing and other accredited local universities which offer numerous Masters level programs for our nurses to choose from when pursuing their advanced education. At this time, 100% of our administrative directors have earned their Masters degree. *(Please see OO 17 for job descriptions).*

**Nurse Residency Program**

The establishment of an enterprise-wide Nursing Residency Program has increased the number of baccalaureate prepared graduate nurses that we hire each year. Please see Table 1 below indicating the percentage of graduate nurses with BSNs that have been hired with each cohort since 2008. We are averaging an 80% hire rate of baccalaureate prepared graduate nurses with each cohort. Our Nurse Residency Program attracts candidates nationally and we have hired graduates from a total of thirty-nine states (plus DC) with representation from 176 different schools of nursing.

**Table SE 3 – 1: Education Preparation for Nurse Residents**

| Cohorts | Summer 2008 | Winter 2009 | Summer 2009 | Winter 2010 | Summer 2010 | Cumulative |
|---|---|---|---|---|---|---|
| **Associate degree** | 34 ( 18%) | 25( 21%) | 16 (14%) | 25 (19%) | 29 (18%) | 129 (18%) |
| **BSN** | 157 (82%) | 87 (75%) | 97 (85%) | 99 (77%) | 130 (81%) | 570 (80%) |
| **BSN matriculation to MSN** | 0 | 5 (4%) | 1(1%) | 0 | 0 | 6 (1%) |
| **MSN** | 0 | 0 | 0 | 5 (4%) | 1 (1%) | 6 (1%) |

Nurses with associate degrees are encouraged to return to school for their BSN through use of our Human Resources tuition reimbursement policy and our Nursing Tuition Assistance Benefit policy. We offer flexible scheduling with 12-hour shift options and the nurses are able to self-schedule around their school commitments using our web-based VandyWorks program.

**Nurse Educators**

We are currently in the process of reviewing the scope of practice and job description for our Nurse Educators in line with the work that has been completed for the nurse managers. A scope of role consensus workshop revealed the top ten role components the Nurse Educators believe comprise their current role in the medical center. These role components include:

- Teaching, coaching
- Staff clinical competency oversight
- On-boarding of new staff

- Quality review and education
- Implementation of new initiatives
- Oversight of unit operations
- IT/systems education
- Development of educational resources
- Program coordination
- Consultant

The VUMC Nurse Educator Council is involved in this work and in the process of comparing their current role to the newly published (2010) *Nursing Professional Development: Scope and Standards of Practice* (NPD S&S).The NE Council plans to complete this work by the end of 2010. Our current job description requires a Masters degree as the minimal educational requirement for this role. Currently, 60% of our Nurse Educators have a Master's degree, we have some in interim roles who do not.

**Doctorates**

In 2009, the Nursing Executive Board made a decision to revise the Nursing Tuition Assistance Benefit policy to include doctoral programs (Doctorate of Nursing Practice and Ph.D.) to encourage Masters prepared nurses to go back to school to complete the terminal degree in nursing. Having access to the Nursing Tuition Assistance Benefit for doctoral programs was a request of several nursing leaders in the organization. Details are provided in SE 3 EO. *(Please refer to the Demographic information for complete entity-wide education information)*

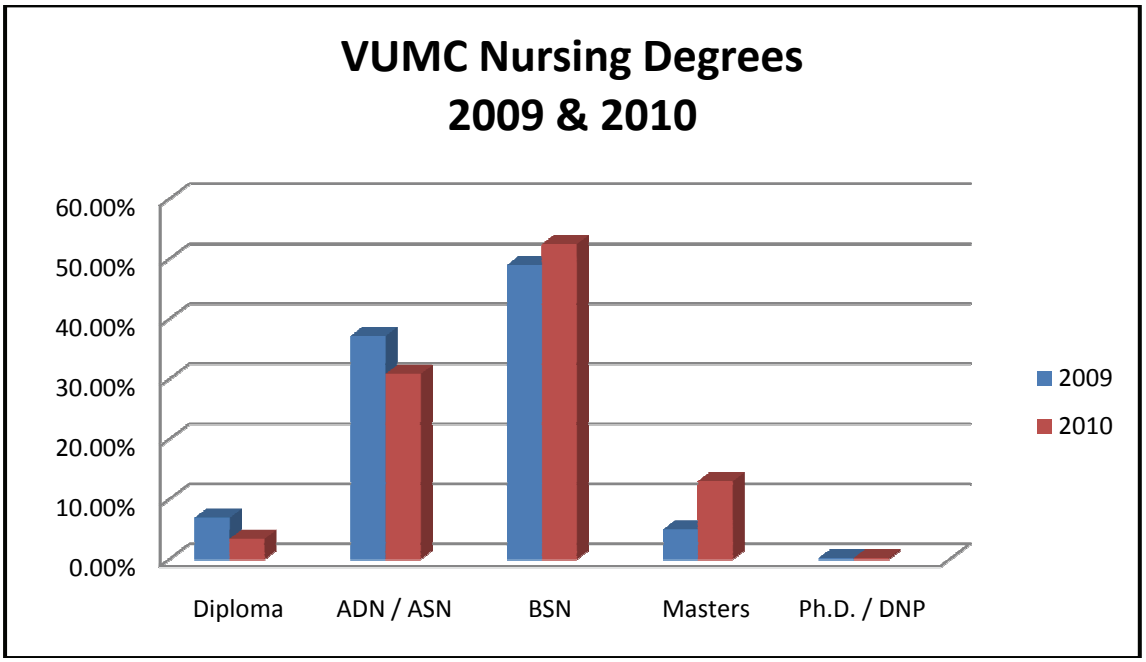
[*SE3-Exhibit B-1-Nurse Educator Roles, SE3-Exhibit B-2-Nurse Educator Council Minutes, SE3-Exhibit B-3-Nurse Educator Survey Data Review 2010*]

**Commitment to Professional Development**

**Source of Evidence 3 EO**

**Describe and demonstrate the organization has met goals for improvement in formal education. Graphically summarize at least 2 years of data to display changes over time.**

**Graph SE 3 EO – 1: VUMC Direct Care Staff Nursing Degrees 2009 and 2010**




**Summary**

**Goals/Progress**

1. All Inpatient Nurse Managers will be Master's level prepared

    - Currently at a little over 50%
    - Currently supported by job description
    - Plans in place and target date set for 2013

2. All Nurse Educators will be Master's level prepared

    - Currently at 60%
    - Currently supported by job description
    - Team is working on a plan that will be similar to the nurse managers

3. Offer tuition benefit for doctorate education (DNP & PhD)

    - Goal met with staff being enrolled and supported since Spring 2009

4. Goals around BSN prepared staff have been to exceed the Magnet norm which was 47.07% (reported at Magnet Conference in 2009) – which we do exceed that number. While we have not set specific goals around the hiring of only BSN graduates, we have begun to look at our residency program to see how we could support that goal if determined to be a goal.

**Vanderbilt Nursing Tuition Assistance Benefit Program**

**Background**

Vanderbilt University Medical Center (VUMC) had a Nursing Tuition Assistance Benefit Program in place that supported employees pursuing their Nursing education in ADN/ASN, BSN, and MSN programs. The program was administered through the Nursing Administration department and was supported by Vanderbilt Temporary Services (VTS) administrative personnel. In the Fall of 2008, the Dean of the Vanderbilt School of Nursing (VSON) asked the Executive Chief Nursing Officer if VUMC would consider endorsing the Nursing Tuition Assistance Benefit to also include support for VUMC nurses pursuing doctoral level studies (Ph.D. and DNP).

The Department of Nursing Education and Professional Development completed a full assessment of current practice and then developed an action plan that included revising the current policy, developing an online database and procedure for processing tuition reimbursement requests, and educating the VUMC community about the changes that would occur. Issues that were identified that needed to be corrected included:

- The tuition reimbursement process was labor and paper intensive and the organization did not have an established database to be able to track employees who had received the benefit in the past.

- The paper process did not provide a mechanism for check-in with the managers during the semester to see if an employee's work status had changed.

- VUMC did not have a tuition reimbursement policy that supported the pursuit of a Nursing doctoral degree.

- There was not an established database to determine who was attending school, receiving tuition reimbursement, or what degrees they were pursuing and from what schools.

This project was overseen by the Director of Nursing Education and Professional Development (NE & PD) who worked with the Administrative Manager of NE & PD to coordinate the completion of the database development to support the launching of the online process for tuition reimbursement. While the database was being developed, the policy was being reviewed and revised and the necessary endorsement processes were completed. A series of town hall meetings were conducted to instruct the current staff members and managers of the changes to the system. There were also instructions placed on the Nursing website (www.vanderbiltnursing.com) for staff and managers to access who could not attend one of the town hall meetings or needed a reminder of steps in the process.

The VUMC Nursing Executive Board fully endorsed the changes to the Nursing Tuition Assistance Benefit Policy, CL 20-06.21*(located in OO 8)* that included support for employees pursuing Nursing doctoral degrees. Additional changes included:

- Moving the administration of the program to the Department of Nursing Education and Development

- Increasing the minimum grade requirement for reimbursement from a "C" to a "B"

- Changing the eligibility requirement from 90 days of full time employment after date of hire to 90 days plus one year of full time service for hourly employees and six months plus one year of full time service for exempt employees

- The process was also moved from a paper and pen process to an online process and a database was established

- The policy was also endorsed by the Nursing Administrative Board and the Clinical Practice Committee. The new process was fully launched in May, 2009.

**Table SE 3 EO – 1: Participants**

| Name | Title/Area | Role |
|---|---|---|
| Colleen Conway-Welch Ph D, CNM, RN | Dean - Vanderbilt School of Nursing | Administrative Oversight |
| Linda Norman DSN, RN | Associate Dean - Vanderbilt School of Nursing | Administrative Oversight |
| Marilyn Dubree, MSN, RN, NE-BC | Executive CNO | Administrative Oversight |
| Debianne Peterman Ph D, MSN, RNC-NIC, NE-BC | Director of Nursing Education and Professional Development | Operational responsibility to oversee the project, revise the policy, obtain endorsement, create online program |
| Becky Keck MSN, RN | Assistant Dean – Vanderbilt School of Nursing | Liaison for VSON |
| **Nursing Executive Board Members**:<br>Robin Steaban MSN, RN<br>Robin Mutz MPPM, RN<br>Carol Eck MSN, RN<br>Pam Jones MSN, RN<br>Margaret Head MSN, RN<br>Nancye Feistritzer MSN, RN<br>Pat Givens M Ed, RN | | Nursing Endorsement |
| Rachael Hamilton | Administrative Manager – Nursing Education and Professional Development | Worked with the program developer to create the online process |
| Chris Wilson MSN, RN | Director Clinical Education and Professional Development – VUH | Operational Oversight (once the project was launched) |

**<u>Outcome</u>:**

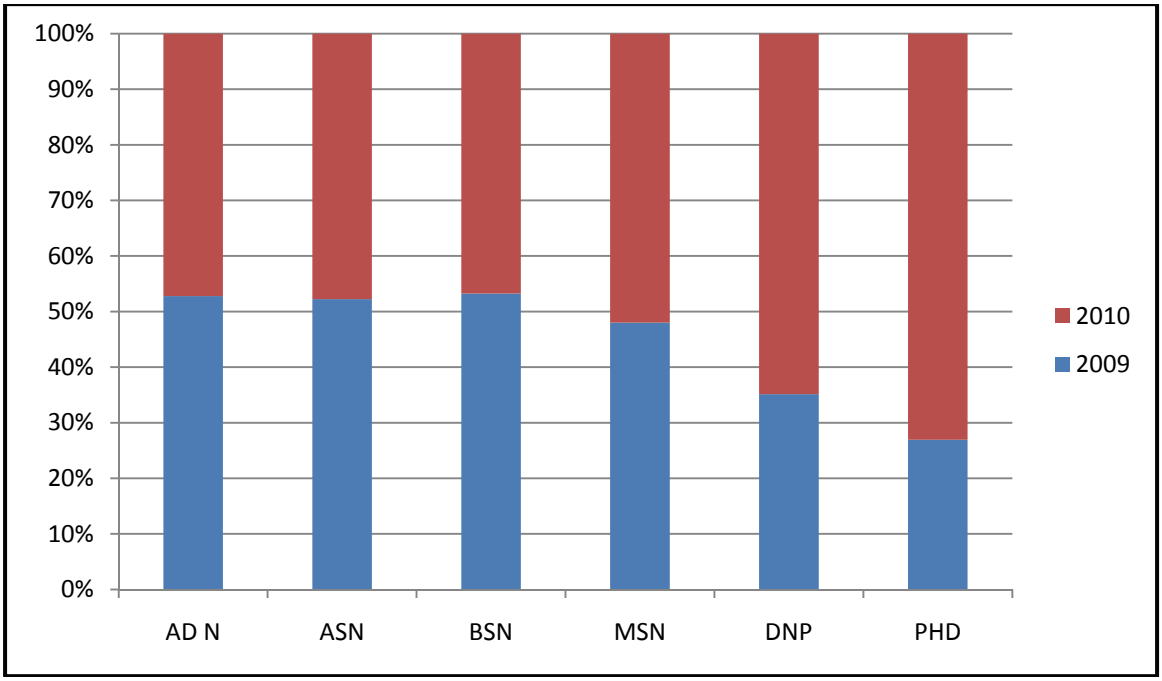
VUMC now has a fully functioning online process for tuition reimbursement for all accredited Nursing programs. We did not have a baseline to measure differences in use of the new system compared to the old system, but we are now able to run reports identifying the number of staff members enrolled, the schools they are attending, and the degrees they are pursuing by semester. This policy is available to all employees pursuing Nursing degrees at all levels as long as they meet the eligibility requirements. Data is shared with the ECNO at the end of each semester and will be shared with the NEB annually or as requested.

A database for tracking VUMC employees seeking nursing degrees was not in place prior to the changes in the Nursing Tuition Assistance Benefit program outlined above. We are now able to track the number of employees and the types of nursing degrees they are pursuing. The Nurse Executive Board will be able to use this data in the future to set goals and project costs. [*SE3EO-Exhibit A-1-TABLE New Degrees*] The table below identifies the number of nurses enrolled in programs by semester:

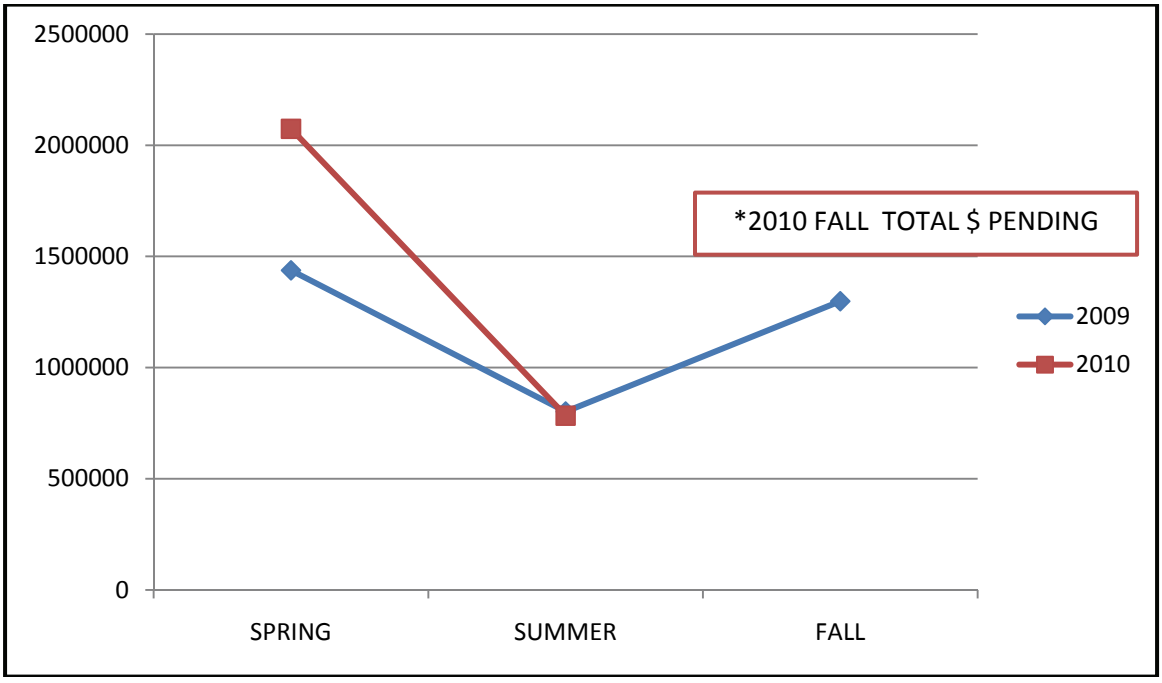
**Table SE 3 EO – 2: Cumulative Data – Nursing Tuition Assistance Benefit 2009 - 2010**

| Semester | Total | ADN | ASN | BSN | MSN | DNP | PhD | $ Total |
|---|---|---|---|---|---|---|---|---|
| **Spring 2009** | 346 | 11 | 23 | 90 | 220 | 1 | 1 | $1,437,375.00 |
| **Summer 2009** | 265 | 1 | 5 | 47 | 206 | 5 | 1 | $802,153.69 |
| **Fall 2009** | 413 | 7 | 30 | 68 | 283 | 20 | 5 | $1,298,280.69 |
| **Spring 2010** | 487 | 12 | 24 | 94 | 328 | 22 | 7 | $2,074,063.00 |
| **Summer 2010** | 289 | 2 | 4 | 35 | 232 | 9 | 7 | $783,533.00 |
| **Fall 2010** | 309 | 3 | 25 | 51 | 208 | 17 | 5 | **Pending** |

**Graph SE 3 EO - 2: Total Number of Applications 2009 – 2010**




**Graph SE 3 EO – 3: 2009 – 2010 Nursing Tuition Assistance Benefit in Dollars**



**"In their own words"**

"*The Nursing Tuition Assistance Benefit has afforded me the opportunity to achieve my life time goal of pursuing a doctoral degree in nursing. Without the Nursing Tuition Assistance Benefit it would be difficult to find the financial resources to attend the DNP program. The Nursing Tuition Assistance Benefit's on line application is extremely user friendly and removes the typical obstacles to the process of applying for financial aid. This is a great benefit to those who otherwise would be unable to earn a terminal degree from a program and university that is nationally recognized for its academic excellence."*

**Susie Leming-Lee, MSN, RN, CPHQ - Director of Perioperative Quality Management**

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*"I graduated from LPN school in March of 1989 and started my nursing career at a hospital in Columbia, TN. Seemed like so many of the patients I took care of were transferred to VUMC. I applied to the Vanderbilt Nursing Registry and started work soon after that. Everything that I had heard about or read about in my nursing books that I really didn't think existed I saw on my first few days of working on 9 South. I was amazed. I wanted to do so much more than I was allowed and couldn't because of my licensure. I quickly knew Vanderbilt was where I wanted to work and applied for a full time position. I worked for 16 years as an LPN before deciding to return to school for my RN. When I first started school I applied for the nursing tuition; in 2005 it was all done by paper and campus mail. You had no way of knowing if it was approved or if the department received your request. I finished my RN in 2009 and enrolled in Aquinas College to continue my nursing education for my BSN. Now everything for nursing tuition is online. It is much more convenient, I can apply online, get an email confirmation, someone contacts my supervisor for me so that I don't have to track them down for a signature and then I receive another email when everything has been approved. Please know I appreciate how much easier you have made it to apply as well as the financial assistance. I have a great sense of pride saying that I work at Vanderbilt. I really enjoy all the compliments I hear from the public when they tell me their story of what Vanderbilt did for them or their family."*

**Kim Boshers, RN – Hepatology, Nephrology**

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*"In 1978, I graduated from a practical nursing program, and began working in a small community hospital. I promptly recognized that the vocation I had been searching for was indeed nursing. The importance of furthering my education quickly became evident as a means*

*to advance my expertise. Accordingly, I enrolled at a local community college in pursuit of my ADN.*

*In 1986, I followed my dream to relocate in order to obtain a position of enhanced responsibility. Vanderbilt University Medical Center provided this challenge for me, and I have maintained a position with Vanderbilt ever since. It was at VUMC that I learned about the extraordinary tuition assistance program that was offered. I was tremendously encouraged by the support of leadership and by having such a viable opportunity to once again improve my skills. I then decided to pursue my graduate degree at Vanderbilt School of Nursing.*

*I now hold the position of Director of Perioperative Services at VUMC. I embrace my status as a resource that allows me to contribute to a greater level of care across a broader spectrum of those in need. This was made possible by the exceptional tuition assistance program that was offered, accompanied by the dedication to excellence that is the cornerstone of practice at VUMC."*

**Diane L. Johnson RN, MSN – Director Perioperative Services**

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Another tuition benefit which can be utilized to support career development is the Vanderbilt University Tuition Benefit. This program provides tuition for staffs taking non-nursing courses at Vanderbilt or outside accredited institutions. The tuition is supported at a rate of 70% for 3 semester courses/year. Several leadership staffs have completed MBA or MMHC degrees utilizing this benefit option. Overall expenses related to this program exceed $10 million per year. [*SE 3 EO-Exhibit B-1-NTAB Policy CL 20-06.21*] Access to this policy is located at: http://www.vanderbilt.edu/HRS/policies/educationassist.html

**Commitment to Professional Development**

**Source of Evidence 4**

**Describe and demonstrate how the organization sets goals and supports professional development and professional certification, such as tuition/registration reimbursement and participation in external local, regional, national, and international conferences or meetings.**

In 2009, the Nurse Executive Board discussed the need to support nurses pursuing certification in a more specific manner. It was determined that if a nurse sat for a certification exam that would benefit his/her practice with the patient demographic served by their department, they would be reimbursed for the cost of the exam if they passed. In early 2010, a more formal policy was drafted and has been passed by all Nursing boards and is in the approval process by the Clinical Practice Committee prior to posting. [*SE4-Exhibit A-1-NLB Minutes 7-21-09, SE4-Exhibit A-2-VMG Clinical Operations Minutes 7-17-10, SE4-Exhibit A-3-VUH NLB Minutes 7-22-09*] The purpose of this policy is to provide a standardized method for reimbursement for certification exams in nursing. This policy specifically states, "*The Vanderbilt University Medical Center Benefit is committed to ensuring that individual, licensed, professional nurses have opportunities to pursue certification within their specialty practice. VUMC supports the professional nurse in pursuing specialty certification through reimbursement of the certification exam fees upon successful passing of one specialty certification exam*." The certification must be one of the nationally recognized certifications. [SE4-Exhibit A-4-Draft Certification Policy]

As outlined in SE 2 for professional organization participation, managers can also use the allocated funds to for staff to attend review courses for certification exams. Staff can also receive professional leave time to take review courses and certification exams. Managers work with them on their schedules to provide flexibility and patient care coverage.

Our clinical policy, CL 20-06.15, *(located in OO 8)* entitled, "Travel/Workshop Funds" provides guidelines for the use of funds budgeted to support travel, educational workshops, and national certification through entities such as the ANCC (American Nurse Credentialing Center) or related specialty-based certification entities. The policy states that, "*Vanderbilt University Medical Center (VUMC) is strongly committed to its threefold mission of education, research, and clinical care. Funds available for travel, workshop attendance, and national certification are viewed as mechanisms that can be utilized to enrich the growth and development of staff within the institution. Funds are made available to promote, support, recognize, and reward staff as they self-actualize and grow within their established role.*

*Inherent to this philosophy is a recognition that staff will typically develop across a continuum of practice performance ranging from novice (beginner) to expert (mastery)*."

**Setting Goals**

In 2008, the Nursing Executive Board recognized that we needed and wanted a more systemized approach to certification. A first step was to offer a certification preparation course for Nurse Executives as phase one of developing a strategy to increase the number of certified nurses throughout the organization. Starting at the top seemed to be the best idea. While we had many leaders who were certified, most were not.

