Accountability, Competence and Autonomy

Source of Evidence 20

Describe and demonstrate that nurses at all levels routinely use self-appraisal performance review and peer review, including annual goal setting, for the assurance of competence and professional development.

Overview

Please refer to Organizational Overview – Exemplary Professional Practice – Question 17 for examples of performance appraisal tools/ job descriptions, including peer feedback tools used for all levels of nursing across the organization.

At the core of VUMC's performance development system is our philosophy of continuously evaluating and improving job performance by developing and recognizing staff. This philosophy is designed to improve the quality of patient care, education and research. Developing and recognizing job performance plays a key role in relationships that enhance staff retention. Performance development supports our ongoing process to communicate goals and evaluate progress between staff and leaders.

The pay for performance appraisal system is designed to:

- Set clear measurable expectations
- Follow an annual cycle for ongoing feedback to support continuous learning, development and improvement
- Focus staff on doing the right thing
- Link individual performance to VUMC's goals
- Create a sense of shared responsibility and accountability between staff and leadership

Managers engage in ongoing assessment of employee performance based on standardized organizational and role specific competencies. The defined competencies range from behavioral to technical in nature. Job descriptions define the competencies for each role and serve as the foundation for the web based performance appraisal system, Vanderbilt Performance Evaluation System (VPES). VPES clearly defines performance expectations and promotes standardization in its deployment across the organization. Role specific competencies are an integral component of each staff member's performance evaluation and embody standards such as patient/customer satisfaction, teamwork, quality improvement and technical clinical competencies.

Our evaluation cycle consists of two parts for all employees: a mid-year discussion and an annual (end of year) discussion. This process includes nurses at all levels. Staff is evaluated on how well they meet the standards for:

- Credo behaviors
- Key functions of their job description
- Area specific standards
- Evaluation of progress toward goals set for the year

Performance is rated on a 1 to 5 scale, with 3 reflecting "meets standard". Annual performance based salary adjustments are given based on individual performance appraisal score. We use a peer feedback evaluation process.

The evaluation process for nurses at all levels includes several sources of data:

- Self-evaluation – completed electronically by the staff member using their job description/evaluation
- Peer evaluations :

  Direct Care Nurses - completed either electronically or on paper; the peer evaluation process is determined by each area and can be done individually or in a group setting with one person entering the data electronically. Peers are chosen both by the nurse and by the management team. They can include: same-shift peers and following shift peers.

  Nurses in leader and other roles - working with their leaders, peers are selected based on the role of the individual. Peers can include: direct reports, nurses in like roles, and leaders from other departments.

- Leaders (Manager/assistant manager/ supervisor, etc. (management team) – completed electronically by the manager or management team utilizing the feedback from the staff member's self and peer evaluations

The annual performance appraisal process is the opportunity for the staff to complete a self assessment as well as receive management and peer feedback. Open dialogue highlights strengths as well as areas for improvement. As the final component of the appraisal process, staff evaluates previous goals and develops new goals for the upcoming year. All of this is recorded in our electronic system VPES.

Newly hired or staff who have transferred to a new area receive feedback on 30, 60 and 90 day cycle. In addition, as stated previously, all staff has conversations with their managers at the mid-year (180 days) mark to assess progress toward goals [*EP20-Exhibit A-1-Orientation follow-up 10-15-09, EP20-Exhibit A-2-Mid Year conversation 10-15-09, EP20- Exhibit A-3-Education Plan 12-21-09, EP2—Exhibit A-4-Education EKG Plan 5-21-10*]. Other examples of these early feedback conversations are provided in this section.