An onsite course was held at the Vanderbilt School of Nursing in August 2008 with 40 nursing leaders in attendance (fees were paid by the Medical Center). A series of study groups were planned over the course of the six months following the review course and were facilitated by Sabrina Downs, MSN, RN, NE-BC (Director – Professional Practice) and Debbie Arnow MSN, RN, NE-BC (Director – Clinical Education and Professional Development – VCH). Of those who attended the certification preparation course, 12 successfully took and passed the Nurse Executive certification exam. At the time of writing of this document, several other nursing leaders have timelines to take the certification exam.

Phase two of our strategy was to pilot offering certification preparation courses for direct care nurses at the Children's hospital which is outlined more specifically below in SE 4 EO. We wanted to do the pilot to see how we could map out a strategy across the Medical Center. Children's is a smaller nursing population, with at least one over arching certification as opposed to multiple specialties. Phase three will be a system-wide approach which is also addressed in SE 4 EO in detail. Examples of our work around supporting and increasing certifications are in SE 4 EO.

**Commitment to Professional Development**

**Source of Evidence 4 EO**

**Describe and demonstrate that the organization has met goals for improvement in professional certification. Graphically summarize at least 2 years of data to display changes over time. Include participation of nurses in all specialties.**

**VUH - Neurology**

**Background**

It was identified in August, 2008 that there were no CCRN certified nurses working in the Neurosurgical unit or in the Neurology Care Unit (NCU 5S – 6T3). Jodie Thompson, RN, MSN, CCRN was hired as the unit educator on August 2008 and then subsequently moved into the Manager role in March 2009. The team set a goal for Neurology that ten (10) direct care nurses would achieve certification as CCRNs by December 2009.

**Methods/Approach**

The NCU team announced the dates of the CCRN review classes to the staff and encouraged all of the direct care nurses to attend the review course by working with their schedules to give them the time off and paying them for education days so that they did not have to use their personal vacation time. The nurses formed their own independent study groups to review for the test and even split the cost of additional review materials – sharing with each other to support and encourage each other. The benefits of certification were discussed in staff meetings and the new policy of reimbursement for the cost of the certification exam was reviewed. Each time a nurse passed the exam the team celebrated at staff and unit board meetings. The weekly newsletter to staff also contained the names of all of the nurses who passed the exam. Jodie states, "*It has been really fun to watch the momentum grow – the excitement is continuing*."

**Outcomes**

This goal was not only reached, but surpassed. By December 2009 there have been 20 staff nurses that have achieved CCRN certification. In the first six months of 2010 an additional 4 staff members were certified—bringing the unit total to 24 staff nurses in 18 months. Four of

those staffs have moved on to other ICU/ER positions. As of August, 2010 the NCU has 20 direct care nurses, the unit educator and the unit manager who are also CCRN certified.

They have an additional six direct care nurses who completed the CCRN review course in July of 2010 and plan to sit for the exam within the next twelve weeks. Their next goal is to have 28 total nurses in Neurology care CCRN certified (36% of total staff). Once we achieve this goal, our next target is to have 50% (39 nurses) of our direct care nurses and all of our charge nurses CCRN certified by December 2011.

In addition to this certification, there was an interest by the direct care nurses to pursue Neurology-specific certification. A group of ten staff (including the manager and educator) formed an independent study group and assigned all content areas for the CNRN (Certified Neuroscience Registered Nurse) exam. They are meeting weekly to "teach" each other and review the content for the exam. Their goal is to test in the Fall of 2010 and they have set a goal for all ten to pass and achieve CNRN certification.

**Children's Hospital**

**Background/Purpose**

Debbie Arnow, MSN, RN, NE-BC in her role as Director of Clinical Education and Professional Development for the Children's Hospital met with the leadership team and set a goal to increase the number of Pediatric certified direct care nurses by the end of 2009. This was to serve as a first step in an organizational pilot/plan. In reviewing the criteria for the exam, the decision was made to set up a program for direct care nurses to prepare for the CPN (Certification in Pediatric Nursing) exam by bringing a national expert onsite to lead a certification preparation course.

**Methods/Approach**

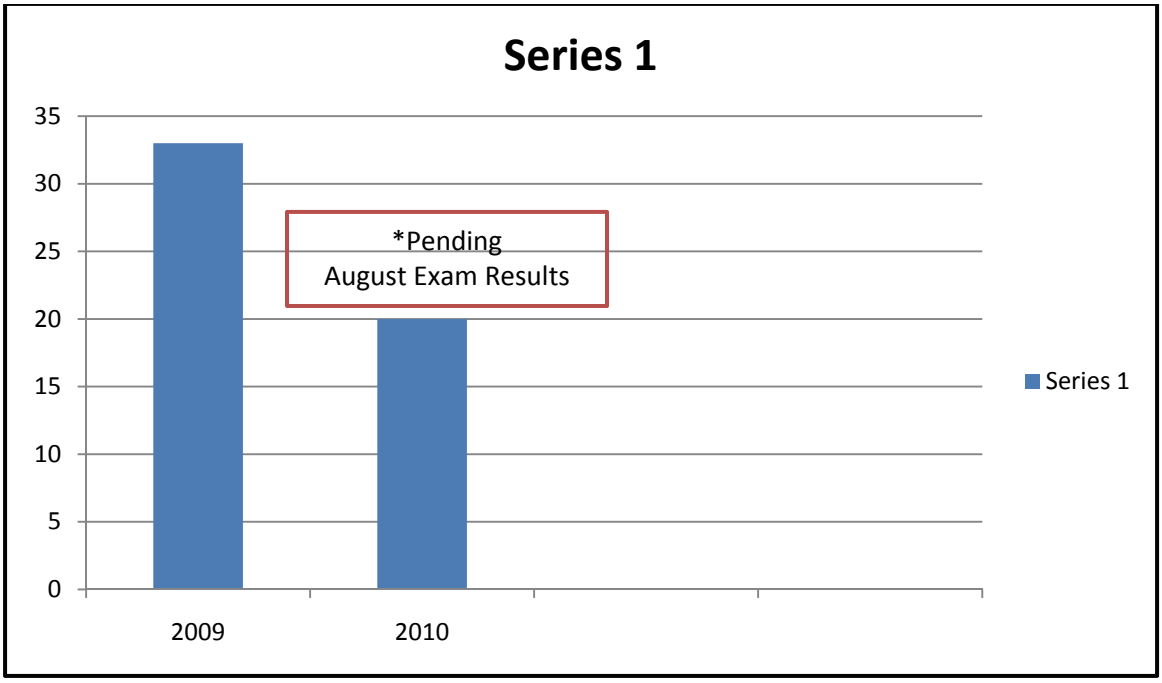
Debbie contacted the Society of Pediatric Nurses (SPN) and obtained the name of a national expert to come to Children's Hospital and provide an onsite certification preparation course. It was determined during the process of securing the speaker that it would be cost effective to conduct the testing onsite as well and would be more convenient for the nurses. Plans were put in place to hold the exam onsite and volunteers were secured to serve as exam proctors.

**Outcomes**

See the summary Graph 1 below demonstrating a total of 53 Pediatric direct care nurses who have obtained certification as certified Pediatric Nurses (CPN) since beginning this certification preparation program. This represents 12.3 % of the total number of direct care nurses at the Children's Hospital which is an increase of 2.7% up from the 9.6 % certified in 2009. The data shared from the Pediatric Nursing Certification Board shows our pass rate to be 100% as compared to 85% nationwide. The staff at Children's Hospital surpassed the scores for each division as compared to the nationwide statistics. [*SE4EO-Exhibit A-1-PEDS Certification Board*]

The success of those that passed is shared with the staff, managers, educators, administrative directors, Children's Hospital CNO, and VUMC ECNO. Recognition was provided through announcements in the Nursing Education Newsletter available monthly. Currently, members of the Nursing Education and Professional Development team who have obtained CPN certification are attending review courses to prepare them to lead future preparation courses and study groups. [*SE4EO-Exhibit A-2-In the Know Newsletter 2009, SE4EO-Exhibit A-3-In the Know Newsletter 2010*]

**Graph SE 4 EO – 1: Summary of Certified Pediatric Nurses 2009-2010**



**Enterprise Plan**

With the obvious success of the plan in Children's, the NEB requested a formalized system-wide approach be taken to assess the direct care nurses' interest in pursuing certification. Based on feedback from a survey, a strategic plan was developed and is currently being administered to provide onsite certification review courses and preparation programs. [*SE4EO-Exhibit B-1-NEB Certification Proposal*] (Please see the table below for the number of nurses currently certified at VUMC). Debbie Arnow, MSN, RN, NE-BC and Sheryl Redlin-Frazier, MSN, OCN (NE&PD) Clinical Learning Consultant) are co-chairing these efforts.

**Table SE 4 EO – 1: VUMC Certified Nurses by Entity**

| Year | VUH | VCH | VPH | VMG | Total |
|---|---|---|---|---|---|
| **2009** | 21.3 % | 9.6% | 0.2% | 2.1% | 33.2% |
| **2010** | 20.7% | 12.3% | 0.2% | 3.7% | 36.9% |

The VUMC Nursing Executive Board has fully endorsed this approach to certification preparation. A staff nurse survey was conducted during the first quarter of 2010 to assess the focus areas for certification review. A two-year calendar of events was planned based on the survey results to address the interests of the staff nurses.

See Table below.

**Table SE 4 EO – 2: 2010-2012 Certification Preparation Courses Calendar**

| FY 2010-11 | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult CCRN* | x | | | | x | | | | | | | |
| Peds CCRN* | | | | | x | | | | | | | |
| Neonatal CCRN* | | | x | | | | | | | | | |
| Pediatric Emergency* | | | | | | | x | | | | | |
| Emergency Nursing | | | | | | x | | | | | | |
| Pediatrics* | | | | | | | | | | x | | |
| CNOR | | | | | | | | | | | | |
| Medical Surgical* | | | | | | | x | | | | | |
| Psych Nursing | | | | | | | | | X | | | |
| Oncology | | | | | | | | | | | | |
| Nurse Manager/Leader | | | | | x | | | | | | | |
| Cardiac Medicine* -tbd | | | | | | | | | | | | |
| Cardiac Surgery* -tbd | | | | | | | | | | | | |
| **FY 2011-2012** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** |
| Ambulatory | | x | | | | | | | | | | |
| Adult CCRN | | | | | x | | | | | | | |
| Peds CCRN | | | | | | | | | | | | |
| Neonatal CCRN | | x | | | | | | | | | | |
| Pediatric Emergency | | | | | | | x | | | | | |
| Emergency Nursing | | | | | | x | | | | | | |
| Pediatrics | | | | | | | | | | x | | |
| CNOR | | x | | | | | | | | | | |
| Medical Surgical | | | | | | | x | | | | | |
| Progressive Care | | | | | | | | x | | | | |
| Oncology | | | | | | | | | x | | | |
| Professional Development | | | | x | | | | | | | | |

As discussed in SE 4 above, a policy was developed and presented to the NEB for endorsement. The policy has been presented to the entity Nurse Leadership Boards and Staff Councils for review and has now been submitted to the Clinical Practice Committee for approval. Staff nurses will have access to assistance from the Department of Nursing Education and Professional Development to access the certification preparation that is most appropriate for their practice.

Our goal is to increase the number of certified nurses by 5 % by the end of 2012. That may not seem like a large percentage, however, in an organization where the N grows significantly each year, 5 % may be a challenge.

We have a Nurse Manager/Nurse Executive certification preparation course scheduled in November along with another CCRN preparation course. With the addition of our new CNO at the Vanderbilt Psychiatric Hospital, we have set a goal of having twenty nurses certified in Psychiatric Nursing in 2011 and have scheduled a preparation course for early Spring. The successful passing of the certification exam will be tracked after each review course. This data will be presented to the Nursing Administrative Board on a semi-annual basis.

**Commitment to Professional Development**

**Source of Evidence 5**

**Describe and demonstrate the structure(s) and processe(s) used by nursing to develop and provide continuing education programs for nurses at all levels and settings. Include how the organization provides onsite internal electronic and classroom methods. Do not include orientation.**

The future of the nursing profession rests upon developing collaborative models between nursing service and nursing education. Nursing staff at all levels of the organization have professional development opportunities. Our academic setting and core mission of education creates a culture of continuous learning. Our partnership with our own school of nursing as well as community nursing schools within Tennessee and surrounding states provides us with the opportunity and responsibility to provide enriching educational and clinical experiences for a wide variety of nurses and student nurses with different levels of education and experience.

The department of Nursing Education and Professional Development was created when the first VUMC Director of Nursing Education and Professional Development (NE&PD) was hired in April, 2005. The department has grown from a staff of four nurses with an operating expense budget of $50,000.00 to a department that now includes a team of thirty-two (32) and an annual operating expense budget of $2.3 million. The team consists of one Director of Nursing Education and Professional Development who is educationally prepared with a Masters degree and Ph.D. in Nursing, two Masters-prepared nurses who serve as Directors of Clinical Education and Professional Development, seven (7) Clinical Learning Consultants, two (2) Nurse Educators, two (2) Pediatric Nurse Resident Coordinators, six (6) part time Clinical Facilitators, one (1) full time Clinical Facilitator, five (5) Program Coordinators, one (1) part time Arrhythmia Instructor, one (1) Art Director, one (1) Media Producer/Director, and two (2) Administrative Assistants. [*SE5-Exhibit A-1-NE & PD Organizational Chart*] The Director of Clinical Education and Professional Development for the Vanderbilt Clinics has a dotted line reporting relationship to the VUMC Director of Nursing Education and Development. Currently the budget for this Director is $482,782. [*SE5-Exhibit A-2-VMG Organizational Chart*]

The mission of the Nursing Education and Professional Development Department is as follows:

- To provide programs that support individuals in their professional development.

- Evaluate the educational and developmental needs of the organization and community. Implement program structured to address those needs.

- Collaborate with colleagues to evaluate data that identifies chasms and provide educational framework for implementation of programs and processes to improve outcomes.

- Implement programs that support the Medical Center's growth and support the achievement of targeted goals. Evaluate existing programs to maximize resources and decrease waste or redundancy.

- Foster the generation, utilization, and dissemination of evidence in practice.

A three-year strategic plan was developed based on one-to-one interviews with leadership, online surveys, and focus group discussions with direct care nurses and nursing leadership. Under that plan, core clinical orientation was assessed and redesigned to better meet the needs of newly hired nursing and unlicensed assistive personnel.

The Center for Frontline Nursing Leadership was developed and implemented in partnership with the Washington, D.C.-based Advisory Board. A nursing website, www.vanderbiltnursing.com was launched and has become a portal for nurses from all over the world to gain information about nursing at Vanderbilt averaging 22,000 hits per month from 150 countries. *Nurse Alerts!* were created in 2009 as a list serve vehicle for staff to receive information about continuing education programs they are interested in. Current subscriptions are as follows:

**Table SE 5 – 1: Nurse Alert! Subscriber List**

| Category | Number of Subscribers |
|---|---|
| General | 1348 |
| APN | 461 |
| Diversity | 174 |
| Magnet | 643 |
| Nursing Residency Program | 461 |
| Nurse Wellness | 896 |
| Nurse's Week | 931 |
| Education | 1197 |

| | |
|---|---|
| Research | 893 |
| Shared Governance | 555 |
| VPNPP | 729 |
| Nursing News | 893 |
| Safety First | 247 |
| Preceptor Dish | 182 |

**Graph SE 5 – 1: Screen Shot of Nursing Website**


Best practice from the existing Pediatric Nurse Residency Program was extracted and applied to the development and implementation of our VUMC standardized Nurse Residency Program launched in the Summer of 2008. This program has now brought in five cohorts of graduate nurses totaling 713 new graduates since its inception.

A partnership with six schools of nursing was created to provide a robust summer nursing internship experience for rising senior nursing students entitled, Vanderbilt Experience: Student Nurse Internship Program (VESNIP). Student clinical placements are coordinated through the NE&PD department throughout the year that include faculty monitored as well as practicum experiences totaling approximately 2000 placements per year.

With the increase of student experiences as well as new employees there was a need to create a preceptor development program. There is an initial workshop offered several times per year and a second workshop in the series is now offered to continue development of "veteran" preceptors. The "Preceptor Dish" was launched in 2009 as an online newsletter to provide real time updates to subscribers (the information remains archived on the Nursing website).

APN Grand Rounds were launched in August 2008 and are open to all nurses and other providers to attend in person as well as view online at a later date. APN Grand Rounds have now evolved into the Clinical Practice Grand Rounds to reflect the multidisciplinary nature of the presentations.

The Vanderbilt Professional Nurse Practice Program (VPNPP) was moved to Nursing Education and Professional Development's oversight in 2008 and with a new "marketing" emphasis in 2009 working with the unit boards and staff councils, saw 100 nurses advance in one year (50% increase from the previous year).

In December 2008 the Nursing Education and Professional Development department received approval to be an approved provider of continuing education by the Tennessee Nurses Association (TNA) and has since developed a network of nurse planners across the Medical Center to participate in the creation and implementation of contact hour continuing nursing educational programs for nurses from Vanderbilt as well as the outside community. Examples of continuing education programs that have been developed based on direct care nurses input include the following:

- *Transplant Pharmacology for Nurses: Liver Transplant* - In 2009, after reviewing outcomes of transplant patients in different critical care unit the staff nurses wanted to have additional information about the medications patients needed to receive pre- and post-operatively. NPs and Pharmacy staff used case studies to identify and analyze positive and negative responses to current medications used in the units that accepted transplant patients (SICU, 9 North and 9 South).

- *Hematologic Malignancies and Transplantation Course* – This program was originally offered in 2009 and offered again by request in 2010. The purpose of this program was to review the various protocols and different medications for patients with Hematologic malignances. Reviewed the current practice for the care of patients with Hematological malignancies before and after bone marrow/stem cell transplant. NPs and Social Workers provided handouts and conducted group discussions with case studies to

identify and analyze positive and negative responses to current and new medications used. Presented for the direct care nurses in the Cancer Center, Hematology clinic, and 11 North.

- *Healthcare-Associated Infections: A Practice-Oriented Update* - The Purpose of this program was to give staff nurses information on the current treatment for bacteria that is found in the environment and VUMC's approach to decreasing hospital acquired infections. Physicians, Nurses and Pharmacists conducted group discussions and Panel Discussions to identify critical issues and strategies to improve success.

**Nurse Educators**

We also have a team of decentralized nurse educators who are based at the local level reporting to the department manager. These educators come together monthly at the Nurse Educator Council and discuss issues such as best educational practice, competency plans, changes in policies and procedures or new equipment purchases that may require staff education, and programs that may need central and decentralized support (i.e. Nurse Residency Program, Safety Fair, etc.).

Our Nurse Educators are integral to the committee work that supports the organization and serve as unit representatives on numerous medical center-wide committees such as the Nurse Residency Program Steering Committee, the Recruitment and Second Year Retention Committee, Nursing Continuing Education Committee, etc. They truly are our "feet on the street" when it comes to providing education to our staff in response to changing policies or regulatory compliance needs. continuing education and professional development.

**Nursing CE Committee**

The Nurse Educators also participate on the Nursing Continuing Education Committee (NCEC). The Nursing Continuing Education Committee meets monthly and is responsible for planning educational events that are multidisciplinary and cross-cultural. This committee has conducted online surveys of the nursing staff along with personal visits to the unit boards by the NECE co-chairs to determine direct care nurses interests and requests for topics. Based on these surveys (See Table below) continuing education programs are offered in a classroom setting and regulatory and compliance education is offered online.

**Table SE 5 – 2: Educational Survey Results**

| Question | Response Percent | Response Total |
|---|---|---|
| **1. Gender** | | |
| Male | 10.20% | 110 |
| **Female** | **89.80%** | **970** |
| **Total Respondents** | | **1080** |
| (skipped this question) | | **4** |

| | | |
|---|---|---|
| **3. Age** | | |
| Under 21 | 0.70% | 7 |
| 21 - 30 | 20.50% | 220 |
| 31 - 40 | 23.00% | 247 |
| **41 - 50** | **30.90%** | **332** |
| 51 - 60 | 22.10% | 237 |
| 61 - 70 | 2.70% | 29 |
| Over 70 | 0.10% | 1 |
| **Total Respondents** | | **1073** |
| (skipped this question) | | **11** |

**14. Modes of Delivery for Educational Offerings**

| | 1st | 2nd | 3rd | 4th | 5th | 6th | 7th | 8th | 9th | Response Average |
|---|---|---|---|---|---|---|---|---|---|---|
| Face-to-Face (FTF) | 33% (294) | 30% (269) | 15% (134) | 6% (55) | 4% (31) | 3% (30) | 2% (14) | 2% (19) | 4% (38) | 3.82 |
| FTF w/Hands On | 45% (387) | 29% (248) | 7% (63) | 4% (34) | 3% (27) | 3% (29) | 4% (35) | 3% (26) | 1% (9) | 3.70 |
| FTF & Computer | 6% (48) | 13% (107) | **39% (316)** | 16% (132) | 9% (73) | 6% (45) | 6% (51) | 2% (19) | 3% (22) | 5.14 |
| Audio & Computer | 4% (27) | 9% (65) | 8% (58) | **21% (160)** | 21% (154) | 15% (115) | 9% (70) | 7% (50) | 7% (51) | 5.95 |
| Computer (online) only | **21% (173)** | 8% (68) | 9% (77) | 13% (113) | 16% (135) | 14% (115) | 10% (87) | 3% (28) | 5% (46) | 2.57 |
| Simulation | 6% | 14% | 16% | **19%** | 14% | 18% | 4% | 4% | 4% | 3.27 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| w/Hands-on | (47) | (107) | (126) | **(150)** | (111) | (142) | (33) | (33) | (29) | |
| Online Simulation | 5% (40) | 10% (73) | 8% (61) | 8% (60) | 15% (113) | 15% (112) | **30% (230)** | 5% (41) | 5% (37) | 3.98 |
| DVD | 3% (21) | 5% (40) | 7% (56) | 8% (62) | 7% (52) | 7% (56) | 13% (99) | **46% (351)** | 4% (33) | 7.02 |
| CD | 1% (10) | 2% (14) | 4% (27) | 7% (51) | 5% (36) | 6% (42) | 8% (57) | 14% (100) | **54% (399)** | 6.94 |
| | | | | | | | | | **Total Respondents** | 965 |
| | | | | | | | | | **(skipped this question)** | **113** |

The NCEC sponsors two annual events, AprilFest and OctoberFest and select themes and topics based on input from staff and leadership. The staffs have access to the online calendar for continuing education events on the Nursing website at http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=18452

The 2009 AprilFest activities included topics such as:

- Management of Peripheral Short IV Access & Midline Catheters: An Evidenced-Based Approach
- Dignity & Respect: Showing Our Patients Cultural Sensitivity
- Central Line Management: An Evidenced-based Approach
- Critical Care Series - Sepsis/Septic Shock

The 2009 OctoberFest event included topics such as:

- Lines of Communication
- Generational Differences
- Healthcare Disparities for the Hispanic Patient
- Spanish Lingo for Healthcare Professionals – Level I
- Cash Flow Planning: Taking Care of Your Finances
- Introduction to Shared Governance

- Leading Without Taking Control
- Conflict & Trust: Attributing Motives to the Other Guy
- Learning Tai Chi for Healing
- Healing QiGong
- Shared Governance in Action

A research day was sponsored with the keynote presentation, "Research and Quality: The Mobius Band Metaphor for Discovery and Improvement" by Julie Morath, RN, MS (Chief Quality and Patient Safety Officer – VUMC). Poster presentations were displayed that included projects by direct care nurses and participants in our Center for Frontline Nursing Leadership program. A sample of these poster presentations is located at https://www.mc.vanderbilt.edu/vunet/vumc.php?site=evidencebasedpractice&doc=20366

**Table SE 5 – 3: Members of the Nursing Continuing Education Committee**

| Name | Credentials | Title | Department |
|---|---|---|---|
| Pam Allen | MSN, RN, ACNP | Clinical Learning Consultant (CE Planner) | Nursing Ed & Development |
| Rebecca Arndt | RN, CNOR | Nurse Educator | VCH Periop. & Special Projects |
| Debbie Arnow | MSN, RN | Director, VCH NED | Nursing Ed & Development |
| James Barnett | MSN, RN | Clinical Learning Consultant | Nursing Ed & Development |
| Connie Bauersachs | RN | | NICU |
| Stephanie Brodtrick | MBA, RN | Consultant | Human Resources |
| Margaret Burns | RN | Charge Nurse | Eskind Diabetes/ Endo Clinic |
| Chantelle Davis | BS | Program Coordinator | Nursing Shared Governance |
| Dawn Ecks | ACNP-BC | Nurse Practitioner | Cardiac Transplant Center |
| Kelly Ernst | MSN, RN | Clinical Learning Consultant | Nursing Ed & Development |
| Teresa Fulwood | CCRN | Flight Nurse | LifeFlight |
| Richelle | MSN, RN, CRNI | Director Clinical Education & | VMG Administration |

| | | | |
|---|---|---|---|
| Hamblin | | Professional Development - VMG | |
| Beth Hodge | MSN, RN | CNS/Educator | 4,5,6 MCN |
| Joan Isom | LPN | Lab Liaison | MCE Lab |
| Laura Kelley | MSN, RN | Program Mgr, Diversity & Inclusion | HR Medical Center Recruitment |
| Sarah Marquardt | RN | Assistant Manager | VMC Home Services |
| Gail Mayo | RN | Research Services Consultant | Pharmacology |
| Jeffrey Miller | RN, MSN | Nurse Educator | VCH Periop & Procedural Services |
| Leanna Miller | MSN, RN | Education Specialist | CVICU |
| Diane Moat | JD, RN | Clinical Risk Manager | Risk & Insurance Mgmt |
| Ginny Moore | MSN, RN | Lifelong Learning Coordinator | School of Nursing |
| Shelly Moore | MSN, RN, CCRC | Director, Shared Governance Implementation | Nursing Shared Governance |
| Christy Mullen | MSN, RN | Clinical Nurse Educator-VCH | Nursing Education & Development |
| Barry Noland | | Program Coordinator | The Learning Center/NE&D |
| Shelly Padgett | RN,MSN | Clinical Nurse Educator | 7 North/6 South |
| Patricia Patterson | RN, BSN, CDE | Staff Nurse | Eskind Diabetes Center |
| Jerita Payne | MSN, RN | Transplant Coordinator | Liver Transplant Program |
| Debianne Peterman | PhD, MSN, RNC-NIC, NE-BC | Director, Nursing Education & Development-VUH | Nursing Education & Development |
| Sheryl Redlin-Frazier | RN, MSN, OCN | Clinical Learning Consultant | Nursing Ed & Development |
| Georgette Smiley | RN, BSN | Staff Nurse | Otolaryngology |
| LeaAnne Smith | MSN, RN | NP Riven Service | Cardiology Administration |
| Sherri Stringfellow | | Art Director | Nursing Education & Development |
| Clare Thomson-Smith | MSN, RN, JD | Director, Center for Advanced Practice Nursing & Allied Health | School of Nursing |
| Irina Tollerson | RN | Staff Nurse | Hillsboro Medical Group MCE |
| Wendy Vincent | MSN, RN | Pediatric Hematology/Oncology | VCH Outpatient Center |

| | | | |
|---|---|---|---|
| Gloria Wacks | RN, PhD | Nurse Educator | Outpatient Surgery PCC |
| Nancy Wells | DNSc, RN | Director, Nursing Research | Nursing Administration |
| Martha White | MSN, APRN, BS | Nurse Educator | 9N / 9S |
| Chris Wilson | MSN, RN-BC | Director, Clinical Education & Professional Development – VUH | Nursing Education & Development |

**Launch of APN Grand Rounds**

**Background**

In February, 2007 the Nursing website was launched to provide a mechanism to deliver information to Vanderbilt University Medical Center (VUMC) nurses at all levels as well as promote Vanderbilt Nursing externally. On the website there is a section that offers users the opportunity to contact the webmaster for the site. An advanced practice nurse from Transplant Services emailed the webmaster expressing her concern that there was not enough information or educational content specific for APNs. The webmaster contacted this APN and requested permission to pass her email over to the Director of Nursing Education and Professional Development for follow-up.

Upon meeting with the APN, the Director of Nursing Education and Professional Development discovered that there was indeed a gap in educational offerings for APNs. In addition, it was discovered that the APN group (approximately 500 nurses) did not have a directory (as the physicians did) to identify Nursing experts in clinical specialties. Meetings with various stakeholders were set up to complete a needs analysis.

**Table SE 5 – 4: Participants**

| Name | Credentials | Title | Department |
|---|---|---|---|
| Clare Thomson-Smith | MSN, RN, JD | Director, Center for Advanced Practice Nursing & Allied Health | School of Nursing |
| Joan King | Ph D, ACNP | Professional Practice Nursing | School of Nursing |
| Debianne Peterman | PhD, MSN, RNC-NIC, NE-BC | Director, Nursing Education & Development-VUH | Nursing Education & Development |
| Sherri Stringfellow | | Art Director | Nursing Education & Development |

**Table SE 5 – 5: Planning Committee Members from the APN Leadership Council**

| Name | Credentials | Title | Department |
|---|---|---|---|
| Amy Hardin | MSN, FNP | Nurse Practioner | Cardiology |
| Sharon Sims | MSN, ACNP | Nurse Practitioner | Hem Onc/Stem Cell |
| Julie Dykes Sumner | MSN, ACNP-BC | Nurse Practitioner | Liver Transplant |
| Pam Allen | MSN, ACNP | Clinical Learning Consultant | Nursing Education & Development |

**Methods and Approach**

The planning discussions began in late 2007 and a committee was formed in March, 2008. The official launch of the APN Grand Rounds was in August 2008 with 134 attendees. The APN Grand Rounds have continued to occur every other month as scheduled since the launch and are currently in their second season. Please see screen shots of Nursing website below for topic listings. [*SE5-Exhbit B-1-Minutes APN Leadership Council 3-18-08*] The link to the APN Grand Rounds offerings is: http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=24353

**Outcomes**

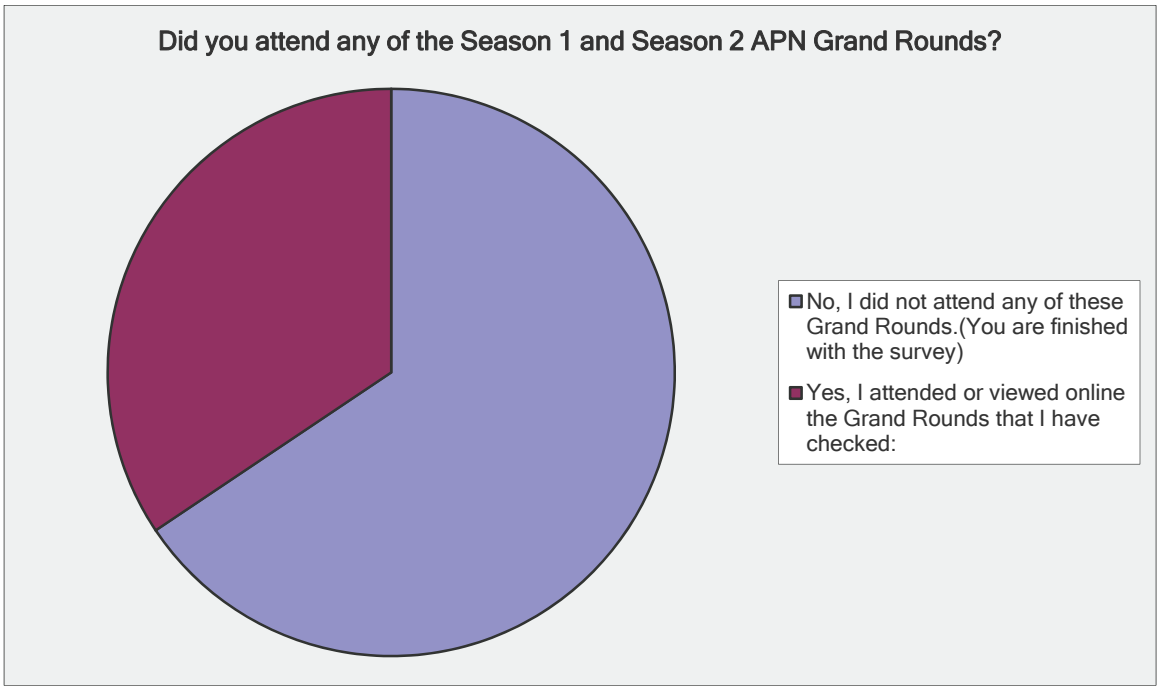
A full season of APN Grand Rounds was established and launched in August 2008. The first season offered sessions every other month and alternated doing an early morning session with a lunchtime session. It was determined after the first year that the lunchtime offerings were better attended and preferred based on evaluation so the second season offerings have all been scheduled for the lunch hour. At the launch, the first year's schedule was handed out and the website was demonstrated so the APNs could find the schedule easily and register for future sessions. The APN directory was also introduced and demonstrated. The Art Director worked with each APN to have their picture taken at the end of the launch by the photographer for placement on the website. An evaluation was handed out at the end of the launch and a list of suggested topics for future grand rounds was compiled. [*SE5-Exhibit C-1-APN GR Eval Summer 08-09*, *SE5-Exhibit C-2-09-10 APN Grand Rounds Season Schedule*]

The first APN Grand Rounds session was offered in September 2008 – Julie Dykes Sumner RN, MSN, ACNP-BC presented HBV/HCV. Each offering was videotaped and placed on the website so that if a nurse could not attend in person they could view the offering later, take the posttest and receive a nursing contact hour for the program. This provides direct care and advanced practice nurses the opportunity to participate online when they may not be able to leave the clinical setting to attend the Grand Rounds in person. The APN Grand Rounds are

available on the website and are available to all nurses at VUMC. There are posters displayed throughout the Medical Center and a *Nurse Alert!* has been established with 461 subscribers.

A survey of current APNs was conducted online with 61 nurses responding. Out of these responses, 34.4% responded that they had attended or viewed one of the APN Grand Rounds sessions.

**Chart SE 5 – 1: APN Grand Rounds Survey 2010**




The survey also asked the respondents to identify how their practice had changed or been impacted by the information that was presented. A summary of responses is presented below.

**Table SE 5 – 6: How Practice Had Been Impacted**

| SESSION | Please specify how you have changed your practice or outline what you have added to your practice based on what you learned from this session. |
|---|---|
| HVB/HCV - presented by Julie Sumner, ACNP-BC | Looking at the long term affects related to risk for cancer |
| Pressure Ulcers - presented by Sheree Lee, BSN, RN, CWOC, Shirleen Chase, RN | Better documentation of the patient's skin |

| | |
|---|---|
| and Martha Davidson, BSN, MN, CWOCN | |
| Inflammatory Bowel Disease - presented by Julianne Wagnon, MSN, JD, FNP-BC | Very informative while providing information regarding services provided |
| Perioperative Evaluation Process - presented by Russell J. Kunic, MSN, FNP-BCC and Mark J. Haffey, CRNA, MSN, RN | Very informative and comprehensive overview of the preoperative process |
| How do your patients sleep? - presented by Suzanned E. Goldman, PhD, FNP-BC | Include a better sleep assessment |
| Legal and Legislative Updates - presented by Clare Thomson-Smith, JD, MSN, RN | Signing up for TN prescriber's database<br><br>I am a WHNP/ANP student, graduating 12/2010. I will use this knowledge when I begin practicing.<br><br>Make sure 20% charts are reviewed<br><br>Generate Reports for self Audit<br><br>More alert to practice change<br><br>Use information learned today with co-workers<br><br>Kept up-to-date regarding changes in practice |
| Does my partner need to be tested? - presented by Lucy Koroma, MSN, WHNP-BC | Will inquire on sexual practices<br><br>Awareness of STDS in my HIV+ population |
| Sniffles, Sneezes, & Headaches - presented by Susan Ficken, FNP-BC | Allows me to enforce patient /family education regarding rhinitis/sinusitis<br><br>History of patient's symptoms.<br><br>More informed/knowledgeable care.<br><br>More effective Tx allergic rhinitis symptoms; better diagnosis ABS |

**Commitment to Professional Development**

**Source of Evidence 5 EO**

**Describe and demonstrate the effectiveness of two (2) educational programs provided in SE 5.**

**VUMC Enterprise Wide**

**New Clinical Leader Development**

**Background/Purpose**

Charge nurses and assistant nurse managers are often asked to apply for the role based on their clinical expertise and other leadership qualities observed in their routine work as a staff nurse. Unfortunately, frequently, once in this role, he/she is offered very little in the way of tools and/or resources to function most effectively in this role. A group of nurses in these roles brainstormed to determine what tools and resources would be valuable to them. A list of the existing course offerings was reviewed and gaps were identified. Content was then developed to cover information that was not currently offered or needed to have further edification from foundation curriculum previously covered.

**Methods and Approach**

Based on this preliminary work, this new course, "*S3: Success, Strategy, and Scope of Nursing Practice: A Series"* was developed. This course was developed over a four-month period. The course is offered quarterly, on two consecutive Tuesdays, from 7:30 am to 3 pm. The program was developed using the above considerations in addition to seeking guidance and input from content experts related to specific needs or issues surrounding individual topics.

The course content and agenda were reviewed and refined by the Nursing Administrative Board. After revisions, the program content was presented to the Nursing Leadership Boards from VUH, Children's Hospital and VMG for feedback. The Nursing Administration Board and entity Nursing Leadership Boards endorsed this course prior to implementation. The Nursing Leadership Development Task Force and Directors of Clinical Education and Professional Development will continue to act in an advisory capacity for future course refinement. Ongoing program evaluation and content refinement will be based on

written and verbal feedback from both participants and speakers will be conducted. Marketing was promoted on the nursing website and via "Nurse Alerts."

The *S3 series* focuses on providing instruction and coaching on practical strategies for the nurse who is in the new role of Charge Nurse or Assistant Nurse Manager. This two-day course highlights resources, communication skills, interpretation of reports and performance evaluations. The goal of this course is to provide the participant with basic tools and resources to begin a successful transition into a nursing leadership role. Other leadership courses offered through various departments will provide more detailed information for many of the topics provided in this course. While this class is designed for the new Charge Nurse and Assistant Nurse Manager, new Nurse Managers as well as front line leaders who have less than a year of experience could also benefit from the content of this course. Class size is limited to provide opportunities for small group work and interaction.

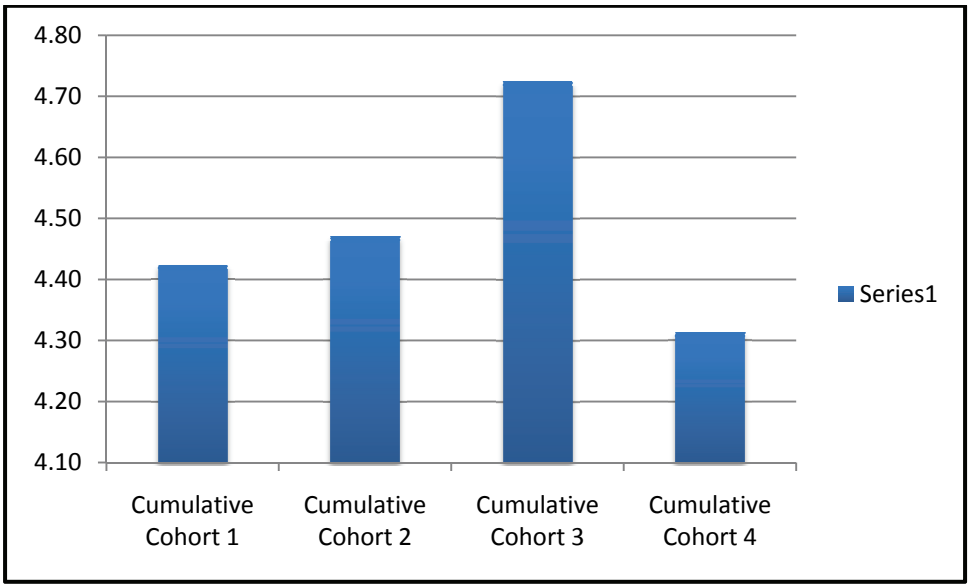
**Outcomes/Impact**

Evaluation of program effectiveness is completed by discussion of course assignment given after Day 1 of the course. This assignment asks participants to incorporate learning from Day 1 into problem solving in an actual situation encountered during the work week. Each course is evaluated individually by using program objectives and speaker effectiveness. Evaluation of program effectiveness is evaluated by discussion of course assignment given after Day 1 of the course as well as completion and follow up at 30- and 90-day period of a long term action plan that incorporates program objectives into daily practice.

We have completed two programs and are still in the evaluation phase of this course's effectiveness. Initial feedback has been very positive from the initial participants. All feedback is taken into consideration while planning the subsequent sessions. Future plans are being considered for long term follow up with participants through short course offerings, informational "brown bag lunch" sessions and/or discussion boards through the on-line learning management system. The graphs below summarize the participants' evaluations of the program by each cohort.

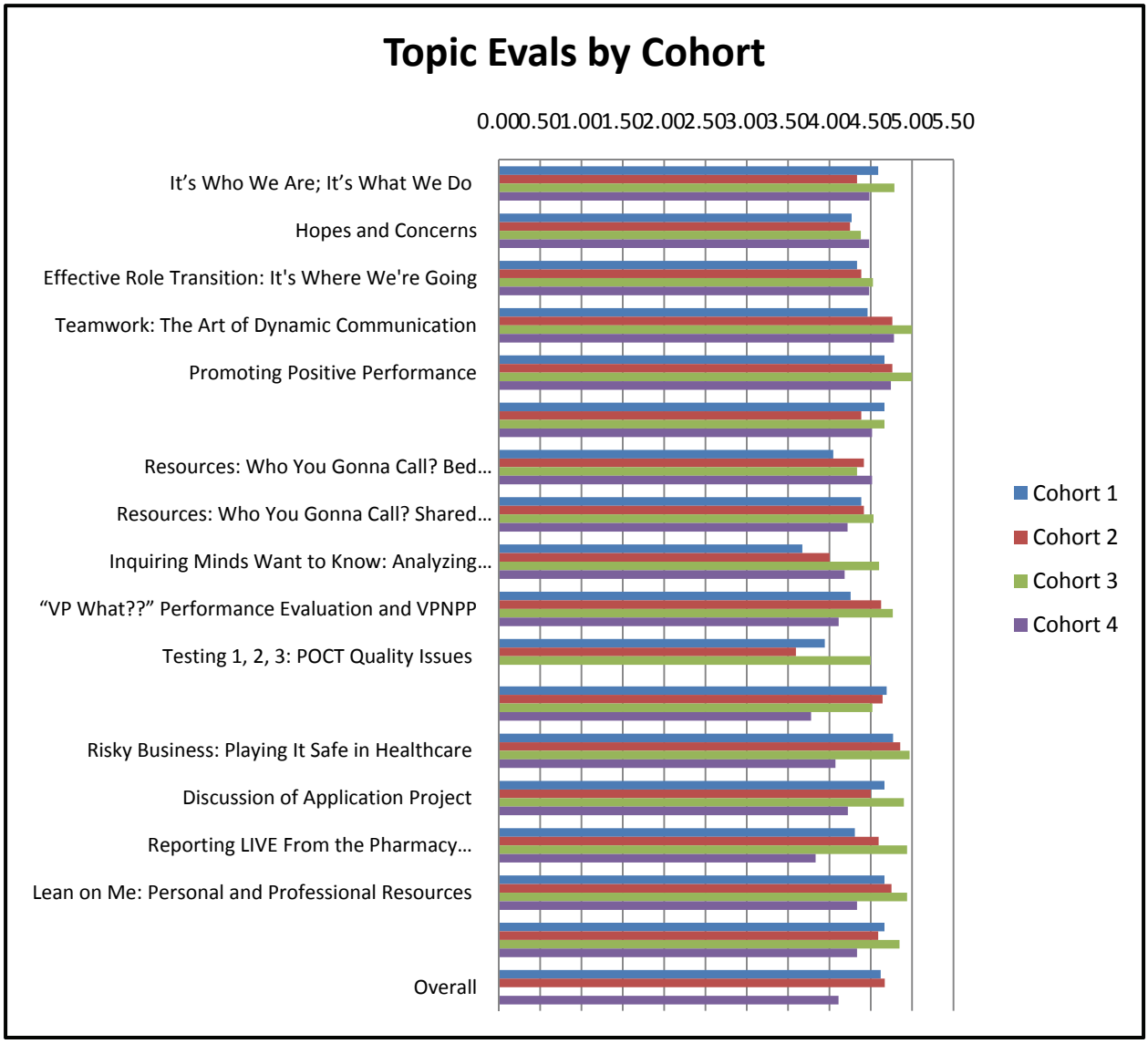
See Graph below.

**Graph SE 5 EO – 1: General Program Evaluations by Cohort**




See Graph below.

**Graph SE 5 EO – 2: Topic Evaluations by Cohort**




A random selection of five participants, six months after their participation in S3 evaluated the program by answering the following objectives and ranking their importance:

1. Identify the key functions of the nursing leadership role at Vanderbilt and describe at least one leadership technique you can apply to help you fulfill a key function.

2. Locate professional and personal resources at Vanderbilt that support management functions.

3. List at least three types of reporting used at Vanderbilt to monitor and improve patient safety and describe how to access them.

The participants were also additional questions to evaluate how useful the information has been to them in their work setting. The following table provides a summary of the results.

**Table SE 5 EO – 1: Summary of Evaluations**

| | **All of the time** | **Some of the time** | **Rarely** | **Never** |
|---|---|---|---|---|
| I was able to apply my action points | 40% | 60% | 0 | 0 |
| | **Once a week or more** | **Once – twice a month** | **Once or a few times over the past 6 months** | **Never** |
| How many times in the past 5 months have you applied your action points in your job? | 60% | 40% | 0 | 0 |
| | **0 – 25% improvement** | **25 – 50% improvement** | **50 – 75% improvement** | **75 – 100% improvement** |
| Choose your current, original, top-ranked objective from above. After completing the $S^3$: Success, Strategy and Scope of Nursing Leadership course, how much better do you feel like you accomplish this task? | 0 | 0 | 90% | 10% |
| | **YES** | **NO** | | |
| Have you or would you recommend this course to another charge nurse or assistant nurse | 100% | 0 | | |

| | | | | |
|---|---|---|---|---|
| manager that you work with? | | | | |
| | | | | |
| What do you feel was the most beneficial point of this course offering? | Networking with other CN/Mgrs to learn from each other & help with each other in communication in all different situations. Learning about different resources throughout the hospital and putting a face with a name.<br><br>Hearing the perspectives/solutions/suggestions of other leaders.<br><br>Hearing information on resources that are available to me as a charge nurse that I was not aware of before or not sure how I was to use them. | | | |

[*SE5EO-Exhibit A-1-S3 Application Assignment, SE5EO-Exhibit A-2-S3 Long-Term Action Plan, SE5EO Exhibit A-3-S3 11-10-09 Agenda, SE5EO-Exhibit A-4-S3 Program Objectives*]

S3 Online Access: http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=23737

**VUH Example**

**Evidence-based Competency Program – 7RW**

**Background/Purpose**

The 7th Floor Round Wing (7RW) has adopted an evidence-based competency program to ensure that care-givers (nurses, graduate nurse applicants, care partners, and nurse externs) are prepared and qualified to deliver safe and quality patient care. Assessment of competency begins with orientation and continues throughout employment. Each staff member is required to demonstrate their ability to competently provide care within their scope of practice at defined intervals throughout the individual's employment. In compliance with hospital policy, the defined interval on 7RW is yearly and will coincide with the annual evaluation period, which is July 1st through June 30th of any given year. The overall competency of each staff member is determined by their annual performance appraisal which includes the successful completion of all competency requirements. Each care-giver is responsible for their ongoing professional growth. To enhance their competency and growth, they have access to numerous unit-level and hospital-wide continuing education programs. Staff members will notify the Educator or Assistant Manager of additional educational needs.