Brief Summary of Vanderbilt Professional Nursing Practice Program Advancement Structure

Registered Direct Care Nurses

The Vanderbilt Professional Nursing Practice Program (VPNPP) is a dual program that is used for annual nursing evaluations and recognition of work toward professional advancement. All registered nurses are classified as RN1, RN2, RN3, or RN4 with classifications adapted from the novice-to-expert model described by Patricia Benner. The novice and advanced beginner categories described by Benner have been compressed into the RN1 category. *(Details in OO 17)*

Licensed Practical Nurses

In April 2009, the Nursing Bylaws Council amended their position to describe and include licensed practical nurses as fully recognized members of the nursing staff. With this change in place, an LPN task force was convened which included administration, education, and practicing LPNs. Focus groups were conducted to determine what type of measurement indicators and metrics describe our current LPN practice. The focus groups also guided knowledge acquisition toward development of an LPN professional ladder. Results from the focus groups were collated and presented to the LPN task force. Results indicated that a modified version of the current VPNPP ladder could be supported. Categories described by Benner's novice-to-expert model have been modified from the RN tools to the LPN tools, resulting in classifications of LPN1, LPN2, LPN3, and LPN4. *(Details in OO 17)*

Brief Summary of VPNPP Advancement Process

Registered Nurse and Licensed Practical Nurse

The process for advancement is the same for all inpatient, outpatient, procedural, and operative nurses at the Medical Center. All nurses seeking advancement from their current level to a higher level:

1. Submit a request to advance to their unit/area manager

2. Managers review the request and determine if advancement can be fully supported; supported with behavior and/or practice changes; or not supported.

3. For any decision beyond "fully supported" an action plan is created with the nurse to describe areas for future growth and to guide future advancement attempts.

4. Once the manager is in agreement with an advancement request, the current evaluation is converted to an advancement packet at the requested level (RN3, RN4, LPN3, and LPN4).

5. Specific metrics that relate to those roles are completed by the applicant, the applicant's peer(s), and the manager via practice examples and exemplars.

6. For those applying to level-4, a Health Care Team endorsement is also required.

7. Once these sections have been completed, the applicant will submit an on-line packet to the VPNPP program coordinator and program manager who will review and distribute the packet to members of the VPNPP Central Committee for review.

8. The VPNPP Central Committee which has RNs 3 and 4 as members serves as a further peer review point (in addition to their workgroup peers) for nurses going through the advancement process.

9. Select representative of the VPNPP Central Committee (including RN 3 and 4) meet with the applicant; and have a dialogue which includes nine specific questions that address:

    - utilization of the nursing process,
    - cost-effectiveness of care planning
    - resource management
    - Involvement in evidence-based practice changes
    - quality improvement initiatives
    - involvement in shared-decision making activities
    - leading interdisciplinary efforts

    The Central Committee members then present the applicants' work to the full committee who votes on whether the examples meet the criteria identified for

advancement [*EP20-Exhibit B-1-VPNPP Central Comm Roster 8-30-10, EP20-Exhibit B-2 VPNPP Steering Comm Roster 8-30-10*].

NOTE: The VPNPP advancement process is electronic to support easier submission of materials. Also, when nurses advance, that information is posted on the Vanderbilt Nursing Website.

Table EP 20 – 1: VUMC Current numbers of RNs 1-4

Job Title	Total
Registered Nurse 1	12
Registered Nurse 2	2040
Registered Nurse 3	249
Registered Nurse 4	34
Grand Total	**2335**

Table EP 20 – 2: VUMC Advancement Activity for last 2 years for RN 3 & 4

Year	VUH	MCJCHV	VPH	TVC/VMG	Total Advancements
7/07 – 6/08	17	20	6	10	53
7/08 – 6/09	28	38	14	20	100
7/09 – 6/10	46	24	7	3	80
7/10 - Present	5	2	0	2	9 (+7 in queue)

Year	RN 3 Advancements					RN 4 Advancements				
	Inpt	Outpt	Procedural	Operative	TOTAL	Inpt	Outpt	Procedural	Operative	TOTAL
7/08 – 6/09	55	21	4	15	95	3	0	2	0	5
7/09 – 6/10	43	3	11	13	70	5	0	3	2	10

7/10 – Present	5	1	0	1	7	1	1	0	0	2

Examples (Complete information/forms available on site)

Following are several examples of how nurses at all levels routinely use self-appraisal performance review and peer review, including annual goal setting, for the assurance of competence and professional development. In some situations, names are not used; however, full documentation will be available onsite.