**Table SE 5 EO – 2: Participants**

| Name | Credentials | Role |
|---|---|---|
| Michael Jorden | RN, MSN, 7RW | Manager - Facilitator, Resource |
| Sandy McGill | RN, MSN, MBA | Educator – Project Director |
| Patricia Galo | RN | Staff Nurse – RN point person |
| Marayet Warner-Francis | RN | Charge Nurse - point person |
| Jessica Bowman | | Care Partner-point person |

**Methods/Approach**

This unit-based competency process was developed a few years ago after the Department of Nursing Education and Professional Development invited a nationally renowned expert on clinical competencies, Donna Wright, to come speak with educators and leaders throughout the organization. Based on Donna Wright's teachings and her published book (see reference below), the program was developed and implemented on three medicine units (8N, 8S, and the TVC Cardiac Observation Unit) We expanded the program to include 7RW this year (2009). This process was also shared with the Educator's Council and is now being used in this or a modified format in a number of other inpatient and outpatient settings. The Department of Nursing Education and Professional Development has adopted a modified version of this process to develop organizational competencies. A collaborative group of leaders and educators conducted a thorough review of the hospital policy on orientation and competency. The group made significant revisions and the revised policy was approved by the Clinical Practice Committee in January 2009. Please see Policy CL 20-07 02 Orientation Competency [*SE5EO-Exhibit B-1-CL 20-07.02 Orientation Competency Policy*]

Over the past few years, the scope of care on 7RW has changed dramatically. Initially it transitioned from a sub-acute unit to an acute care medicine unit. Not soon after this, the unit experienced further change by adding telemetry to the list of modalities offered on 7RW. Then, in March 2009, 7RW merged with another inpatient medicine unit that specialized in geriatric care. Thus, 7RW is now an inpatient medicine, telemetry unit that also specializes in geriatric care. Each of these populations (medicine, telemetry, and geriatric) requires specialized knowledge and skills in order to provide competent care to these patient populations. Though there was specialized training offered prior to each change, there was no ongoing, unit-based

competency program developed to demonstrate and measure staff competencies on an annual basis. As the unit continued to grow, new skill sets were required to meet the changing needs. For instance, staff would need to measure and interpret telemetry strips, provide moderate sedation, and assess risks and implement measures to prevent falls and pressure ulcers. We determined educational needs by asking staff to offer input as to which skills they needed training on. We also looked at unit-specific needs, organization requirements, and reviewed risk management reports to identify unit trends.

The Unit Leadership Team, in conjunction with staff members from each job category (CN, RN, CP), met to determine annual competency requirements for the upcoming year (evaluation period). To help determine which skills to include, the leadership team and direct care nurses conducted brainstorming sessions to answer the questions below and held discussions during unit board meetings:

1. What are the **new** procedures, policies, equipment, initiatives that impact our unit?
2. What are the **changes** in procedures, policies, equipment, initiatives that impact our unit?
3. What are the **high risk** aspects of the job?
4. What are the **problematic** aspects of the job?

Once staff needs were identified, the Leadership Team prioritized the skills and the top 8-10 were chosen. The Educator, in collaboration with unit management, developed the methods of validation and competency forms for each skill. Competency requirements and forms were disseminated to staff by July 31st, 2009. Staffs are currently working on their self-paced competency skills.

Staffs will submit all competency requirements to the nurse educator, assistant manager, and/or designee by March 1st, 2010. Competencies will be checked for completeness and returned to the staff member if incomplete. (Reminder: all completed requirements are due no later than March 1st – Table below) Once complete, a summary sheet will be completed and placed in the employees personnel file and the competency forms will be returned to the staff member. Examples of all competency requirements and forms will be maintained by the nurse educator for reference.

See Table below.

**Table SE 5 EO – 3: Competencies**

| Month/Year | Who | Process/Procedure/Task |
|---|---|---|
| Mar-09 | Unit Leadership | Identified unit and organization trends and needs |
| Apr-09 | All Staff | Receive staff input on educational needs |
| Apr-Jul 09 | Educator | Develop unit competencies |
| Jul-09 | Educator | Distribute competency folders |
| Jul 09-Feb 10 | All Staff | Complete self-paced competencies |
| Mar-10 | All Staff | Competency folders due to educator |
| Mar 10-Apr 10 | Unit Leadership | Incorporate competency data into annual evaluation |

This change affected all charge nurses, registered nurses, licensed practical nurses, and care partners that work on 7RW. Staff buy-in was critical to the initial success of this program. Involving the direct care staff up front in the development of the competency skills proved to be vital. Thus far, we have been able to achieve 100% compliance with moderate sedation and basic arrhythmia training by all nurses. This demonstrates a high degree of "ownership" by the staff.

**Outcomes**

Outcomes include compliance rates for completion of the competency folders. Also, each competency skill includes 1-3 tools to measure each staff members understanding and/or ability to perform each skill. Tools include post tests, exemplar statements, audit tools, checklists, article reviews, medication sheets, and policy statements. Each tool will be reviewed and graded in an effort to establish competency and/or identify further education needs.

We had 100% compliance with competency folders by the time evaluations were completed. The educator checked each competency folder for completion and gross inadequacies. None were identified. The educator then set up multiple feedback sessions for the staff members to attend. Competency folders were handed back to each staff member at these sessions and the group reviewed the forms together. This provided the staff with an opportunity to discuss the skills with their peers and it gave them direct access to the educator to address any specific outstanding questions they may have had. Staff members who could not attend one of the sessions received their folders and were given the opportunity to meet one-on-one with the educator. The educator had planned to meet one-on-one with any staff members who were not able to attend one of the planned sessions, but those meetings were not necessary because all staff members were able to attend one of the planned feedback sessions.

All 7RW staff members were "deemed competent" at the end of the competency process. All staff have been given the opportunity to participate in the development of last year's competency program and the educator is in the process of soliciting staff volunteers to develop the competency program for the next evaluation period. She is also gathering feedback about the program and plans to revise/update future programs based on staff satisfaction and input. [*SE5EO-Exhibit C-1-Competency Worksheet RN, SE5EO-Exhibit C-2-Competency Forms CP*]

**VPH Example**

**Background**

It was identified during chart audit that legibility and timing of patient care records by direct care nurses and physicians was an area requiring improvement. This issue was noted as a deficit for staff at all levels. It is critical for the delivery of safe patient care that medical records are legible and are dated and timed accurately. In order to improve this issue, nursing leadership outlined an educational plan for all VPH staff.

**Participants and Methods**

The leaders of this project were Lori Harris, RN, VPH Interim Nursing Leader and Adult Program Coordinator and Tiffany Badgett, Manager Health Information / Utilization Management. Education was provided via power point in Web in-service for VPH staff nurses. It included a posttest that required 100% to pass. The power point and posttest were distributed electronically to nurses, physicians and residents. They were required to return the answered and signed posttest either in hard copy or electronically. Audits were performed weekly by Tiffany Badgett and reported through Medical Records. This education module had to be completed by 9/30/2009. Audits continued weekly and were reported to VPH leadership and VUMC Accreditation & Standards.

**Outcomes**

The audit clearly showed an improvement and achievement of the established goals (please see Table below). Following the audits of the paper medical record, the electronic conversion of the medical record occurred. Several staff attended training sessions to become super-users. These staff nurses were also selected to participate in planning sessions to make suggestions in terms of format, selections, work flow, etc. These suggestions were collected by

a manager at VPH (Jon Coomer), and addressed through the HED advisory committee. The changes were then implemented into the HED modules.

**Table SE 5 EO – 4: Patient Chart Audits**

| DATE / ISSUE | % COMPLIANCE |
|---|---|
| 11/21/09 – 12/11/09 Legibility | 37/40 = 93% |
| 11/21/09 – 12/11/09 Date/Time Compliance | 56/60 = 93% |
| | |
| 1/16/10 – 2/12/10 Legibility | 88/90 = 97% |
| 1/16/10 – 2/12/10 Date/Time Compliance | 100% |

[*SE5EO-Exhibit D-1-Charting Principles Presentation*]

**CLINIC**

**Williamson County TVC Leadership Team**

**Background and Purpose**

From October 2008 to April 2009 twenty-four VMG Williamson County leaders participated in the Leadership Investment Series (LIS), a twelve course series designed to provide leaders with effective leadership skills, build their team, and create a shared language and understanding amongst team members. Participants were members of the VMG Williamson leadership team, including nurse managers, non-nurse managers, office supervisors, billing managers, administrative assistants, directors, and other leaders. As an interdisciplinary team, they were able to build networks, relationships, and learn from each other.

The need to develop this leadership training program was identified by reviewing the results from the annual 2007 Community Survey, which is an enterprise-wide survey that measures staff satisfaction, indicating that the management staff in Williamson County exhibited weak leadership skills (please refer to OO12 for community survey results) The community survey included a tier report which ranked work units under a given manager by workforce commitment and action planning readiness, two factors determined by pertinent survey questions. The question was rated on a 1-5 Likert scale with 5 being the highest, and the

tier rankings used an average of the scores for these question categories. The tier scale is as follows:

- Tier I: Average >= 4.15; minimal action planning needed
- Tier II: 3.80 <= Average < 4.15; action planning needed
- Tier III: Average < 3.80; significant action planning needed

In the VMG Williamson group, only three groups scored in tier I; seven scored in tier II and two scored in tier III. The Leadership Investment Series was custom created in order to improve workforce commitment and staff satisfaction after reviewing these results.

**Methods and Approach**

The **Planning Team** for developing the curriculum included:

- Ellen Johnson, Administrative Director, VMG Williamson County
- Ann Cross, Director of Nursing, VMG Williamson County
- Debra Grimes, Director of Training and Organizational Development, VMG

This team created a custom curriculum to address leadership deficiencies identified by Williamson County staff in Vanderbilt's annual Community Survey. After determining the topics of the twelve courses, the planning team identified subject matter experts from the organization to facilitate the sessions.

No managers

The **Facilitators** for this program included:

- Debra Grimes, Director of Training and Organizational Development, VMG
- Laura Litchfield, Senior Financial Analyst, Department of Finance
- Tammy Key, Organizational Effectiveness Team Consultant
- Stephanie Brodtrick, Organizational Effectiveness Team Consultant
- Marla Ballou, HR Representative

The twelve topics included:

1. Introduction, Five Levels of Organizational Effectiveness, and Personal Mission Statement

2. Communication Styles

3. Financial Performance & Analysis

4. Leading Through Change and Transition

5. Establishing Accountability

6. Improving Team Performance

7. Coaching and Developing Staff

8. Asking Questions—A Powerful Leadership Tool

9. Dealing with Difficult Behaviors and Negativity

10. Seven Ways to Make Decisions

11. Providing and Receiving Feedback

12. Graduation, Tapping into Motivation, Personal Mission Statement

The courses were held twice a month from November 2008 to April 2009. The facilitators conducted a classroom-style event in Williamson County. At each course, a senior leader came and gave a brief talk to the participants.

Visting leaders included:

- Marilyn Dubree (Executive CNO)
- Margaret Head (TVC/VMG COO/CNO)
- Denis Gallagher (CAO, VMG Williamson County)
- Robin Steaban (Administrative Director,VHVI)

- Cindy Wedel (Senior Coach, Center for Organizational Learning)

**Outcomes**

As a result of the series, the twenty-four participants grew as a leadership team. They participated in teambuilding activities, learned each others' work styles, and built a common language. They began to see each other as resources in addition to building their individual skills and knowledge base. The group developed a mission statement: "*To deliver world-class care within our community*." Clinic staff was positively affected by this strengthened leadership base, which in turn benefitted the patient experience. The participants filled out evaluations at the end of each session. The evaluations asked for Likert ratings of 1-5, with five being the highest, and asked about the participants to rate how much they learned, the effectiveness of the presenters, whether the course was a good use of time, and other similar measures. Over all sessions, the average ratings ranged from 4.44 to 4.79, indicating a very high level of satisfaction with the course. In a separate, post-series survey, 100% of respondents said they were able to apply what they learned on the job, with 25% applying it sometimes, 50% applying it usually, and 25% applying it always. In that same survey, 66.6% of respondents thought their community survey results would improve if the survey were given after completion of the LIS. The results of these evaluations were shared with high level leaders, including Margaret Head, Denis Gallagher, and Ellen Johnson. The positive results of the LIS continue to influence the development of other training and development programs throughout the VMG.

Participants completed an evaluation, described above, at the end of each session. Six months after the end of the series, participants were sent a survey asking them to evaluate the following ten items for each of the twelve courses:

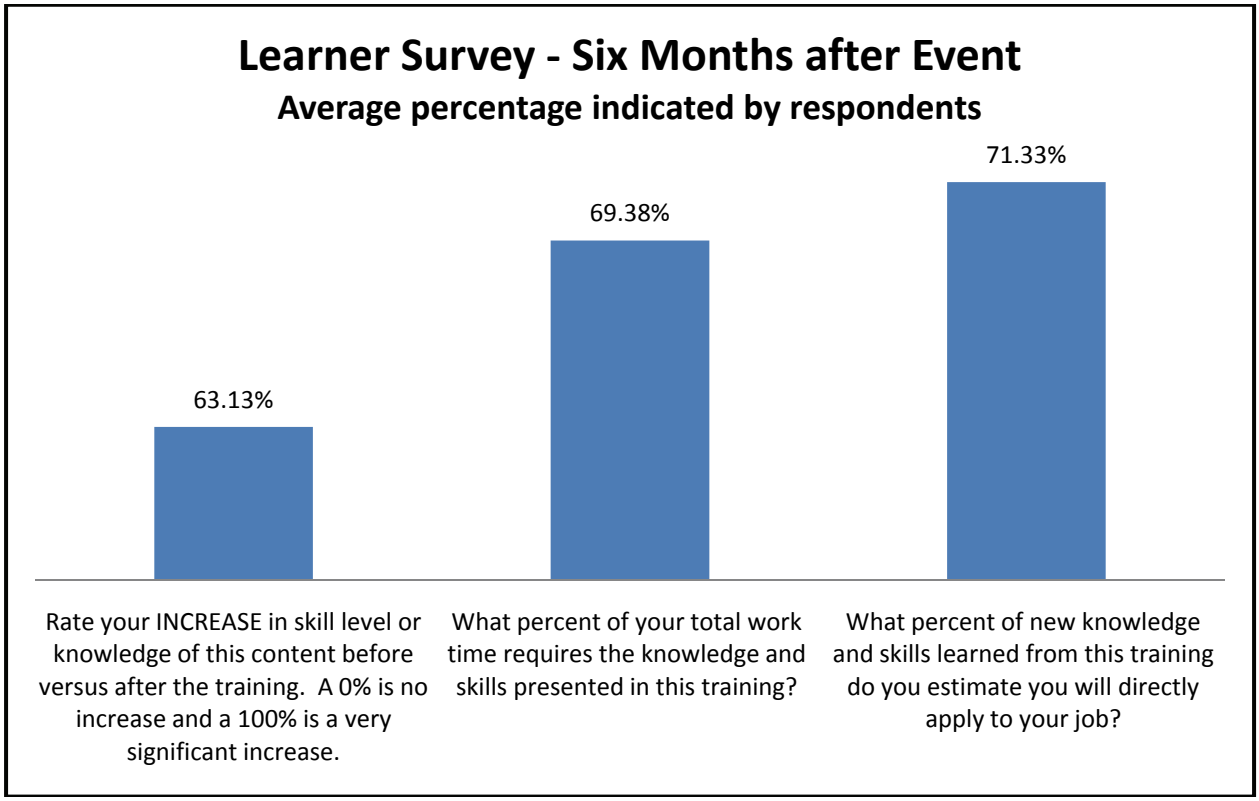
1. Instruction
2. Courseware
3. Learning Effectiveness
4. Job Impact
5. Business Results
6. Return on Investment
7. What about this class was MOST useful to you?
8. What about this class was LEAST useful to you?

9. How can we improve the training to make it more relevant to your job?

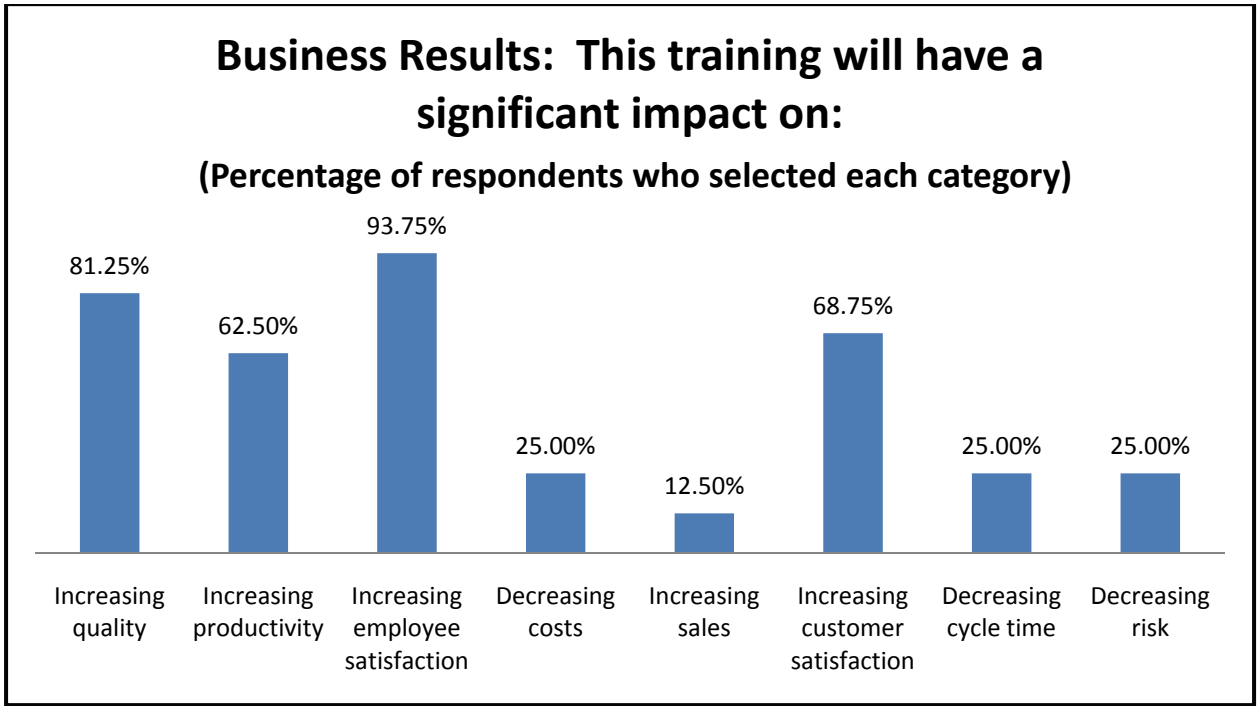
10. If you feel you have been successful in applying this learning, please provide a few tangible examples of how you have applied it.

The graphs below outline the results of the survey indicating a high level of success in learning retention and transfer:

**Graph SE 5 EO – 3: Survey Results**



**Graph SE 5 EO – 4: Business Results**




VUMC changed Community Survey providers the year following the LIS, so the new results cannot be compared to the results which triggered the creation of the LIS, but anecdotal evidence and survey comments suggest changes in leader behavior and staff satisfaction after the series. The results of these evaluations were shared with high level leaders, including Margaret Head, Denis Gallagher, and Ellen Johnson. The positive results of the LIS continue to influence the development of other training and development programs throughout the VMG.

[*SE5EO-Exhibit E-1-LIS Mission Statements, SE5EO-Exhibit E-2-LIS Evaluations – all, SE5EO-Exhibit E-3-Overview for LIS*]

**Commitment to Community Involvement**

**Source of Evidence 11**

**Describe and demonstrate the structure(s) and process(es) used to identify and allocate resources for affiliations with schools of nursing, consortiums, or community outreach programs.**

Our senior leadership encourages nursing to be innovative and collaborative. VUMC is perceived as the destination of choice for many schools of nursing to complete their clinical rotation requirements. We were one of the founding partners with Belmont University and the Tennessee Center for Nursing to form a consortium partnership to pave the way for easier placement of students in healthcare facilities. We budget $10,000 per year to continue to support this online placement process and have four staff members committed to participating in the monthly meetings and/or conference calls as well as the ad hoc work that evolves from those meetings.

Nursing has encouraged partnerships as demonstrated by the development and support of the Vanderbilt Experience: Student Nurse Internship Program (VESNIP) that brings six schools of nursing together to offer an eight-week robust clinical internship immersion experience for rising senior nursing students at the medical center. Vanderbilt University Medical Center budgets $252,000 per year through the Department of Nursing Education and Professional Development to support the stipends for these students. The VESNIP Committee meets regularly to provide support to the faculty, Nurse Educators and preceptors who will work with the student participants and coach them through the experience each summer. Many of these students apply to the Nurse Residency Program when they graduate from their respective nursing programs. [*SE11-Exhibit A-1-TABLE Adjunct Faculty*]

**Commitment to Community Involvement**
**Source of Evidence 11 EO**

**Describe and demonstrate the result(s) of affiliations with schools of nursing, consortiums, or community outreach programs.**

**Vanderbilt Experience: Student Nurse Internship Program**

**Background/Purpose**

In the 1970's Kramer identified a phenomenon described as reality shock. This experience described by nursing students and new graduates has been further identified as a decreased sense of confidence and competence with routine tasks during their academic clinicals and first year of practice. It has been identified in the literature that immersion clinical experiences (internships/externships) enhances the nursing students' sense of confidence and competence (Ashworth & Saxton, 1990; Daigle, 2001; Tappen, et al., 2001; Ward & Berkowitz, 2002). Transitioning from academia to nursing practice is increasingly difficult and stressful for the new graduate. To alleviate a stressful transition we created a robust clinical immersion student nurse internship program.

**Methods/Approach**

We began with a small pilot project that only included five students from one school (Belmont University) in the Women's Health track in 2005. From the success of that pilot we contacted other nursing schools in the region and held an informational tea to share the results of the pilot and to determine if the leadership from these nursing programs would be interested in partnering with us to grow the program. One of the students, Sarah Shipley spoke about her experience and the confidence she gained during the clinical rotations. Sarah now works as an RN on our orthopedics/urology floor (a unit she fell in love with during her VESNIP experience). See Sarah's story below and to see her picture, please go to the Nursing website at http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=10877

**Sarah's Story:**

*"I was introduced to a career at Vanderbilt University Medical Center by participating in the Vanderbilt Experience: Summer Nurse Internship Program (VESNIP). My VESNIP experience was wonderful! My nursing skills became more developed and I grew confident in my ability to be a competent nurse. The staff and preceptors were friendly and willing to teach. I feel the most important thing I learned was how to multi-task and manage more than one patient. It*

*truly made the transition from school to my nursing career smoother and less daunting. I would sincerely recommend VESNIP to any nursing student.*

*When I started my job at Vanderbilt, I felt prepared and confident. I wasn't as overwhelmed as I thought I'd be because of the preparedness VESNIP provided. It helped me know what to expect and I wasn't afraid to walk into a patient's room or perform an assessment. My transition from school to working at VUMC felt natural.*

*I love working at Vanderbilt Medical Center. I've felt welcomed from the beginning. The doctors, nurses, and staff are all friendly and truly caring. I feel respected as a nurse and there are always opportunities to learn. The resources available have made my first few months as an RN seem like a breeze. I can't imagine working anywhere else!"*

Six schools (Austin Peay University, Belmont University, Cumberland University, Fisk University, Lipscomb University, and Western Kentucky University) made the decision to partner with us and VESNIP was created.

**The *Vanderbilt Experience: Student Nurse Internship Program (VESNIP)*** is an eight-week robust immersion clinical experience allowing nursing students between their junior and senior year to work side-by-side with a licensed nurse in a specialty track area that they would like to learn more about. Five specialty areas are available: adult critical care, adult acute medicine, adult acute surgery, pediatrics, and women's health. Students rotate weekly to different units within these specialty tracks. Four weeks are spent on day shift and 4 weeks are spent on night shift. It is the intent of the program to increase the nursing students' sense of confidence and competence with nursing care. An oversight committee meets throughout the year to plan the students' experience.

**Table SE 11 EO – 1: Oversight Committee Members**

| Committee Member | Title/Role | Role in the Work |
|---|---|---|
| Debianne Peterman, PhD, MSN, RNC-NIC, NE-BC | Director – Nursing Education and Development | Administrative Sponsor |
| James Barnett, RN, Ph.D, (C) MSN, CNRN | Clinical Learning Consultant – Nursing Education and Development | Program Manager |
| Christina Bogdanova – Program Coordinator | Program Coordinator – Nursing Education and Development | Coordination, Room Reservation, Support |
| Amy Johnson, RN, BSN | Nurse Educator – VCH | Pediatric Rotation Leader |

| | | |
|---|---|---|
| Laura Jarosemich, RN, MSN | Nurse Educator – Labor and Delivery | Women's Health Rotation Leader |
| Gloria Wacks, DSN, RN | Nurse Educator – Outpatient Surgery | Acute Care Rotation Co-leader |
| Martha White, RN, MSN, APRN-BC | Nurse Educator – 9 North / 9 South | Acute Care Rotation Co-leader |
| Lori Martin, RN, BSN, CEN | Nurse Educator – Adult ED | Critical Care Rotation Co-leader |
| Richard Benoit, RN, MSN | Nurse Educator - SICU | Critical Care Rotation Co-leader |
| Richard Corcoran, RN, BSN, MSHA | Manager – 9 North | Managerial Support |
| Amy Hamlin, RN, MSN (APSU) | Clinical Instructor – Austin Peay State University | Faculty and Student Support for APSU |
| Leslie Folds, EdD, PMHCNS-BC (Belmont) | Clinical Instructor – Belmont University | Faculty and Student Support for Belmont |
| Diane Thorup, RN, ADN (Cumberland) | Clinical Instructor – Cumberland University | Faculty and Student Support for Cumberland |
| Liz Bradley, RN, MSN (Fisk/Lipscomb) | Clinical Instructor – Vanderbilt University (Lipscomb and Fisk University programs) | Faculty and Student Support for Fisk/Lipscomb |
| Sarah Woodall, RN, BSN (WKU) | Clinical Instructor – Western Kentucky University | Faculty and Student Support for WKU |

Through a collaborative partnership between Vanderbilt Medical Center and six schools of nursing (Austin Peay State University, Belmont University, Cumberland University, Fisk/Lipscomb/Vanderbilt Universities, and Western Kentucky University), clinical faculty created an elective summer course. The program runs every summer and the results of the 2009 and 2010 programs are included in this document. Placement opportunities and requests were agreed to by faculty with student interests considered. All students attended an orientation day and a skills day (including simulation). [*SE11EO-Exhibit A-1-VESNIP Agenda and Minutes*]

**Evaluation/Outcomes**

The 2009 program ran from May 16, 2009 through July 10, 2009 with 62 students participating. Evaluations were collected online using Survey Monkey © from VESNIP participants and quantitative and qualitative data was summarized. The overall outcome of the program addressed the students' satisfaction with the program (5 point Likert scale) and other quantitative metrics as identified in the feedback summaries. Qualitative comments focused on

identifying increased confidence and perceived competence of the student. [*SE11EO-Exhibit B-1-VESNIP Qualitative Comments*]

**Table SE 11 EO – 2: Weekly Satisfaction Scores – VESNIP 2009**

| Weekly Program Satisfaction Scores | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Week 1 | n | Week 2 | n | Week 3 | n | Week 4 | n | Week 5 | n | Week 6 | n | Week 7 | n |
| Introduced me to colleagues | 4.30 | 45 | 4.37 | 42 | 4.39 | 33 | 4.35 | 37 | 4.26 | 34 | 4.26 | 38 | 4.29 | 34 |
| Excited to work with me | 4.47 | 45 | 4.34 | 42 | 4.52 | 33 | 4.35 | 37 | 4.38 | 34 | 4.26 | 38 | 4.24 | 34 |
| Prepared/Knew I was coming | 3.58 | 45 | 4.20 | 42 | 4.25 | 33 | 4.00 | 37 | 4.18 | 34 | 3.92 | 38 | 3.91 | 34 |
| Discussed nursing procedures | 4.51 | 45 | 4.56 | 42 | 4.55 | 33 | 4.57 | 37 | 4.59 | 34 | 4.18 | 38 | 4.50 | 34 |
| Demonstrated nursing | 4.56 | 45 | 4.61 | 42 | 4.67 | 33 | 4.65 | 37 | 4.59 | 34 | 4.26 | 38 | 4.59 | 34 |
| Assisted me with nursing | 4.58 | 45 | 4.50 | 42 | 4.61 | 33 | 4.68 | 37 | 4.59 | 34 | 4.21 | 38 | 4.53 | 34 |
| Integrated my nursing plan | 3.98 | 45 | 4.03 | 42 | 4.18 | 33 | 4.22 | 37 | 4.29 | 34 | 4.00 | 38 | 4.15 | 34 |
| Viewed me as a team member | 4.43 | 45 | 4.13 | 42 | 4.36 | 33 | 4.32 | 37 | 4.44 | 34 | 4.11 | 38 | 4.35 | 34 |
| Conducted end of shift discussion about the day | 4.10 | 44 | 4.11 | 42 | 4.18 | 33 | 4.17 | 36 | 4.36 | 33 | 3.81 | 38 | 4.24 | 34 |
| Used VESNIP Passport | 3.90 | 45 | 4.26 | 41 | 4.07 | 33 | 3.94 | 36 | 4.00 | 34 | 3.49 | 38 | 3.44 | 34 |
| **OVERALL AVERAGES** | 4.24 | 45 | 4.31 | 42 | 4.38 | 33 | 4.33 | 37 | 4.37 | 34 | 4.05 | 38 | 4.22 | 34 |

| | |
|---|---|
| Average n | 38 |
| Percent of responses per total group (N = 62) | 60.48% |
| Average Score | 4.27 |

**Table Se 11 EO – 3: Skills Day Satisfaction – VESNIP 2009**

| Skills Day Report (n = 56) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Skill Station** | 1 | % | 2 | % | 3 | % | 4 | % | 5 | % |
| Bedside Shift Report / Pressure Ulcers | 0 | 0 | 2 | 3.6 | 7 | 12.5 | 18 | 16.0 | 31 | 55.4 |
| Airway Devices | 1 | 1.8 | 1 | 1.8 | 15 | 26.8 | 15 | 15.0 | 24 | 42.9 |
| Assess the Situation | 6 | 10.7 | 11 | 19.6 | 11 | 19.6 | 17 | 17.0 | 11 | 19.6 |
| Mock Code | 0 | 0.0 | 1 | 1.8 | 5 | 8.9 | 7 | 7.0 | 43 | 76.8 |
| Medication Administration | 1 | 1.8 | 9 | 16.1 | 14 | 25.0 | 15 | 15.0 | 17 | 30.4 |
| Simulation Event | 0 | 0 | 4 | 7.1 | 9 | 16.1 | 10 | 10.0 | 35 | 62.5 |
| Case Study Station | 4 | 7.1 | 9 | 16.1 | 16 | 28.6 | 14 | 14.0 | 14 | 25.0 |
| Case Study Review (end of day) | 2 | 3.6 | 2 | 3.6 | 12 | 21.4 | 17 | 17.0 | 23 | 41.1 |
| Overall Review of Day | 0 | 0 | 1 | 1.8 | 12 | 21.4 | 18 | 18.0 | 25 | 44.6 |
| **OVERALL AVERAGES** | 2 | 2.8 | 5 | 7.9 | 12 | 20.0 | 15 | 14.3 | 25 | 44.3 |

1 = Poor, 5 = Excellent

Comments collected on online survey from 2009 student participants:

*"The first day I was in Newborn Nursery I had the chance to practice every skill that I was taught in nursing school: assessment, collecting blood, monitoring the newborns"*

*"Although I have heard the importance of continuity of care, I saw it in action this week. My patient had been on the unit for some time and most of the nurses were familiar with the family. It happened that the oncoming nurse was not. My preceptor went above and beyond to make sure the oncoming nurse was familiar with the family as it had been very difficult for the family. It really made a deep impression on me that the nurse was so considerate and caring to look out for not only her co-worker but more importantly the family."*

*"I learned a lot about end of life care. This week was the first week I had a patient die and I was able to go through that process and see how to handle this situation and meet the needs of the family going through this process. It was sad, but I'm glad I was able to do this and see how the nurse can ease this process for the patient and family."*

*"I saw firsthand how it can be easy to judge a family and their care for their dying child. It was quickly evident that until I am in the family's position, I have no idea what they are facing and that I should refrain from judgment. I also learned that being a nurse is so much more than giving medication and treating the physical patient; it is just as important to treat the inner person. It is about holding a lonely, dying child and not judging his family."*

*"I worked with a really wonderful nurse my last two nights on 5RW who really helped me learn what nursing is all about. I experienced personal growth during my fourth week of the rotation and learned that I was truly meant to be a nurse."*

The 2010 program ran from May 19, 2010 through July 9, 2010 with 82 students participating. We opened the program up to ten students in the Vanderbilt School of Nursing bridge Masters program. The evaluation data is in outlined in the tables below.

**Table SE 11 EO – 4: Weekly Satisfaction Scores – VESNIP 2010**

| | Week 1 Avg | Week 2 Avg | Week 3 Avg | Week 4 Avg | Week 5 Avg | Week 6 Avg | Week 7 Avg | Week 8 Avg |
|---|---|---|---|---|---|---|---|---|
| # of Preceptors | 1.76 | 1.76 | 2.41 | 3.25 | 3.03 | 3.39 | 3.46 | 3.70 |
| Please rate the following items related to your preceptor(s) using a Likert Scale of 1 - 5. (1=not at all/not satisfied to 5=always/extremely satisfied) | | | | | | | | |
| Introduced me to colleagues | 4.24 | 4.36 | 4.42 | 4.06 | 3.84 | 4.14 | 4.15 | 4.46 |
| Excited to work with me | 4.39 | 4.36 | 4.59 | 3.95 | 3.57 | 3.97 | 3.94 | 4.13 |
| Prepared / Knew I was coming | 3.53 | 3.55 | 4.19 | 4.10 | 3.71 | 4.08 | 4.12 | 4.31 |
| Discussed nursing procedures and process | 4.57 | 4.63 | 4.82 | 4.27 | 3.97 | 4.24 | 4.27 | 4.62 |
| Demonstrated nursing procedures and processes | 4.66 | 4.73 | 4.81 | 4.23 | 3.97 | 4.23 | 4.27 | 4.61 |
| Assisted me with nursing procedures and processes | 4.62 | 4.64 | 4.84 | 4.10 | 3.92 | 4.16 | 4.04 | 4.48 |
| Integrated my nursing plan suggestions into patients plan of care | 4.27 | 4.27 | 4.45 | 4.08 | 3.87 | 4.13 | 4.11 | 4.49 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Viewed me as a team member | 4.39 | 4.43 | 4.64 | 3.96 | 3.83 | 4.13 | 4.09 | 4.47 |
| Conducted end of shift discussion about the day (provided feedback) | 4.07 | 4.12 | 4.33 | 4.33 | 4.23 | 4.49 | 4.24 | 4.47 |

**Table SE 11 EO – 5: Skills Day Satisfaction – VESNIP 2010**

| SKILL DAY REPORT VESNIP 2010 (N = 75) (1 = POOR...5 = EXCELLENT) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **SKILL STATION** | **1** | | **2** | | **3** | | **4** | | **5** | |
| Geriatrics | 4 | 5.3% | 11 | 14.7% | 16 | 21.3% | 24 | 32.0% | 20 | 26.7% |
| Parenteral Tube Management | 0 | 0.0% | 1 | 1.3% | 11 | 14.7% | 23 | 30.7% | 41 | 54.7% |
| IV Insertion | 0 | 0.0% | 0 | 0.0% | 3 | 4.0% | 21 | 28.0% | 51 | 68.0% |
| Foley Insertion & Management | 2 | 2.7% | 2 | 2.7% | 5 | 6.7% | 29 | 38.7% | 37 | 49.3% |
| Tracheostomy Care/Suctioning | 0 | 0.0% | 0 | 0.0% | 3 | 4.0% | 32 | 42.7% | 40 | 53.3% |
| Patient Teaching | 3 | 4.0% | 6 | 8.0% | 17 | 22.7% | 28 | 37.3% | 21 | 28.0% |
| Dressing Change | 1 | 1.3% | 3 | 4.0% | 13 | 17.3% | 27 | 36.0% | 31 | 41.3% |
| Mock Code | 1 | 1.3% | 2 | 2.7% | 6 | 8.0% | 17 | 22.7% | 49 | 65.3% |
| Sim 3 (Peds) | 0 | 0.0% | 1 | 1.3% | 1 | 1.3% | 9 | 12.0% | 64 | 85.3% |
| Sim 2 (Report/Code) | 0 | 0.0% | 1 | 1.3% | 4 | 5.3% | 18 | 24.0% | 52 | 69.3% |
| Sim 1 (Color Blind) | 0 | 0.0% | 2 | 2.7% | 3 | 4.0% | 12 | 16.0% | 59 | 78.7% |
| **OVERALL AVERAGES** | 1.09 | 1.33% | 2.82 | 3.52% | 7.73 | 9.94% | 22.18 | 29.09% | 42.73 | 56.36% |

Comments collected on online survey from 2010 student participants:

Week 2

*"I think I learned to be more comfortable with my skills today. I always feel like I have no idea what I'm doing when I am in clinical and am terrified of patients and family members asking me questions. After today, I feel like I am realizing that I do know things and can perform skills well, and if I don't know the answer, it is okay because I can't possibly know everything in the entire medical field, but I can always find out."*

Week 3

*"I learned that you should not always listen to the doctor just because they are a higher figure. The nurses and the NP for one of my patients knew that something serious was wrong with the patient despite the assurance of the MD that nothing was wrong. I learned that you always need to trust your instinct and speak up when you think that something is wrong. You need to not let others intimidate you. No comments or thoughts are stupid ones and so in the end it is always better to err on the side of caution."*

Week 4

*"I feel more comfortable and confident when talking with patients. This makes the patient / nurse relationship more therapeutic….easier to accomplish things through communication such as teaching and providing encouragement. Being able to perform skills such as drawing blood, starting IVs, and administering medications gets easier the more I do it. I've seen how to maintain professionalism in difficult circumstances in which patients might be angry or disrespectful and I have also learned what not to do in terms of professionalism."*

Week 5

*"The key thing that I learned this week is that no matter what, it is more important to ask questions if you are unsure that to keep quiet and make a mistake. From now on, I will ask questions instead of simply doing as I am told."*

Week 6

*"During the beginning of the program, I was very focused on skills: on what I had been able to perform that day. While I am still excited to start an IV, etc as I have worked my way through the program my focus has widened (not shifted). Skills are still important, and I still need a lot of practice, but I have realized through the VESNIP program that being able to perform the "nursing skills" does not make you a good nurse. A good nurse is organized, and it takes practice and skill to be able to organize your day in such a way that you can handle the unexpected. Being a good nurse means making time for your patients, questioning doctors' orders if they do not seem correct and communicating with the multiple teams that stop by your patient's room each day. There is a lot more that goes into "being a good nurse" than inserting a Foley flawlessly or finding a pedal pulse right away. Nursing is about organization, teamwork, communicating, listening, and thinking for yourself… "*

Week 7

*"This week I had more independence than I have had in previous weeks. With [my preceptor] on 8B I was able to do a lot of patient care independently while still having [her] close by for any questions or problems. This made for an exceptional experience for me. Rather than being told what to do and when to do it, I was able to keep my own schedule and learn the best way that things work for me. In previous weeks, I have had good experiences with testing my independence but this week was the week it all came together for me. I felt like a competent member of the team. The atmosphere on 8B was very helpful and non-judgmental. Everyone seemed excited to explain things to me, answer questions, and allow me to do new procedures. I was able to put in an NG tube as well as take one out, which I have not had the chance to do before. My experience this week was excellent. "*

Week 8

*"I learned multiple new skills that I had not seen or done before but every time I answer this question it is always a "life lesson" that I want to share. So I will tell you that because I am sure that you figured I would learn skills. So, my life lesson for my last week is that nurses are more than people who pass out medications and answer call lights. We are individuals who care for people holistically, not just the patients but also the families. It is amazing to see the difference in a patient's attitude when you show them that you really care. I have heard all the stories about how all nurses start out wanting to "save the world." I do not want to do that, I just want to make sure that when I go into work I do my best to make everyone's night around me a little bit better by saying a nice comment, listening or giving the best care possible. I hope that makes sense."*

The 2009 evaluation data was shared with the Nursing Leadership Board, Nursing Administrative Board, and Nurse Educator Council. Additionally, managers and nurses received thank you notes at the end of the program based on comments collected from the students. During the 2010 program, thank you notes were sent on a weekly basis. The 2010 data will be shared with respective boards in the fall. Once school is back in session, the VESNIP committee will review the evaluation data with the faculty and committee members and begin planning the 2011 VESNIP experience. We are exploring ways to expand the program and potentially offering a "visiting student" opportunity through one of our partnered schools to be able to offer the experience to students outside the Middle Tennessee and western Kentucky geography. [*SE11EO-Exhibit C-1-VESNIP Roles and Tasks*]
VESNIP Online: http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=18539

**Robert Wood Johnson Partners in Nursing (PIN) Grant**

**Background/Purpose**

The Tennessee Center for Nursing received matching funds for a 2007 grant from the Robert Wood Johnson Foundation. The partners included: Community Foundation of Middle TN, Vanderbilt University Medical Center (VUMC), and additional private, public, corporate, and government agencies (including Belmont University). The overall purpose of the project was to increase the supply of RN's in TN by expanding educational capacity and by improving retention of practicing RN's. The specific purpose of the component that Vanderbilt was involved in was to develop a hospital / School of Nursing faculty partnership model that would be replicable and sustainable. This project included defining the role of the faculty extender, creating a curriculum, identifying and training direct care nurse candidates, piloting a student clinical experience using faculty extenders and evaluating the process.

There is a recognized faculty shortage in schools of nursing nationally. Hospitals have a vested interest in students' rich learning experiences in their clinical rotation.

There is a shortage of clinical instructors to guide those clinical experiences. Literature and common sense tell us that instructors who are themselves competent to practice in specific clinical areas and who have a working relationship with the staff in those areas can provide a high quality clinical experience for nursing students. Our project was to identify and train qualified staff nurses to function as clinical faculty (in a defined Clinical Teaching Associate role).

**Participants**

VUMC partnered with Belmont University to develop the Clinical Teaching Associate (CTA) model. The project began in May 2008 and was completed in December 2009. A specific action plan was developed as a collaborative effort between VUMC and Belmont School of Nursing. A literature review was completed, the CTA job description was developed and core competencies were identified, CTA training was developed and implemented. Three VUMC direct care Registered Nurses were recruited, oriented and then functioned in the CTA role for the 2009 Fall semester. The committee members who contributed to this project included:

See Table below.

**Table SE 11 EO – 6: Participants**

| Name | Credentials | Area |
|---|---|---|
| Chris Algren | EdD, MSN, RN | Associate Dean, Nursing, Belmont University |
| James Barnett | PhD (C), MSN, RN, CNRN | Clinical Learning Consultant, VUMC NE&PD |
| Jean Blank | MSN, RN | Nursing Faculty, Belmont University |
| Leslie Folds | EdD, PMHCNS, BC | Nursing Faculty, Belmont University |
| Hilary Hinton | MSN, RN | Nursing Faculty, Belmont University |
| Debianne Peterman | PhD, MSN, RNC-NIC, NE-BC | Director, VUMC NE&PD |
| Sheryl Redlin-Frazier | MSN, RN, ONC | Clinical Learning Consultant, VUMC NE&PD |
| Donna Ruth | MSN, RN | Clinical Learning Consultant, VUMC NE&PD |
| Chris Wilson | MSN, RN-BC | Clinical Education & Professional Development VUMC-VUH |

[*SE11EO-Exhibit D-1-CTA and Student Responsibilities for Clinical*]

**Methods/Approach**

Focus groups were conducted prior to the Fall semester to determine the characteristics of a good clinical experience and the qualities students would look for in clinical instructors. Focus groups were held with the following groups: New graduate nurses, current clinical faculty, nurse educators, and staff nurses. New graduates expressed that clinical faculty should be patient, competent, non-intimidating and should look for opportunities for students to perform skills. They described "successful" clinical experiences as ones where students were able to relate the disease process of the patient with what had been taught in class and where they could watch a skill demonstrated and then perform it themselves. Clinical faculty believed that a CTA should be competent and experienced and be able to explain real world practice based on the "book world." The faculty also felt that CTAs should be able to partner with the student and serve as a mentor. [*SE11EO-Exhibit D-2-RWJ-PIN Focus Groups*]

**Evaluation/Outcomes**

The three nurses who served as CTAs were Jane Patey, RN, BSN and Joy Fidel, RN, BSN (from 7 RW) and Pam Salazar RN, BSN (from 5/6 RW). These nurses along with one Clinical Learning Consultant from Nursing Education and Professional Development evaluated the curriculum from the orientation day held in August prior to the beginning of the Fall semester. The evaluation scores are outlined below.

**Table SE 11 EO – 5: Evaluation**

| Section | Quest | Objectives | 1 | 2 | 3 | 4 | COMP-OSITE | 4 COUNT | 3 COUNT | 2 COUNT | 1 COUNT | NA COUNT | DIVISOR | QUESTION AVG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| I | A | There was a pleasant environment for learning to occur. | 4 | 4 | 4 | 4 | **16** | **4** | **0** | **0** | **0** | **0** | **4** | **4** |
| I | B | The objectives were easy to understand. | 4 | 3 | 4 | 4 | **15** | **3** | **1** | **0** | **0** | **0** | **4** | **3.75** |
| I | C | The material was organized and clearly presented. | 4 | 4 | 4 | 4 | **16** | **4** | **0** | **0** | **0** | **0** | **4** | **4** |
| I | D | There were opportunities for application of the material. | 4 | 4 | 4 | 4 | **16** | **4** | **0** | **0** | **0** | **0** | **4** | **4** |
| I | E | Questions were answered and material clarified, if needed. | 4 | 4 | 4 | 4 | **16** | **4** | **0** | **0** | **0** | **0** | **4** | **4** |
| I | F | The simiulation activity provided practice of the objectives. | 4 | 4 | 4 | 4 | **16** | **4** | **0** | **0** | **0** | **0** | **4** | **4** |
| I | G | Objectives for the training were met. | 4 | 3 | 4 | 4 | **15** | **3** | **1** | **0** | **0** | **0** | **4** | **3.75** |

A series of focus groups were held with staff nurses, students, clinical teaching associates and unit leadership at the end of the semester to evaluate the program. The staff nurses expressed that having clinical instructors who were staff nurses on their unit was beneficial because the CTA s were familiar with the unit, were able to do more things with the student, and in general stated that it was a better way to teach students. A few nurses stated that they were not aware of the program and had not had it explained to them before the program was launched. The students stated that they were asked to think more critically than the previous semester and that they were "*treated more like nurses*" because the CTA made sure that they knew how to perform the task or skill before going into the patient's room ("*had more time to practice skills*"). The unit leadership expressed concerns about the staffing schedule and stated that the schedules were not adversely affected by having the CTA come from the unit staffing and acknowledged that they would be supportive of the CTA coming from their unit in the future. [*SE11EO-Exhibit D-3-CTA Project Evaluations*]

**Tennessee Clinical Placement System**

**Background/Purpose**

According to the Tennessee Center for Nursing (TCN), the shortage of clinical placement sites for nursing students has been identified as a major barrier to expanding enrollment in schools of nursing and forestalling a projected shortage of 35,300 RNs in Tennessee by 2020. To address this concern, the Tennessee Center for Nursing organized a consortium of Schools of Nursing and Healthcare Facilities to improve the efficacy and capacity of student nurse clinical placements in Tennessee healthcare facilities through the use of a centralized, coordinated, on-line clinical placement and orientation system.