VUH

Direct Care Nurse A from VUH Critical Care Unit

Direct care nurse received peer feedback that she needed to improve her clinical skills with no real specific examples. She went to her manager for assistance in establishing goals to improve her performance and influence her peers' perception of her performance. The goal that was established was, "***To become visible as a clinical leader by seeking out opportunities to improve knowledge and skills, request complex patient assignments and become more involved in improving unit performance".***

Specific action steps to meet this goal included:

- Request more complex patient assignment from the charge nurses
- Work with the nurse educator on more opportunities to act as a preceptor
- Request routine feedback from peers and leadership regarding her performance
- Remind the Charge Nurses that she had been trained to be an Rapid Response Team (RRT) responder
- Take the Continuous Renal Replacement Therapy Course (CRRT – skill level would include more complex procedures)
- Become more actively involved in unit committee work
- Act as a resource and share her knowledge with her peers

Outcome:

- Took the CRRT course and started providing care for those patients
- Attended preceptor retreat/training and to date has acted as a preceptor for six nurses and two students
- Is regularly assigned to the RRT/Help All Role
- Active participant on the CLABSI unit improvement team – doing 1:1 rounding/coaching with her peers and conducting product review for IV and central line products that could improve performance
- Assumed the role of chair for the preceptor committee
- Developed and presented content on Minnesota Tubes at a unit- based education day for new nurses and care partners
- Is being assigned to complex patients and is a resource for her peers
- Working on advancement to RN 3 – evaluation and peer feedback supports her pursuit of RN 3

Assistant Nurse Manager D from VUH

Using self and peer appraisal feedback to develop professional development goals to move into an assistant nurse manager role was key to D's success. This nurse was in a charge nurse role and set a goal for increasing knowledge base to help develop leadership skills to more effectively and efficiently serve as a leader.

Steps that were outlined included:

- Taking the S3 and emergency preparedness training
- Reflection on previous leadership experience and training – take those principals and apply them to his current charge nurse role
- Ask an experienced charge nurse to be a mentor
- Continue to function in the Help All role for clinical skills and use the time to lead by example
- Re-read "The Seven Habits of Highly Effective People" by Steven Covey

- Continue to support the shared governance model as co-chair of the unit board and mentor a new co-chair

- Seek opportunities to take on new responsibilities which could be challenging and build new skills – taking lead in family conferences and as the unit move coordinator to the new Critical Care Tower

Outcome:

With coaching and mentoring, D was very successful in meeting these goals. D quickly gained the respect and appreciation of the staff and applied for and was chosen as an assistant manager for the unit.

Nursing Manager A in VUH

Nursing manager A received high scores in the September 2009 community survey – some of the highest in the organization. Almost 90% of the unit staff completed the survey. A focus group was held to dig deeper into comments and identify if there were any opportunities for improving the performance of this already high-performing nurse leader. The area that was identified as an opportunity for helping improve this leader's organization was in the area of improving accountability for performance improvement. Conversations with this leader demonstrated difficulty with developing a performance improvement philosophy within her team that focused on systems improvements and staff development rather than focusing on negative or punitive measures.

As a leader who is lives the Vanderbilt nursing philosophy of shared governance, this manager assures that a robust process of peer feedback occurs within her department for her staff members. For the 2009-2010 performance evaluations for the leadership team, the Administrative Director requested feedback from those who report directly to the manager, physician leader and the charge nurses. This manager received many, very positive comments about all areas of her leadership style and unit management. The suggestion for improvement from several members of the team indicated that the unit might benefit from a more comprehensive approach and philosophy about performance improvement within the leadership team – not totally depending on the manager for coaching and mentoring when there are identified concerns.

As a result of the feedback from the community survey and conversations about how to improve the culture of accountability in this manager's unit, this manager decided to adopt

David Marx model of "just culture" for working toward improvements. She identified this as a goal prior to coming in for her formal performance evaluation conversation. The desire with adopting this philosophy is to improve the overall awareness of patient safety philosophy as well as commitment to provide and accept feedback as this unit rolls out quality and patient safety initiatives. Along with shared responsibility for decision-making there is shared responsibility for creating safe systems and coaching others when they slip into "at risk" behaviors. This team will welcome two additional members in 2010, one assistant manager hired in April and a second assistant manger that will be hired this summer. This is an excellent opportunity for this manager and the team to learn and grow in the important area of staff accountability to quality, service, and safety.