In 2005, the Tennessee Center for Nursing brought a small group of nursing leaders together representing healthcare organizations, schools of nursing, and other healthcare entities to discuss how we could increase the educational capacity in Middle Tennessee to increase the number of nursing students we could prepare to help combat the nursing shortage. Vanderbilt University Medical Center was an initial partner providing $10,000 as seed money to begin the development of an online database to track student clinical placement needs from schools of nursing and open placement opportunities at healthcare facilities. The partnership's mission is to improve the efficacy and capacity of student nurse clinical placements in Tennessee healthcare facilities through the use of a centralized, coordinated, on-line clinical placement and orientation system.

This partnership has grown to now include 32 partners that include the following:

**Table SE 11 EO – 6: Partners**

| | |
|---|---|
| Middle Tennessee Aquinas College | Austin Peay State University |
| Belmont University | Columbia State Community College |
| Cumberland University | Fisk University (Vanderbilt partnership) |
| Lipscomb (Vanderbilt partnership) | Martin Methodist College |
| Middle Tennessee School of Anesthesia | Middle Tennessee State University |
| Motlow State Community College | Tennessee State University |
| Tennessee Technology Center - Hohenwald | Vanderbilt University School of Nursing |
| Tennessee Technology Center –McMinnville | Baptist Hospital |
| Tennessee Technology Center –Murfreesboro | Centennial Medical Center |
| Tennessee Technology Center – Nashville | Maury Regional Medical Center |
| Tennessee Technology Center –Shelbyville | Middle Tennessee Medical Center |
| Nashville General Hospital | Northcrest Medical Center |

| | |
|---|---|
| St. Thomas Hospital<br>Sumner Regional Medical Center | Southern Hills Medical Center<br>University Medical Center |
| Veterans Tennessee Valley – Murfreesboro & Nashville campuses | Vanderbilt University Medical Center |
| Vanderbilt Stallworth Rehabilitation | Williamson Medical Center |

**Methods/Approach**

A series of meetings began with all of the partners represented. Subcommittees were formed to focus on different aspects of the project such as building the database, making policy and procedure decisions concerning setting up clinical rotations, and establishing one standard orientation curriculum for the students to complete (creating a "clinical passport" into each partnered facility). An action plan was created with specific goals and timelines.

**Outcomes**

Through a partnership with the Tennessee Nurses Association and the Tennessee Center for Nursing, an electronic database of open positions across the state of Tennessee was developed. This database is now called the Tennessee Clinical Placement System (TCPS©) which was adopted from original work which began in Colorado. The TCPS© allows partnering schools and healthcare facilities to list needs and availabilities for group clinicals and 1:1 preceptorships. Using the TCPS© has allowed VUMC to increase the number of placement offerings to an average of 1,200 per semester. Of this number approximately 1/3 are group clinicals (6 students: 1 instructor) and 2/3 are 1:1 preceptorships. The TCPS allows partnering schools and healthcare facilities to list needs and availabilities for group clinicals and 1:1 preceptorships. Using the TCPS has allowed VUMC to increase the number of placement offerings to an average of 1,200 per semester. Of this number approximately 1/3 are group clinicals (6 students: 1 instructor) and 2/3 are 1:1 preceptorships.

The partnership has grown across the state and it has become evident that there are barriers that exist for all healthcare professional educational programs. This is an issue that is not just Tennessee-specific, but has been identified across the country as a national issue of concern with many educational institutions turning away qualified applicants due to a lack of faculty and/or clinical placement opportunities. The Tennessee Clinical Placement System has been opened to the allied health professionals in Tennessee.

Other regions of the state are in varying stages of organizing:

- West Tennessee (Memphis area) - ACTIVE (Fall 2007)

- Southeast Tennessee - ACTIVE (Fall 2008)
- MidWest Tennessee (Jackson, Dyersburg areas) - ACTIVE( Spring 2008)
- East Tennessee - ACTIVE (Fall 2009)
- Upper Cumberland - Exploring interest
- Northeast Tennessee - Pending further interest by region related to an existing placement system.

Partnership has been extended across state lines to schools and facilities in other states that bring students into Tennessee and/or supply clinical placements to students from Tennessee. For example, Western Kentucky University in Bowling Green, Kentucky is a partner because they bring students into Tennessee Clinical Facilities. Issues that have been identified as common barriers to clinical placements include the following:

- Knowledge about potential open clinical placements
- Time required to secure placements – both in the school and the clinical facility
- Redundant clinical requirements and orientation content for both students and faculty
- Time required in the clinical facility to orient multiple student groups to the facility
- Time to secure new clinical facility contracts

**According to the TCPS© website located at http://tcn-tcps.org/**

*"As the TCPS has grown into a national provider for improving the capacity of healthcare education, the Tennessee Center for Nursing determined that it's initial goal was realized and divested of the TCPS in January 2010 in order to pursue other initiatives. Today the Tennessee Clinical Placement System is operated by Cyber Healthcare Solutions, LLC.*

*In keeping with the TCN's mission to guide the ongoing development of a diverse and qualified nursing workforce to meet the healthcare needs of Tennesseans through professional advocacy, industry research, recruitment efforts, and public awareness activities , the Tennessee Clinical Placement Partnership or TCPP joined Schools of Nursing and other healthcare programs with clinical facilities to jointly provide ongoing clinical learning opportunities for students pursuing a healthcare profession.*

*This vision continues under the leadership of Cyber Healthcare Solutions to provide schools and clinical facilities with technology-based tools to increase clinical capacity!"*

In working with the collaborative partnerships within the TCPS©, VUMC has worked hard to help design solutions that are streamlining the clinical placement of students within our healthcare entities. These solutions have been designed to address all but the last of the critical barriers listed above. It was determined by the Tennessee Clinical Placement Partnership (TCPP) that the complexities of clinical contracts were beyond the initial efforts of the group. VUMC works with individual schools to establish individual affiliation agreements.

Frequently nursing students are assigned to multiple facilities during their clinical rotations. Educators identified that there were many repetitious requirements before clinicals could begin at each facility. Representatives from facilities (hospitals) and schools came together to discuss and agree upon a common set of training requirements that could be completed once by the student and suffice for each hospital. Once this list was gathered and agreed upon, facilities were encouraged to submit additional training that was facility specific. The VUMC staffs who are involved with this work include the following.

**Table SE 11 EO – 7: Participants**

| Name | Role at time of Work | Role in Work |
|---|---|---|
| James Barnett, PhD(c), MSN, RN, CNRN | Clinical Learning Consultant Nursing Education and Professional Development - VUMC | Chair Student Placement Program (adult and psychiatry) |
| Amy Johnson, BSN, RN, CPN | Nurse Educator - Children's Hospital | Co-Chair Student Placement Program (pediatrics) |
| Debianne Peterman, PhD, MSN, RNC-NIC, NE-BC | Director – Nursing Education and Professional Development - VUMC | Administrative oversight |
| Christina Bogdanova | Program Coordinator - Nursing Education and Professional Development - VUMC | Technical and Placement Support |
| Blair Burnette | Program Coordinator - Nursing Education and Professional Development - VUMC | Technical and Placement Support |

Vanderbilt nurses have unique opportunities to work as preceptors with nursing students from multiple schools. Nurses who serve as preceptors for nursing students are allowed to use this as an example for key criteria during their annual evaluations. The advantage for students who will be going to various healthcare organizations for clinical rotations is that they are able to complete their orientation online by completing the generic

education that is applicable to everyone and the site specific education from one website giving them a "clinical passport." The TCPS website may be accessed through: http://tcn-tcps.org

**Table SE 11 EO - 8: VUMC School Affiliation Agreements**

| | |
|---|---|
| Aquinas College Nursing Program | Nashville State Community College |
| Auburn University at Montgomery | Saint Louis School of Nursing |
| Austin Peay State University | Samford University |
| Belmont University | Tennessee Technology Center at Nashville |
| Bethel College N8rusing Student Training Agreement | Tennessee Board of Regents |
| Bethel College Physician Assistant Clinical Training Agreement | Tennessee State University |
| Birmingham Southern College | Tennessee Technological University |
| Coconino Community College | Tennessee Technology Center at Dickson-Franklin Campus |
| Columbia State Community College (RN, EMT/Paramedic) | Tennessee Wesleyan College – Fort Sanders Nursing Department |
| Cumberland University | University of Alabama - Birmingham |
| Emory University (Enterostomal Therapy) | University of Alabama - Huntsville |
| Graceland University | University of Mississippi Medical Center |
| Hopkinsville Community College (LPN, RN) | University of North Alabama |
| Madisonville Community College | University of South Alabama College of Nursing |
| Memorial University School of Nursing | University of Tennessee – Knoxville |
| Metropolitan State University | Western Kentucky University |
| Middle Tennessee State University | Motlow State Community College |

**Commitment to Community Involvement**
**Source of Evidence 13**

**Describe and demonstrate how the organization or nursing addresses the healthcare needs of the community by establishing partnerships.**

VUMC is a respected partner in our immediate and surrounding communities. Throughout this document, there are examples of how we have partnered to educate and improve the health of our communities. From restoring an all but abandoned mall into a thriving clinic space to providing parenting classes, through heart walks and breast cancer runs, we are a part of the community.

Vanderbilt as an organization does much for and in our communities. In addition, many nurses at all levels of the organization provide community services. A supporting document shows a sample of the volunteer work that our nurses do. [*SE13-Exhibit A-1-TABLE Volunteer Activity*]

**Improving the Health of Our New Babies**

A joint venture between VUMC and the Metro Nashville Public Health Department launched in January 2010 provides an opportunity for new mothers to enroll in Women, Infants and Children (WIC) before leaving the hospital. WIC, also known as the Special Supplemental Nutrition Program, is a federal program that provides supplemental foods, health care referrals and nutrition education to low-income pregnant, postpartum and breastfeeding women, and to infants and children until the age of five. Women and infants must reside in Davidson County in order to meet eligibility requirements to participate in the in-hospital program. Participants must also meet the established income guidelines and be at nutritional or medical risk.

Eligible participants receive supplemental food vouchers and food packages comprised of grains, fruits and vegetables, dairy and protein. Nutrients such as calcium, iron and vitamins A and C are frequently lacking in the diets of low-income populations. Different food packages are provided for different categories of participants. Chris Biesemeier, director of Clinical Nutrition at VUH states that "*the positive impact [of WIC] is the program's effectiveness in lowering rates of anemia, prematurity and low birth weight infants*." Participants who are breastfeeding receive packages that contain more food. "*We want to promote that breastfeeding is best*," Biesemeier said. Davidson County WIC also provides breastfeeding support, including counseling and education materials. The primary locations where WIC services are offered are 4 East Obstetrics, Newborn Nursery and the Neonatal Intensive Care

Unit (NICU). After nurses identify patients who are interested in the program, WIC staff members provide services to eligible patients. During the first two months of this program, "*262 participants left the hospital with their WIC vouchers already in hand*," said Kelly Whipker, WIC registered dietitian and certified lactation consultant. [*SE13-Exhibit B-1-Reporter Article WIC Services*]

**Healthcare-Associate Infections – Invite the Community**

On April 21, 2010, VUMC Nursing Education and Professional Development (NE&PD) presented a continuing education program titled "Healthcare-Associated Infections: A Practice-Oriented Approach". NE&PD partnered with the Vanderbilt School of Medicine and the Department of Infection Control and Prevention to sponsor The Healthcare Associated Infection (HCAI) program. The multidisciplinary program provided an overview of major healthcare infections with a focus on causative microorganisms and current antimicrobial treatment. Because healthcare associated infections are so widespread and affect every size and type of health care facility, the decision was made to open the program to the public (charging only a nominal fee to cover parking and food breaks). The decision was made to invite students to attend at no charge. We had 72 outside participants attend.

Infectious disease experts shared concepts of disease transmission, prevention strategies, and clinical treatment guidelines. A discussion panel concluded the session and responded to questions related to serious infections complicating the course of hospitalized children and adults. Automated audience response tools provided participant interaction with faculty during presentations and the panel discussion. The program was approved for 4.5 contact hours through the Department of Nursing Education and Professional Development.

Notice of the educational opportunity was provided using several venues. The program was posted on the VUMC Nursing web site. It was also distributed to the Middle Tennessee community via Tennessee Nurses' Association on-line continuing education listing, personal emails to clinical educators of area healthcare facilities, brochure distribution at professional organization meetings (such as Infection Control practitioners), and communications to area schools of nursing

Multiple healthcare disciplines were represented by the program faculty. The HCAI program overview lists specific topics, learning objectives, and content description as presented by the following faculty:

See Table below.

**Table SE 13 – 1: Presenters**

| Name | Area |
|---|---|
| Vicki Brinsko, RN | Director and Infection Preventionist, Department of Infection Control and Prevention |
| Titus Daniels, MD, MPH | Assistant Professor of Medicine – Infectious Disease, Associate Hospital Epidemiologist |
| Sloan B. Fleming, PharmD, BCPS | Clinical Pharmacy Specialist, Trauma |
| Cori L. Nelson, PharmD, BCPS | Clinical Pharmacy Specialist, Infectious Diseases |
| William Schaffner, MD | Professor and Chair, Department of Preventive Medicine, Professor of Infectious Diseases, Department of Medicine |
| Thomas Talbot, MD, MPH | Assistant Professor of Medicine and Preventive Medicine, Chief Hospital Epidemiologist |
| Greg Wilson, MD | Assistant Professor, Pediatric Infectious Diseases, Children's Hospital Epidemiologist |
| Patty Wright, MD | Medical Director, Infectious Diseases Outpatient Clinic, Assistant Professor, Infectious Disease – Medicine (Adult) |

The initial impetus to provide a continuing education program on healthcare associated infections grew from participant discussions during the Critical Care Case Studies Sepsis class (in fall, 2009). In late fall, Vee Rice, RN, MSN met with Tom Talbot, MD and other nurse educators to discuss the possibility of a clinically focused program on this important hospital issue. The 2010 National Patient Safety Goals (published in the Joint Commission Resources Quality and Safety Network Resource Guide) clearly identify the need to educate staff and to implement policies and procedures to reduce healthcare associated infection, including hand hygiene standards. Public news articles and in-house infection data supported the importance of the problem and the need to educate all members of the healthcare team.

**Program Evaluation**

Participants were asked to complete a written program evaluation, and the evaluation summary is attached. Overall, the participants rated the program very high and found the content clinically useful. In response to the question "*How well did the program objectives relate to the overall purpose/goals of this program/activity*?" – the response summary score was 3.92 (on a scale of 1-4). Based on the post-program evaluations and informal feedback, the program increased awareness and knowledge of healthcare associated infections and provided

strategies to prevent disease transmission. The written comments from the participants indicate the program met its goals. [*SE13-Exhibit C-1-HCAI Flyer, SE13-Exhibit C-2-Health Associated Infection Evaluation*]

All lectures were videotaped and are currently in the process of being loaded into the Learning Exchange (our learning management system). VUMC staffs are able to access individual lecture presentations (including PowerPoint handouts). VUMC staff will also be able to view all the program video lectures and complete a post assessment to earn 4.5 contact hours (through Nursing Education and Professional Development).

**Partners in Towboat Wellness**

An innovative program, Partners in Towboat Wellness was created in 2004 to provide captains, pilots, and other personnel from Ingram Barge with comprehensive physicals, treadmill tests, and healthy living guidance. A corporate agreement was established between the company and the Dayani Center at Vanderbilt University Medical Center (VUMC). Teresa Roberts, RN, executive physical nurse at the Dayani Center is no stranger to riding on the 140-foot twin-engine towboat that Captain Mark Burkhart expertly maneuvers on the Cumberland River. Teresa is responsible for coordinating the comprehensive physical and U.S. Coast Guard (USCG) renewal process and has been with the program from the beginning.

**"In her own words":**

"*In my health coaching role, I partner with Ingram Barge associates to empower them to take control of their health through meaningful lifestyle changes that can reduce their risk factors for developing chronic, diseases, and, along the way, they discover that they are not just healthier, but they feel better*!"

**Teresa Roberts, RN**

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The Dayani team includes, in addition to Roberts, two part time physicians (Robert Workman, M.D., and Mark Jacokes, M.D.), an exercise physiologist (Zafer Karabulut, Ph.D.), and other health care professsionals, including registered dietitians. The Ingram program, which has more than 600 participants, is the largest of about 40 corporate health contracts managed by Dayani. The license renewal cycle is for five years and the Dayani program checks each participating Ingram employee every two-and-a-half-years, providing plenty of time to work on correcting any health concerns that are identified.

Roberts reports that there has been a reduction in risk factors and improved health among the Ingram Barge associates. Some of these improvements include:

**Table SE 13 – 2: Improvements**

| INITIATIVE | RESULTS |
|---|---|
| Exercise Tolerance | 40% have improved their exercise tolerance as measured by increased treadmill time |
| Blood Pressure | 23 % have reduced their BP |
| Cholesterol | 35% have decreased their cholesterol levels |
| Blood Glucose | 20% have reduced their fasting blood glucose level |
| Smoking Cessation | 10% have quit smoking |

The priorities of the program include safety, prevention and reducing risk factors so that the Ingram Barge employees can get out on the river and be healthy and safe.

**Stroke Systems of Care**

Jackie Moreland, RN, BSN, MS is the Stroke Coordinator for VUMC and sits on the statewide Stroke Systems of Care Taskforce through the American Heart Association and American Stroke Association (AHA/ASA). This project was initially a pilot funded through a grant through the Delta States Stroke Network. The overall purpose and goal of the program was to provide specialty consultations in real time to assist in the diagnosis of acute stroke and increase the usage of Intravenous Tissue Plasminogen Activator (IV TPA). The monies were administered through the Tennessee Department of Health and the Tennessee Hospital Association. The telemedicine vendor was REACH Call. Vanderbilt University Medical Center had expressed an interest in telemedicine for stroke through this taskforce and when the funding was made available for Tennessee to pilot this technology, VUMC was asked to be the hub hospital for the pilot. VUMC was chosen as the hub hospital because it is an academic medical center, is centrally located in the state, participates in the GWTG-stroke program and is a Joint Commission certified disease-specific care primary stroke center. Jackie was involved as a member of the state taskforce but also as the stroke nursing coordinator for VUMC.

Jackie coordinated work on this project with Devin Carr, MSN, RN, ACNP-BC (Administrative Director - Surgery and Trauma Patient Care Center); Dr. Howard Kirshner, medical director for the stroke program; Dr. Anne O'Duffy, Dr. Derek Riebau, Dr. Rishi Gupta and Dr. Brandi French (all stroke attending physicians).

Jackie traveled to our VUMC's spoke hospital, Hardin Medical Center in Savannah, TN three times during the pilot project. She was at Hardin in the ED during initial training sessions to make sure the system was functioning and their staff was in-serviced about not just the telemedicine system but also about VUMC's ED processes for acute stroke patients. Jackie made two subsequent trips and numerous phone calls to insure everyone was on board with the system.

The pilot project ended on 12/31/09, however, the spoke hospital made the decision to continue the program. The tables below summarize the data through January 2010. Jackie, along with Dr. Gupta, Dr. Connors (interventional neuroradiology), and Candace Tillquist (administrative director for the Neurosciences Institute) made a trip to Hardin early in the Summer of 2010 to discuss and update the program with the CEO, the key ED and Internal Medicine physicians and ED nurse manager. The Delta State Stroke Network lost the funding effective June 30, 2010 as did other similar networks. Jackie now reports program progress to the Tennessee Department of Health due to their continued interest in the project. Routine reports are also submitted to VUMC's stroke committee.

**Table SE 13 – 3: Summary Data November 1, 2008 – December 31, 2009**

| Total Contacts | Total Consults | Number of Acute Stroke/TIA Diagnoses | Number of non-stroke diagnoses | Number of patients receiving IV tPA | Number of patients transferred to VUH |
|---|---|---|---|---|---|
| 29 | 22 | 12 | 10 | 3 | 15 |

**Table Se 13 – 4: Summary Data since January 1, 2010**

| ISSUE | TOTALS | COMMENTS |
|---|---|---|
| Total number of contacts/consults | 12 contacts/11 cons | One contact did not receive consult as family arrived and requested that patient be taken to Jackson-Madison County Hospital after telestroke contact made |
| Total of acute stroke/TIA/non-stroke diagnosis | • 6 acute strokes<br>• No TIA's/5 non-stroke diagnoses | |
| Total doses of IV tPA | • 4 doses | |

| | | |
|---|---|---|
| Total number transferred | 10 of 11 consults transferred | 3 of the non-stroke diagnoses transferred were for significant etiologies i.e. R/O SAH, CT indicative of brain mass, and stroke-like symptoms in pregnant female with no significant past medical history |

At the termination of the pilot project Vanderbilt made the decision to continue this program and is looking to add additional spokes. Currently additional sites are being considered, although no decisions have been finalized to date. Although there have been some additional technology challenges (eg. PACS images not loading onto the system or technical issues with the video feed/camera resulting in transferring the patient to insure proper diagnosis/treatment), the project has been considered successful. [*SE13-Exhibit D-1-TN Telestroke Pilot Project Update*]

**Benefits of Stroke System of Care Project**

- Increased usage of IV tPA at rural facility due to face-to-face consultation with stroke neurologist at hub facility
- Appropriate transfers
- Increased relationships between hub neurologists and spoke ED physicians
- Portability of system via laptop computer
- Teaching/learning between hub specialists and spoke physicians

**LifeFlight Outreach**

EMS Night Out (ENO) is one of the outreach educational programs that LifeFlight offers. ENO is presented on a monthly basis, rotating through the different counties in Tennessee that comprise LifeFlight's service area. At each event two different EMS related topics are presented to provide continuing education credits to EMS professionals. The topics vary from event to event and are presented by LifeFlight Staff Nurses and Paramedics, Vanderbilt Faculty, and other EMS-Medical Experts.

One of LifeFlight's mission objectives is to provide high quality education to its staff but also to the providers in its service area. Healthcare is an ever changing process, and as the

evidence and knowledge changes, the providers in the field need to be educated. ENO is a great venue to provide this education at no fee to EMS professionals in Middle Tennessee. Several of the areas we service do not have full time educational staff to provide education and ENO is a beneficial service we provide to our customers. Presenters of educational topics include:

- LifeFlight Staff – Flight Nurses and Flight Paramedics
- Vanderbilt Faculty and Staff – EM Attendings and Residents, Pediatric Faculty, Cardiology Faculty and Staff, Toxicology Faculty, Neonatal Faculty, Neurology Faculty

The outcome was providing continuing education to the area EMS Professionals – EMTs, Paramedics, and First Responders. At the conclusion of each event, the attendees are asked to complete evaluations. On the evaluations the attendees are asked to score the speakers and presentations. Questions include relevance to their practice and did the presentation meet their expectations. [*SE13-Exhibit E-1-ENO Evaluation Data*]

**LifeFlight Outreach – "In their own words"**

*"Once a month, I and at least one other LifeFlight (LF) nurse visit an outlying facility that calls us for transport. On this visit, we offer an educational presentation that has been predetermined by the needs of the outlying ED manager. The participants are awarded contact hours with LF and VUMC Nursing Education and Development as sponsors. In addition, we make ourselves available to answer any questions about our transport capabilities and field questions about any issues with our service.*

*I plan and coordinate the visits and some of the educational presentations. Amy Moore, RN (LF) is responsible for the submission and planning for continuing education units for the presentations. Any of the LF staff is invited to participate in developing an educational topic, presenting at the outlying facility, or simply going along on a visit to answer questions about LF.*

*At the outset of the program, we found that outlying ED staff might not always be able to anticipate what was needed for transport and successful transfer of care for air transport. We sent out a survey to the nurse managers of the ED's in the outlying facility that we serve. The surveys were returned with specific requests for certain educational offerings. As the program has now been in existence for a few years, we call or e-mail the nurse managers in the facilities and ask them what needs they currently have, then try to accommodate what is their most pressing educational need by developing a presentation or accessing someone who can (eg. the VUMC stroke coordinator, etc.) We try to schedule with a facility anytime from 2-4 months ahead of time.*

*Outcome is twofold. The ED Outreach program results in better relationships with outlying ED staff as evidenced by increased flight volume from the facility after a visit."*

**Teresa Fulwood, RN (LifeFlight)**

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As a valued partner in the EMS community, LifeFlight provides numerous outreach programs each year to community partners. The following comments were received from two of our partners:

**Maury Regional EMS-Daniel Fleming – "In his own words"**

*"LifeFlight has not only provided a great service for our area, but they are also known to me as friends. I was working EMS when LifeFlight started and they visited and valued the input of other agencies to develop such a strong program. They have also worked hand in hand on many projects through schools, scouts, and other charity organizations. They have not been afraid to give to my home community and therefore they have developed much friendship and respect to me as well as my peers.*

*LifeFlight has been a positive addition to our community. They provide many hours of not only service to patients, but to community events. They are a large part of many public relation ventures and community education programs. Likewise they have provided much in-service and education to the responders and medical staff in our area. Their continued team-player role with other services has been huge in not only the education but the saving of lives in our area. Not only a benefit to our community, but being centrally located in our region, but they have provided much of the above mentioned to South Central Tennessee. They have also participated on boards and planning areas to make Emergency Services stronger in our area.*

*Vanderbilt LifeFlight is to be commended for their true professionalism in working within our area. Also they have been a large tie and liaison for the hospital and all the services they represent and provide."*

**Danny Fleming, EMT-P, Education Coordinator, Maury Regional EMS, Columbia, Tennessee**

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**Horizon Medical Center**

*"Horizon Medical Center has a contracted agreement to utilize Vanderbilt LifeFlight for air transports. The ED physicians and nurses feel very comfortable calling LifeFlight for*

*assistance with the transports and other needs. The Vanderbilt LifeFlight nurses present in-services to the ED and EMS staff on a quarterly basis. The in-services are beneficial to the staff and the community we serve by providing the staff with a better understanding of how to manage critical patients. The in-service topics are chosen by the staff that plans to attend and taught in manner that allows for an open forum and the opportunity to ask questions. The feedback is always very positive from those in attendance. A LifeFlight nurse is assigned to Horizon to serve as a contact person for any additional needs or issues that arise. This person is always available and prompt with responses. This community is fortunate to have a service that is readily available to assist at any time."*

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**Tennessee Initiative Perinatal Quality Control**

In the Spring of 2009, nurses from VUMC attended the annual TIPQC (Tennessee Initiative for Perinatal Quality Care) meeting. TIPQC is a statewide organization designed to improve the quality of care for all mothers and infants in Tennessee. The annual meeting brings together healthcare providers from all over the state to set the initiative goals for the next year. One of the projects selected was to improve the percentage of very low birth weight (VLBW) infants who receive human milk in the Neonatal Intensive Care Unit (NICU). The Regional Medical Center in Memphis was designated as the lead on this project and the Monroe Carell Jr. Children's Hospital volunteered to co-lead the development of the pilot project for this initiative.

Since March 3, 2009, two additional hospitals have joined the pilot project. The additions to the project are East Tennessee Children's and Parkridge East Hospital in Chattanooga. The teams have met multiple times since March, 2009 and developed a Toolkit of Best Practices increasing human milk usage in the NICU and are using the REDcap data base to collect information in order to monitor multiple data points. These include birth weight, gestational age, race, ethnicity, composition of first feeding, and composition of feeds when reaching full feeds. Additionally, information will be gathered at discharge to determine if the infants experienced a CLABSI or Necrotizing Enterocolitis (NEC) while hospitalized as well as what their diet was at discharge.

The Children's Hospital Lactation Consultants (LC) have been involved in this project from the beginning and have assisted in developing the toolkit and the focus of the project. The lactation consultants, nurse practitioners, certified nurse midwives, NICU nurses, postpartum and newborn nurses will be key to the success of this project because of their interaction with the mothers from the beginning. Participants include:

**Table SE 13 – 5: Participants**

| Name | Role |
|---|---|
| Claire Slone, MSN, NNP-BC | Manager for NICU- Lead on this project |
| Bonnie Parker, RN | Team Member |
| Eric Sullivan, MSN, RN | Educator for NICU-team member |
| Betty McDaniel, RN, IBCLC | Team Member |
| Angela Lane, MSN, PNP-BC | Nurse Practitioner-Team Member |
| Carol Huber, BSN, RN, IBCLC | Lactation Consultant-Team Member |
| Emily Griffeion-RN | NICU Staff Nurse-Team member |
| Steve McElroy, MD | MD-Neonatologist –Co-Lead on Project |
| Barbara Engelhardt, MD | Neonatologist-Team Member |
| Staphanie Walker, MD | Neonatologist-Team Member |

Along with this program, Vanderbilt had already established several plans to improve the breastfeeding of these preterm infants. These plans include the following:

- All NICU and Newborn staff received a 4 hour class instructed by our Lactation Consultants to increase the staff nurse involvement in assisting and encouraging breastfeeding. The 4E (postpartum) nurses were also involved in these classes.

- The OB department added to their order set an automatic request for a breast pump and an LC consult for any mother who had a neonate transfer to the NICU. We have seen an increase in the use of breast pumps and breast milk being available for these NICU babies. (There has been an increase in par levels needed for our breast milk containers).

- We established the need for a dedicated NICU LC and made this a full time position effective July 1, 2010. As a group they developed a notebook to include information on the baby's nutritional status and how the mom is doing with her breast pumping. If they are unable to see mom after a few days they will give her a phone call and check in with her and offer advice for any of her breastfeeding concerns or needs.

This project is ongoing and we began collecting data for the pilot August 1, 2010. The new toolkit is being used to direct each change that will be made to determine the impact on human milk usage. While the TIPQC project's focus is on the VLBW infant, all babies who are admitted to the NICU at the Children's Hospital for at least 48 hours will be followed. *(See Related story on VCH Lactation Store in EP)*

**Children's Safety Store**

Unintentional injuries are the leading cause of death and disability for children ages 1 to 14 nationally. In 2007, Children's Hospital saw 827 unintentional injury related admissions, which was an increase of 15% over the previous year. Approximately, 3,420 children were seen in the pediatric emergency department. Many of these injuries happen in or around the home and most can be easily prevented through education and the proper use and maintenance of child safety products.

As the only comprehensive children's hospital serving Middle Tennessee, southern Kentucky, and northern Alabama, we work closely with a network of community pediatricians and clinics that serve over 500,000 children annually. As lead agency of the Safe Kids Coalition of Cumberland Valley, our reach into the community extends to even more – over 2,000,000 people in 39 counties throughout Middle Tennessee. Many of our community partners as well as hospital staff expressed an interest in seeing us complement our community education programs by creating a place where parents can purchase products to help keep their children safe.

The safety store is a logical enhancer to the education and interventions offered by the Children's Hospital for a number of years. We have been conducting car seat checks in the community for more than seven years and have experienced brisk sales since we began selling child passenger safety seats in our Gift Shop in 2005. Because of our reputation as the expert in child safety, we had been looking for a way to expand our product line and corresponding education to other safety items prior to the opportunity to obtain funding for the safety store. The Safe Escape program is of particular interest to us in light of Middle Tennessee's weather-related tragedies experienced over the past few years. Nursing staff in particular remembers vividly the times when tornadoes touched down in the Middle Tennessee area leaving death and destruction in their wake. Parents and caregivers with special needs children are especially vulnerable to seeking protection in these kinds of emergency situations. Estimates of children with disabilities and other special health care needs living in our region vary with some as high as 10% or 50,000.

In 2008, Monroe Carell Jr. Children's Hospital at Vanderbilt was selected as one of six children's hospitals across the country (the only hospital in the South) to receive funding from the National Associate of Children's Hospitals and Related Institutions (NACHRI) to open a hospital-based safety store. Our store is located inside the Junior League Family Resource Center on the main floor of our hospital. The store is the anchor to our larger injury prevention and intervention efforts operating under the name of Kohl's Safety Central. Our goal is to

provide education related to child safety and injury prevention to families – as well as provide convenient access to low-cost safety products.

The products in our store cover a wide range of injury topics – from fire safety to child passenger safety – and we have corresponding educational materials for each topic. All products are priced at-cost to ensure that these important products are affordable to as many families as possible. All other expenses (staff salary, office supplies, etc) are covered by grants – with the bulk of our funding coming from Kohl's Department Stores and its Kohl's Cares for Kids program.

Kohl's Safety Central includes a wide range of community safety education programs including the unique Safe Escape, which provides education, information and access to adapted evacuation products so that families may plan for, practice and safely evacuate children with health care needs or disabilities during any fire, emergency or natural disaster. Products from the store are integrated into all of our community outreach and education programs.

The participants on the Planning Committee included:

- Kim Harrell, Grant Writer
- Sarah Haverstick, Safety Coordinator
- Karen Kaiser, VCHIP Coordinator
- Mary Kate Mouser, Director, VCHIP
- Lee Ann Ruffing, Director Operations
- Kristi Skeeters, Community Volunteer
- Purnima Unni, Trauma Injury Prevention Coordinator

The Children's Hospital worked with Riley Children's Hospital in Indianapolis, Indiana who has had an in-hospital safety store in their outpatient clinic tower for the past five years. They provided all of the technical assistance and training during the NACHRI grant award period (March 2008 – March 2009). After receiving the grant award five Children's Hospital staff members traveled to Riley to attend the Safety Store/Safe Escape Replication training (April 2008). Upon returning to Children's Hospital this group met on a bi-monthly basis to develop the plans for our safety store Initially, numerous meetings were hosted, staff nurse meetings were attended by the planning committee and a survey was conducted with internal nursing staff to gauge staff feedback in store design, store operations hours and product selection. Based on feedback from staff and the technical assistance and information provided by Riley

Children's Hospital our team developed the general framework for the store: location, hours of operation, construction and store design.

Products were chosen with feedback from the Children's Hospital Family Advisory Council (FAC). An initial inventory list was shared by Riley Children's Hospital, sample products were procured by the nursing staff and the products were then tested by FAC members. Products were tested to ensure ease of use, clarity of product instructions, and usefulness of product for families. FAC members provided invaluable feedback throughout the store development process. As parents and frequent visitors to the hospital, FAC members were able to provide insight into their experiences with safety products and feedback regarding the layout and promotion of the store to ensure the area remained consistent with the rest of our hospital.

Committed volunteers worked alongside the staff throughout the process to ensure the store opened as planned and on-time. Kohl's A-Team volunteers attended community events to promote the safety store and child safety programs. Student volunteers were also engaged prior to the store opening unpacking, sorting, labeling and pricing all product inventory. Volunteers photographed each product and uploaded images to the product inventory page of the website.

An online Point of Sale (POS) system was created by the Children's Hospital Web team. In addition to recording customer sales, the POS tracks all products in inventory, generates sales reports and has a custom mailer feature used to send information as necessary (e.g. recall notices) to customers.

A major communications effort was undertaken prior to the store's grand opening to ensure hospital staff was fully informed about this new resource for families. For nursing staff, the team members attended staff meetings to promote the store opening and to request support in promoting the safety store as a resource to families and patients. Internal hospital staff members are a significant referral source, and nursing staff in particular have proven essential to the success of our safety store roll out. Print materials were distributed to hospital staff to assist with promotion and referrals included prescription pads, flyers, buttons and magnets. Hospital nursing staff will continue to be updated regularly about the safety store and other safety initiatives through meetings, website updates or emails. A program assistant was hired in July 2009 to perform daily operations at Kohl's Safety Central. Since the store is open to the entire community, staff have continued community outreach efforts and included information about the store and products available at all community activities.

**Success**

We have measured the success of Kohl's Safety Central, in part, on the statistics we have been able to gather related to the retail aspects of the store. Included below is a breakdown of actual store statistics from 3/9/09 – 11/30/09:

**Table SE 13 – 6: Kohl's Safety Store Statistics**

| **Visitors** | |
|---|---|
| Average Visitors/Day | 19 |
| **Total Visitors** | **3,565** |
| **Sales** | |
| Total Orders Placed | Total Orders Placed |
| Total Products Sold | Total Products Sold |
| Average Pre-Tax Sales/Month | Average Pre-Tax Sales/Month |
| **Total Pre-Tax Sales** | **Total Pre-Tax Sales** |
| **Diabetes Clinic Pilot** (7/29/09 – 11/30/09) | |
| Total Orders Placed | Total Orders Placed |
| Total Products Sold | Total Products Sold |
| Average Pre-Tax Sales/Month | Average Pre-Tax Sales/Month |
| **Total Pre-Tax Sales** | **Total Pre-Tax Sales** |

Our educational efforts also extend beyond the hospital and into the community with our outreach initiatives related to child safety. Included below are statistics from calendar year 2009 (as of 11/30/09):

**Table SE 13 – 7: Community Outreach Statistics**

| **Community Car Seat Checks** | |
|---|---|
| Total # of Seats Checked | 377 |
| Total # of Seats Replaced | 118 |
| Total # of Technician Hours at Checks | 256 |
| **Total Community Car Seat Checks** | **12** |
| **Car Seat Fitting Station** | |
| Total # of Seats Checked | Total # of Seats Checked |
| Total # of Seats Replaced | Total # of Seats Replaced |
| **Total Car Seat Fitting Station Appointments** | **Total Car Seat Fitting Station Appointments** |

| Community Events | |
|---|---|
| Total Attendance at Events | Total Attendance at Events |
| **Total Community Events Attended** | **Total Community Events Attended** |

We have averaged about $800.00 above our initial pre-tax sales goal of $1,000.00 in sales per month. The initial goal was based on information provided from other hospital-based safety stores. Of our 926 orders, 84 came from repeat customers – and 23 customers have returned to the store or Diabetes Clinic and purchased items on three or more occasions. Even though our products are not priced with a typical retail mark up, safety staff regularly checks the prices of products against those of other retailers to ensure our products are competitive.

The retail portion of the safety store has been so successful to this point, that staff has considered moving forward with potential expansion plans (online product sales, satellite locations or other clinic sites) sooner than initially anticipated. Anecdotally, in speaking with store customers, it seems we are meeting a need and providing quality service. In particular, hospital or clinic patients' families have noted the convenience of shopping for these items when they are already visiting the hospital. In an effort to gauge the outcome of our educational efforts, safety staff members are in the process of distributing a survey to store customers three to six months after purchase.

The educational information our staff provides and the products at Kohl's Safety Central are available to anyone in the community. The majority of our visitors, however, come from hospital in-patients or the clinic – as a result of our prominent location on the main level of the hospital. With a number of our clinics located in the Children's Hospital Doctor's Office Tower (DOT), next to the Junior League Family Resource Center, a visit to the safety store has been convenient for the hundreds of clinic visitors daily. However, a number of our outpatient clinics are not located in DOT, and in an effort to provide easier access to the store and the safety education for those families, we initiated a pilot project with the Diabetes Clinic, bringing store sales directly to the clinic.

In this instance, the Diabetes Clinic had an interest in one category of safety products available at the store – medical alerts. Their clinic is located across campus, next to the adult hospital, and therefore the store is not as conveniently located for their patients. In order to enhance the continuum of patient care provided by the clinic, Kohl's Safety Central staff provided the clinic with an inventory of medical alert products. These items are available to all clinic patients and are sold by clinic staff at the reception desk. Clinic staff created displays advertising the sale of the items and includes education about the importance of medical alert products during patient visits. Clinic staff utilizes the online Point of Sale system to record

purchases and complete the same paperwork as the store. Kohl's Safety Central staff pick up all paperwork and deposits once a week. Thus far, clinic staff has reported positive feedback from their patients with the addition of this service. Diabetes Clinic customers will be included in the customer survey developed by Kohl's Safety Central staff. Future Kohl's Safety Central plans include the potential expansion of clinic specific product sales, based on the need of individual clinics and their patient population. [*SE13-Exhibit F-1-VCH Safety Store*]

**Community Resource Fair**

On January 22, 2010 a Community Resource Fair was held to provide a forum for numerous community agencies that serve children and families to discuss their programs. The forum also helps providers obtain information about how to appropriately refer patients and families to these agencies. Some of the agencies that came together to exhibit included:

- Children's Special Services
- Coordinated School Health
- First Steps
- Health Assist TN
- Jr. League Family Resource Center
- Mental Health Cooperative
- VUMC Social Work
- WIC

[*SE13-Exhibit G-1-Community Resource Fair Flyer*]

**Children's Hospital Emergency Department partners with Williamson Medical Center EMS**

The Children's Hospital Emergency Department partnered with paramedics, physicians, and educators to answer the question posed by Williamson Medical Center EMS on how to restructure current protocols and resource tools to improve the management of pediatric patients. Because pediatric patients typically comprise less than 10% of emergency patients, healthcare workers in medical transport services are not always prepared for the unique challenges sick or injured children present. The Comprehensive Regional Pediatric Center (CRPC) Outreach Team recognized this fact and has worked diligently to improve the comfort level and knowledge of the healthcare provider. Through collaborative efforts, protocols were revised and a drug dosing tool was created.

The main participants in this project included:

- Michael Wallace – Paramedic Supervisor, Williamson Medical Center EMS
- Eric Clauss – Assistant Director, CRPC Outreach Team
- Lee Blair – EMS Coordinator, CRPC Outreach Team
- Dr. Mark Meredith – Clinical Director for Pediatric EMS, CRPC Outreach Team

The members of this team, each with extensive experience, collaborated to revise the protocols that Williamson Medical Center EMS utilizes. Michael Wallace developed a "drug dosing" tool that has specific weight-based drug doses calculated down in milliliter of volume. By developing current practice protocols and a drug dose tool to use during emergent pediatric situations, the apprehension of caring for these children is often overcome.

**Process**

We wanted to impact the outcomes of children *prior* to arrival at Children's Hospital. Since the new tools have been implemented, we have seen impressive results – children's lives being saved according to our (Children's Hospital) Medical Director, Dr. Tom Abramo. The following was completed:

- Recognized the need – completed evaluation, review and revision of current practice
- Drafted the new protocols and reviewed with medical directors
- Educated staff on the new protocols
- Implemented the protocols

The drug dosing tool that Michael Wallace developed enables paramedics to quickly determine the correct drug dosage, based on patient weight, for every drug they carry in their ambulances.

**Success**

We have seen an improvement in pediatric patient care and an increased level of comfort for paramedics when managing pediatric patients during transport. Michael Wallace has had numerous written and verbal compliments on this work and how it has improved the care of pediatric patients. Our medical director (Dr. Abramo) has sent letters to the CEO, CNO,

EMS Director and to Michael Wallace elevating the EMS crews on tremendous patient care. The crews give the credit to the updated protocols and drug dosing tool. [*SE13-Exhibit H-1-Letter to EMS Director Williamson Cty*]

Through collaboration with Michael Wallace (Williamson Medical Center EMS) and the CRPC Outreach team, we have received IRB approval to conduct a research project. The research will evaluate current practice and management of pediatric patients at select EMS agencies. After the initial evaluation is complete, the participants will be provided the updated protocols and the drug dosing tool, and then be reevaluated. We believe there will be a measurable difference in the outcome. The State EMS Board along with the Committee on Pediatric Emergency Care (CoPEC) is interested in assisting in these efforts.

**"Parent University"**

A one-day Parent University workshop was offered through collaborative efforts of the Office of the Mayor, Metro Nashville Public Schools (MNPS), and Alignment Nashville on 7/25/2009. This workshop provided participating parents of economically disadvantaged children within the Metro-Davidson County area with useful information about how to get involved with their child's education both at school and at home. This was accomplished by a series of educational sessions offered throughout the day that parents could enroll in, depending on their level of interest. Sessions were offered by various community providers and by a wide range of Nashville community partners.

Staff from the Vanderbilt Psychiatric Hospital participated as presenters and volunteers. The staff who participated included:

- Shirley Berry-Yates MA, MEd, Vanderbilt Psychiatry- presenter ("Effective Communication Skills for Parents")

- Emma Finan RN, MMFT, Vanderbilt Psychiatry- presenter ("Understanding Child Development")

- Johnny Woodard RN, BSN, Vanderbilt Psychiatric Hospital- logistical volunteer for the conference day

Through funding from MNPS, the Nashville Area Chamber of Commerce, and the Orrin H. Ingram Fund, Parent University held its first annual "Be A Plus Parent" conference on the Avon Williams Campus of Tennessee State University. Almost 200 parents and more than

200 children attended the event on July 25, 2009. Through the Alignment Nashville Invitation to Participate (ITP) process, the committee identified 24 community organizations willing to participate in the conference by providing a variety of workshop sessions. The sessions covered such important and relevant topics as:

- Parent advocacy
- Creating resilient children
- Comprehensive child development
- Communicating available resources
- Importance of parent engagement
- Youth culture
- Non-traditional supports

[*SE13-Exhibit I-1-Parent University Brochure*]

The Parent University Committee provided transportation, breakfast, and lunch for the attending parents and children, while the YMCA provided outstanding and engaging learning activities for all of the attending children. As a grand finale to the informative day, each parent was presented with a Parent University diploma by Belmont University President, Dr. Bob Fisher and Tennessee State University's (TSU) Interim Vice President for Academic Affairs, Dr. Kathleen McEnerney. Each parent also received vouchers for two school uniforms, and backpacks filled with school supplies were given to every child. Parents were also eligible to win other great incentives such as laptop computers and gift certificates for school supplies.

**Success**

Evaluations were completed by the participants at the end of the conference day. Overall, 95.7 % of the participants indicated that their knowledge base increased, correlated to the topics attended. This event was a success due to the collaborative efforts of all involved. Outcome data was shared with all participants with plans for increased frequency of similar educational events.

**Recognition of Nursing**

**Source of Evidence 15**

**Describe and demonstrate that the nursing community and the community at large (e.g. local, state, national, international) recognize the value of nursing in the organization. [Need examples]**

**Overview of Vanderbilt and the Community**

Vanderbilt University Medical Center's tri-fold mission of education, research and patient care positions us to serve our community locally, regionally, nationally and internationally. Our strong relationship with the Vanderbilt Schools of Nursing and Medicine, as well as other allied health organizations, advances healthcare by:

- Educating health care providers of the future
- Providing breakthrough research to improve healthcare of individuals and groups
- Providing, most importantly, exceptional care to our patients

As a result, our organization is perceived as a strong, positive and productive corporate citizen whose partnerships support improved outcomes and the overall health of the communities we serve.

Vanderbilt University and the Medical Center are the largest private employer in middle Tennessee and the second largest in the state. VUMC employs 17,993 full time employees. Vanderbilt has an annual regional economic impact of approximately $4 billion; with the Medical Center's share totaling over $4.1 billion. Vanderbilt provides more that $220 million each year in uncompensated care to members of the community unable to pay for their own care. It is the largest provider in the region under the state's Medicaid program for the poor and uninsured, *TennCare*. We have received over $500 million in sponsored research and project awards.

The following examples identify the level of involvement that Vanderbilt nurses have in the larger community outside of the walls of the hospital of clinic. Our nurses have contributed to the improvements in healthcare here in the United States as well as abroad in wartime conditions. These examples indicate how the nursing community and the community at large value these nurses contributions. Although feeling this form of recognition is wonderful, it is

our nurses' commitment to providing care and compassion to their patients in a variety of settings even when their own lives are in danger that is most rewarding.

**VUMC Examples**

In October, 2008 two nurses dedicated to research received awards for Excellence at the fifth annual Research Staff Awards luncheon held at the University Club. Christa Hedstrom, Ed D, RN, is the manager of patient care services in the Clinical Research Center (CRC) overseeing a staff of 26 nurses and support personnel. Christa won the award for Excellence in Research Contributing to a Multi-Investigator Team. The CRC is responsible for conducting investigator-initiated clinical research.

Christa Hedstrom has also served as a volunteer nurse with the Siloam Family Health Center since 2001. In an email memo to Christa, Blair McLeod stated, "*she (referring to Christa) volunteers on a monthly basis serving faithfully with volunteer physicians, Drs. Alan Boyd and David Gregory.*" Christa has been an integral part of helping Siloam fulfill its mission of serving the healthcare needs of the community.

Diane Kent, RN, received the Vivien Thomas Award for Excellence in Clinical Research. Since 2001, Diane has served as a research nurse specialist in the Department of Preventitive Medicine. In her role as the local coordinator for the New Vaccine Surveillance Network, Diane has been instrumental in developing and orchestrating surveillance activities at three local hospitals, four local pediatric clinics, and in the clinic and Emergency Department of the Monroe Carell, Jr. Children's Hospital at Vanderbilt.

The awards were presented by Dr. Jeff Balser, MD, Ph.D., Vice Chancellor for Health Affairs at Vanderbilt University Medical Center, Colleen Conway-Welch Ph.D., RN, Dean of the Vanderbilt School of Nursing, and George C. Hill, Ph.D., associate dean for Diversity. The awards included a crystal trophy and a check for $1,000. [*SE15-Exhibit A-1-Hedstrom Reporter Article, SE15-Exhibit A-2-Hedstrom Tennessean Article*]

**Daphne Hardison wins ELSO Award**

In February, 2008, Daphne Hardison, RN, BSN applied for the Extracorporeal Life Support Organization (ELSO) Award for Excellence on behalf of the Monroe Carell Junior Children's Hospital at Vanderbilt Extracorporeal membranous Oxygenation (ECMO) team. The ECMO team was awarded the award of excellence in September, 2008. The Monroe Carell Junior Children's Hospital at Vanderbilt has supported the ECMO program for greater than

twenty (20) years. The program is recognized for its strength and has had excellent support from our administration. Leaders of the program have consistently used data to guide decisions and have tracked outcomes. The team routinely follows up with its patients. A fundamental philosophy of the team is that training is an integral part of the program's success. Other institutions have sought guidance and emulated the intensive training program we have in place. The Vanderbilt ECMO team is well represented at national meetings such as those presented by the Extracorporeal Life Support Organization (ELSO). Team members have shared their knowledge through poster presentations at these meetings. In addition, there is a structure to support evidence-based practice through a Director's Group literature review. Medical support is provided by a dedicated physician staff.

The leadership team for the ECMO team include:

**Table SE 15 – 1: Leadership Team Members**

| Name | Credentials | Area/Role |
|---|---|---|
| Donna Williams | MSN, RN | Administrative Director – Perioperative Services |
| Daphne Hardison | BSN, RN | ECMO Coordinator |
| Cindy Thomason | RN | ECMO Coordinator |
| John Pietsch | MD | Surgical Director |
| Mary B. Taylor | MD | Medical Director |
| William Walsh | MD | NICU ECMO Champion Physician |
| Peter Grubb | MD | NICU ECMO Champion Physician |
| David Bichell | MD | Chief of CT Surgery (Peds) |
| Tom Klein | MD | CCP Chief of Perfusion |
| All ECMO Team Members including RN's, RT's | | |

Daphne stated that she wanted to join the ECMO team about 6 years ago because she loved the adrenaline rush that came with helping a very sick patient make it. She had always looked up to the other ECMO Specialists and was thrilled to be a part of the team. She came back to work in a full time status to be on the ECMO team. Daphne states, "*This team is like a family and as the co-coordinator I felt the team deserved to be recognized for the excellent service they provide. This is just one step towards the recognition of the BEST ECMO TEAM in the world!!*"

**Outcome**

The Extracorporeal Life Support Organization created the "Excellence in Life Support" award to recognize and acknowledge extraordinary achievement in the following three categories:

- Excellence in training, education, collaboration, and communication that supports the ELSO guidelines and contributes to a healing environment
- Excellence in patient care by using the highest quality measures, processes, and structures based upon evidence
- And excellence in promoting the mission, activities, and vision of ELSO

One of the reasons Daphne's application was found noteworthy as specified by the ELSO Award Committee is:

*"You are awarded this honor based on several aspects of you excellent program. Even though you are a busy center, you maintain a primed back-up circuit for all ECMO patients. You have an excellent orientation program. All new ECMO specialists must sit pump for 200 hours prior to being released from orientation, with orientation lasting as long as 9 months. You have a standardized process for educating new fellows and attendings which includes lectures and wet labs."*

[*SE15-Exhibit B-1-ELSO Award Letter Vanderbilt, SE15-Exhibit B-2-ELSO Award Info*]

**Military Nurses Bring their Battlefield Skills Home**

Lt. Col. Donna Coker and Keith Evans, a former air force captain and military nurse were highlighted in the Winter 2010 issue of *Salute to Nurses* honoring their military service and the recognizing the skills that they brought home with them from the battlefield. Donna was deployed in Afghanistan for 14 months and is currently serving at the Monroe Carell, Jr. Children's Hospital at Vanderbilt as a charge nurse in pediatric invasive cardiology. Keith serves the medical center as LifeFlight nurse after serving on active duty.

Both of these nurses contribute their success as civilian nurses on having learned discipline and time management while serving in the military. They learned how to provide care under extreme circumstances even while their own lives were at risk from potential

mortar attacks. Both of these nurses had adjustment periods when they returned to civilian nursing at Vanderbilt and are grateful for the support of their colleagues, friends and family who helped them through that difficult time.

Neither of these nurses will forget the faces of the soldiers that they cared for and feel that it was the greatest reward for them was in knowing that they made a difference in these soldiers' lives by providing care when they needed it the most. Both of these courageous nurses have brought tremendous leadership and problem solving skills back to Vanderbilt. We are proud of their heroic contributions to the soldiers that they touched and to the patients that they care for everyday now that they have returned home. [*SE15-Exhibit C-1-Salute to Nurses*]

**"In their own words":**

"*I will never forget the faces of every soldier I treated in the combat zones. It's one of the hardest things to let go of. You will always carry the around the memories of war. Unless you were there, you can't fully understand.*"

**Keith Evans**

"*In the combat zone you're plagued with mass casualties, trauma from ballistic and explosive devices and such. Figuring out how to survive mentally was the hardest part*."

**Lt. Col. Donna Coker**

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**Leadership provided outside of the Vanderbilt Clinics**

Margaret Head, R.N., M.S.N., MBA, chief operating officer and chief nursing officer of Vanderbilt Medical Group and The Vanderbilt Clinic, has been elected to the American Medical Group Association's board of directors. The AMGA represents medical groups and organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. Margaret's election represents a first for AMGA, as she will be the first executive registered nurse to serve on this board. Head will serve as an at-large director for a three-year term.

The AMGA improves health care for patients by supporting multi-specialty medical groups and other organized systems of care. Approximately 95,000 physicians practice in AMGA member organizations, providing health care services for 96 million patients. Head is an

active member of the American Medical Group Association and has participated in its Chief Administrative Officers/Chief Operating Officers Council since its inception.

Margaret has been at Vanderbilt since 2007 and has also served as an adjunct assistant professor of Nursing. She received her R.N. from the Methodist Hospital School of Nursing in Memphis, her B.S.N. from the University of Texas Medical Branch in Galveston, her M.S.N. in nursing administration from the University of Texas Health Science Center at Houston, and her MBA, with a focus in health care administration, from the University of Houston at Clear Lake. In 1993, Head was a Commonwealth Fund executive nurse fellow. [*SE15-Exhibit D-1-AMGA Appointment Letter, SE15-Exhibit D-2-AMGA-Head Reporter Article*]

**"In her own words":**

"I am very excited about the opportunity to represent the Vanderbilt Medical Group and nursing in this multidisciplinary role. The future really is about patient-centered care and building a team that supports that."

**Margaret Head MSN, MBA, RN**

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**VUH Example**


The January 2010 *NURSING* newsletter distributed monthly out of the Executive Nursing Officer's office highlighted the achievement of the Beacon Award by the Surgical Intensive Care Unit (SICU) at Vanderbilt University Hospital. The January 15, 2010 edition of *The Reporter* also lauded the SICU for this magnificent achievement.

Highlights from these articles include:

After more than two years of work and a grueling application process, Vanderbilt University Hospital's Surgical Intensive Care Unit has received the acclaimed Beacon Award for Critical Care Excellence. "*This is acknowledgement of the hard work that has gone into creating*

*a healthy work environment that provides excellent patient care*," said Devin Carr, administrative director.

Given by the American Association of Critical-Care Nurses, the Beacon Award is meant to challenge acute and critical care units to improve standards of care. Units must meet rigid standards in recruitment and retention, training, evidence-based practice and research, patient outcomes, healing environment, leadership and organizational ethics.

"*The Beacon Award recognizes the efforts people put in on a day-to-day basis*," said Ashley Staniewski, M.S.N., R.N., interim manager of patient care services. "*You don't come in and decide to be Beacon. It takes a lot of hard work, paying attention to detail and not accepting the status quo*."

There are about 6,000 intensive care units in the United States and only 188 have received the Beacon Award. Vanderbilt's SICU is the first adult unit in Tennessee to be recognized. "*I am very proud and excited about this important award*," said Pam Jones, M.S.N., R.N., chief nursing officer of VUH. "*The SICU leadership and staff have worked very hard to ensure excellent, evidenced-based practice nursing is delivered in a consistent manner to patients and families. It is quite an honor to be the first adult unit in the state to achieve this recognition*."

"*I am extremely proud of the unit and what they have accomplished*," said Larry Goldberg, chief executive officer of VUH. "*I recognize how dedicated and committed the staff and leadership in the SICU are to providing outstanding patient care, but it is particularly gratifying when they receive such recognition from creditable sources outside the organizations*."

The application process began in spring 2007 when several interested staff members gathered to look at the 42 questions and assess how the SICU measured up. Staff were then assigned specific questions to answer, a final document was compiled and reviewed, and the application was submitted in August 2008.

"*Basically we had to tell them our story and pull in everything we knew about the unit*," said Mike Daly, M.S.N., R.N., assistant administrator of the Trauma and Surgery Patient Care Center. "*We don't meet all of the standards, but we were able to show how we were analyzing our work and trying to meet or exceed the standards. We know we're not perfect, but we never stop striving for perfection*."

After a five-month review process, the application came back requesting more information on many items. The staff pulled together once again to resubmit. "*I was much*

*more confident on the resubmission*," Daly said. "*When the award was announced, I first felt relieved because we had worked for so long and were finally finished*."

Medical Director Addison May, M.D., said the key to the SICU's success is teamwork. "*We could not have achieved this award without support from numerous groups at all levels of the hospital: nurses, physicians, respiratory therapists, pharmacists, etc*.," May said. "*All these groups have to function as a team in a single complex location. This is recognition for what the team has felt we've done well for a long time*."

The Beacon Award is given for one year, and there are plans to apply again in the future. "*Now we have a sense of ownership and obligation to maintain these high standards. The reapplication will help keep us focused on quality improvement and where to put our efforts*," said Richard Benoit, R.N., nurse educator.

Key application writers included: Benoit; Daly; Staniewski; Billy Cameron, M.S.N., R.N.; Barbara Gray, R.N.; Lindsey Robertson, R.N.; Donna Sabash, R.N.; and Regina Wisecarver, R.N.

[*SE15-Exhibit E-1-Beacon Award Reporter Article]*

**Children's Hospital Example**

**Beth Chatham's Story:** http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=21572

*"One of the things that make working at Monroe Carell Jr. Children's Hospital at Vanderbilt so enjoyable is not only the multiple age groups I work with, but also the various cultures I have a chance to interact with every day. Along with this enjoyment of world differences comes the frustration of not being able to communicate with my patients, especially with our increasing number of Hispanic patients. I wanted to at least say something comforting to a child and mother while waiting for the translator or language line.*

*Excited by what I learned in the Spanish classes offered by Vanderbilt through Hablemos, I was inspired to increase my proficiency and wanted an immersion experience. The Central American Spanish School offered a chance to learn Spanish while doing volunteer work in a medical setting, along with a home-stay providing room and board. I chose the school in La Ceiba, Honduras on the recommendation of a fellow nurse traveler who said the people in Honduras were wonderful. She was so right! And it didn't hurt, since Latin dancing is my hobby that La Ceiba is famous for its night life in the Zona Viva, pulsating with the bachata beat until dawn.*

*In the mornings I would walk to school through the streets of central La Ceiba, past the contrast of women selling tortillas from their laps across the street from a Dunkin Donut's shop. Mi profesor, Mauricio, was infinitely patient with me but strict, making sure I pronounced each word correctly. I must admit that my head felt about to bust by noon. It was a relief to walk home for lunch past shops blaring infectious music from their open doors. My meals were always delicious, with Laudia, the cook, serving traditional Honduran dishes.*

*The afternoon was spent doing volunteer work in La Ceiba's city hospital in the NICU. My first day I stood in the unit, donned in my gown, hat, and booties, with very little Spanish asking, "What do I do?" I was grateful for the fact that NICU routines seem to be universal. "Si" I could do the afternoon vitals and record them in the worn log book at the nurses' desk. "Si," I could feed a sick infant with a syringe of formula "despacio."*

*The maternity unit was a Lactation Consultant's dream come true. All new mothers breast fed. The term-newborns were transitioned and then placed beside their mothers in the ward where they stayed until going home 24 hours later. Because of the scarcity of sterilization equipment, the "premies" were fed by sterile syringes, eliminating nipple confusion. Mothers would stand at the unit door waiting to receive their baby out of the isolette, then go into a small room with chairs to breast feed. These poor women literally stayed in the waiting room all day, feeding their infants every three hours.*

*Two weeks was not enough time to improve my Spanish to any degree of comprehension. However, to my surprise, I am actually able to pick out words in conversation and in songs now. More importantly, I enjoyed La Ceiba and the people I met and worked with. And, yes, I did get to dance the bachata until 3am the weekend I was there!"*

**Beth Chatham MSN, RN – Nurse Educator Children's Hospital**

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**Recognized by a Colleague**

*"I had the pleasure of working directly with Beth Chatham when she first began at Monroe Carell Jr. Children's Hospital at Vanderbilt and now work with her indirectly as a team mate in Nursing Education and Development. The traits that I immediately admired in Beth were her 'gung-ho attitude,' willingness to dive into her new role, and provide valuable insight from her prior experiences to make improvements. Beth has a consistent cheerful attitude, a deep caring for others, and a world of experiences, including living abroad. When a co-worker told me of Beth's adventures in Honduras built around her need to care for others, this summed up my first impressions of Beth and exemplifies what makes VMC Nurses so special."*

**Sherri Stringfellow, Art Director, Nursing Education and Professional Development – VUMC**

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**Wura Adesinasi's Story**

The *Vanderbilt View* is a monthly publication for the Vanderbilt University community replacing the *Vanderbilt Register,* which was retired in September 2007 after 27 years in print. The *View*, which launched Oct. 1, 2007, is published on the first of each month by Vanderbilt's Division of Public Affairs, and is available on racks across campus and a few off campus. The September, 2009 issue featured one of our operating room nurses, Wura Adesinasi in the following article:

Wura Adesinasi has answered the call to heal, both at Vanderbilt and in her Nigerian homeland. Growing up in Ekiti State in Southwest Nigeria, Wura Adesinasi found her career path at an early age. "*When I was a child, I went for an immunization*," she said. "*I looked at the nurse and thought, 'I want to be like her*.'" Adesinasi's course was set. "*I've never had any job outside of a hospital*," she said. "*Even though in Nigeria I was working in an office, I was comfortable with helping patients. I would step out of the office and talk to patients and comfort them. You don't have to be a nurse to offer, 'What can I do to make you feel better*?'"

When she came to the United States with her husband, she earned a bachelor of science in nursing and a master of science in family nursing at Tennessee State University. Currently, she works as a circulating nurse in neurosurgery at Vanderbilt University Medical Center and is quite comfortable in intense medical situations. "*I love neurosurgery*," Adesinasi said, flashing her signature broad smile. "*I also love working as a circulator in the operating room. I make sure the surgeons have what they need for the smooth progress of the surgical procedures. I empathize with the patient and make the family members comfortable. I love to comfort and hold patients' hands (as they are) gradually going to sleep in surgery*."

Adesinasi prepares the operating room and keeps track of everything that goes on, including accounting for all of the instruments, sponges and gauze used, making sure nothing gets left behind. "*I don't know what's scheduled until I get to work each day*," she said. "*It is constantly changing, but that is part of what keeps it so interesting. I work with some talented and wonderful people and that makes it a joy*."

Working in Vanderbilt's state-of-the-art medical center is a stark contrast to the conditions that exist in hospitals back in Nigeria, Adesinasi said. "*In Nigeria, if you go*

*to the clinic or the hospital with a problem, you have to provide your own medical supplies*," she said. "*So for people who live on less than a dollar a day, where will they get the money to pay for surgery or hospital care? "Many people just go home. They say, 'You know what, I'll survive with the power of God. We will pray about it*." Sadly, Nigerians regularly succumb to ailments that are commonly treatable in the United States, such as hypertension and its complications, diabetes, hernias and malaria. Even a normal pregnancy can be exceedingly dangerous for Nigerian women because of the lack of prenatal care. "*The state of health care in Nigeria is depressing*," Adesinasi said. "*So many women of child-bearing age die there each year of pregnancy-related illnesses. Reports indicate that every 10 minutes, a woman dies there due to such complications. It's heartbreaking*."

Many of Adesinasi's family members still live in her home state, and she tries to visit once a year. On several occasions, she has returned to Nigeria with a group of medical professionals to provide free health care. They visit with patients and performing numerous surgeries over the course of a week - from Caesarean sections and thyroidectomies to removing fibroids and goiters and correcting massive hemias. Frequently, she collects unused supplies from the United States, such as gowns, drapes and gloves that will otherwise be discarded, to take on these trips. "*We have people from all over the country that help*," she said.

Though she is always mindful of the need in Nigeria, Adesinasi never fails to be jolted by the urgency of that need when she arrives. "*The last time I went home it was really overwhelming*," she said. "*You don't even know where to start. Should you take care of the little ones first? Those with chronic illness? The pregnant women? I know the problems that exist because I grew up there. But I didn't realize it was that terrible. It couldn't have been so bad growing up there, so it seemed*." She recounted a time when she walked into an operating room that had no lights and the power generator was out. "*We had to operate using a flashlight*," she said. "*But we made it work*." She also described surgeries in which the only form of anesthesia available was valium. "*Medical professionals who go there for the first time have a hard time adjusting to the conditions*," she said. *'"How can this be?*'" the surgeons will often say. But that is how it is in the underdeveloped world." Adesinasi said her medical missions colleagues hail from institutions across the country, including Vanderbilt co-workers Lara Aworunse, Valerie Davis and Betty Slusher.

But there is always a need for qualified volunteers. On her next trip she hopes to provide community-based educational programs on hypertension, heart disease, diabetes and prenatal care. "*People are walking around there, some with 300-plus blood glucose levels, and they don't know how to treat it*," she said. "*Over a long period of time, they go on b develop*

*complications and blame it on witchcraft. Education is key to changing the people's attitudes toward wellness*."

Adesinasi recently completed her family nurse practitioner licensure and intends to use those skills on future trips to her home country. "*It means a lot to me to give back," she said. "I don't have the money to give to anybody there, but the opportunity I have in going there on medical missions is priceless. You see there is so much need. If I can make a difference in one person's life, it is all worthwhile*."

**Two VUMC nurses awarded the national Future of Nursing Leadership Award**

Since 2006, Vanderbilt has partnered with the Advisory Board to make the Center for Frontline Nursing Leadership program available to Vanderbilt nurses. VUMC has conducted four cohorts through the program and beginning in the Fall of 2010, the program will continue as the Frontline Leadership Academy. As such, participation will be open to frontline leaders in nursing and other disciplines across the medical center to promote interdisciplinary collaboration.

The Frontline Leadership Academy is a joint endeavor of the Advisory Board Academies and healthcare organizations such as Vanderbilt. This comprehensive leadership development program is for leaders at the front lines of patient care. The objective of the program is to help you enhance the skills you need to:

- Prevent and manage conflict with patients and families, and within the team
- Tackle recurring problems in your department
- Prioritize time more effectively
- Build teamwork
- Act as a leader and role model for others
- During the program, participants will experience four semester-long courses, each devoted to a specific leadership topic

The program is a 15-month program that includes one full-day intensive classroom session taught by Center faculty and held on-site at Vanderbilt University Medical Center. Each participant is required to complete a practicum project designed to help apply classroom teaching to daily practice. These projects are then presented in different forums that include poster presentations during our annual OctoberFest Research Day or oral presentations at Staff Council meetings or entity Nursing Leadership Boards. Every participant is assigned a coach to

guide them through the program and provide mentoring and assistance as needed. Frontline nurses who successfully complete the program earn certification in the Frontline Leadership Academy.

Each year, participating organizations from around the country are asked to submit two projects to the Advisory Board for consideration for the Future of Nursing Leadership Award. Each project is submitted to blind review by the Advisory Board selection team. VUMC has the honor of having two nurses receive the award. The nurses who received the award are Lee Ann Grimes, RN (Charge Nurse – Women's Health) in 2008 and Tanika Wilson, RN, BSN (Assistant Manager in PCCU) in 2009. The Advisory Board sent a film crew to VUMC to film each of the award recipients each year and posted their video on their national website at www.advisory.com. Lee Ann's project focused on improving the acuity-based staffing model on her unit and Tanika initiated work on double-checking drip medications in the PCCU to decrease medication errors. Each nurse is featured on the VUMC Nursing website with direct links to their videos on the Advisory Board website.

VUMC website on Lee Ann Grimes:
http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=18887

Video of Lee Ann Grimes on Advisory.com website:
http://www.advisory.com/public/fnla/2008/

VUMC website information on Tanika Wilson:
http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=18887

Video of Tanika Wilson on Advisory.com website: http://www.advisory.com/public/fnla/2009/

**VESNIP Highlighted as Best Practice**

In 2008, the Advisory Board recognized VUMC's student nurse internship program, VESNIP (Vanderbilt Experience: Student Nurse Internship Program) as best practice for bridging the preparation-practice gap for graduate nurses. The Advisory Board prepared a research compendium entitled, *Bridging the Preparation-Practice Gap, Volume II: Best Practices for Accelerating Practice Readiness of Nursing Students.* This information was presented around the country at national Leadership Meetings and the document remains on the website for reference.

The document outlines eleven best practices for enhancing the practice readiness of graduate nurses. The research includes strategies for improving student clinical rotations,

elevating the quality of clinical instruction, collaborating with local schools of nursing, and preparing students for complex acute care environments. VUMC was recognized as developing a best practice student internship program because of the collaborative partnership with six schools of nursing and the provision of a robust clinical experience for students in five tracks (Adult Critical Care, Adult Acute Medicine, Adult Surgical, Women's Health and Pediatrics). [*SE15-Exhibit F-1-VESNIP Best Practice Report*]

Advisory Board website:
http://www.advisory.com/members/new_layout/default.asp?contentID=74334&collectionID=966&program=4

VUMC Nursing website – VESNIP
http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=18539

**Vanderbilt University School of Nursing Example**

Vanderbilt University School of Nursing has received a new $1.3 million grant from the Health Resource and Services Administration (HRSA) for faculty development in informatics, simulation and telehealth.

"*Today's nursing faculty are faced with the complex task of educating nurses for a world facing a workforce shortage, increasing patient complexities, and an ever-increasing dependence on technology for patient care, documentation and communication*," said Betsy Weiner, Ph.D., R.N., F.A.A.N., senior associate dean for Informatics at VUSN and principal investigator of the grant. "*On top of that, patient safety and quality are important priorities*."

According to the Institute of Medicine's 2003 report on health education, the education of health professionals is viewed as a bridge to quality care. This grant will address faculty development in areas that are both new to nursing and instrumental in meeting educational challenges. VUSN has partnered with the University of Kentucky on this project.

Plans include piloting the project in Kentucky and Tennessee, followed by a regional board representing sixteen Southern states with a high incidence of life-threatening diseases. The goal in the final years is to expand offerings to all nurse educators in the nation. The grant will run concurrently with Weiner's earlier $1.6 million HRSA grant for faculty development in simulation.