An additional piece to the puzzle will be looking at the AHRQ culture of safety survey results. This survey was available to staff to complete in March and April of 2010. This year feed-back from this survey were sent to the entire team including staff and leaders. The results of this survey may provide opportunities to have conversations about the importance of patient safety, may provide some measure as to whether all staff knows that safety is valued in the organization, and identify whether members of the team feel ownership to continuously look for risks that pose a threat.

The success of whether adopting this model will assist the manager in developing a just culture in her unit will include:

- Activities within Unit Board, Best Practices Committee and other unit-based teams focusing on improving feedback processes and points at which issues need to be elevated to leadership
- Peer feedback
- Improvement in quality scores such as Central Line Associated Blood Stream Infection

http://www.ismp.org/newsletters/acutecare/articles/20060921.asp

"Our Long Journey towards a Safety- Minded Just Culture." ISMP Medication Alert, September 21, 2006.

Advancement to Assistant Administrative Director A – VUH

One of the nurse managers had a goal to broaden his leadership through committees and projects outside of his unit and work toward advancing to a higher leadership level. In a mid-year conversation with his Administrative Director, they discussed his professional

development. As previously discussed, A had taken on responsibilities outside of his unit, including: leadership in the VUH Expansion Project, serving as a nursing representative for a new pharmacy system and serving as the co-chair for a quality initiative. He had also been working on enhancing his leadership and communication skills through a training program.

In the annual evaluation, A further identified a goal that would be helpful in assessing his growth with his leadership skills. He identified a trusted peer mentor who could provide regular feedback on progress and perception. Already a respected leader, these conversations and goals enhanced his ability to advance and A is now as assistant administrative director.

Peer Review Example for Direct Care Nurse in Burn Unit – VUH

"A took care of a critically ill patient in room XXXXX with CEA grafts. She delegated appropriately and concisely and instructed the other RNs where invasive lines were, where she wanted care partners, RNs and respiratory therapy to be placed and would also instruct them and do a "time out", before rolling the patient. The patient's wife was beyond satisfied with the care A gave her husband and requested her multiple times. A helped teach other staff members about the CEA grafts and would provide materials to family members.

She also educates patients (if appropriate) and family members on why patients might need to be restrained and why it is so important to protect medically necessary devices. If completing wound care on the night shift, she will educate the patient and family members on why she is doing a dressing change, what goes where and will encourage them to participate if appropriate.

As a team leader, she does a really effective job and triages appropriately. She is able to delegate appropriately, and also directs staff members and keeps them up-to-date on situations. As a team leader, she acts as a resource and does a fantastic job of making sure that her team is OK – that we have all the necessary tools to complete our shift and if they need help.

She rounds constantly to make sure all members of the team are on target and if not, will try to delegate to ensure that everyone is able to complete their job effectively and efficiently and leave on time. As a team leader, she walks around and talks with patients and families to make sure that the healthcare team is doing the best possible job they can.

She was really amazing with the family members of a large burn that decided to withdraw care on the patient after resuscitation was attempted. She was empathetic, told the

family what to expect, and made every attempt to allow the family to be with the patient when he died."

30 & 90 Day Conversation Example- Direct Care Nurse on Surgical Unit 9 South – VUH

A. came to the unit as an experienced nurse. The information below is from her 30 and 90 day check-in conversations.

"A told us that everyone has been helpful and made her feel welcome. She said that the patient care is what she expected, but that she needed time to adjust to our computer systems. She really enjoys the patient population though it is busy a lot of nights. She recognized on of her preceptors, Maria Martinez, RN saying that she is wonderful. All of her passwords are working and her only concern at the time of this 30 day conversation is adapting to the computer charting – which she said will just take time.

At her 90 day conversation and evaluation meeting, A indicated that the unit and the work still matched what we said during the interview process. She said that it is still very busy but she is becoming more comfortable with the systems and workflow. She again said that she feels everyone is helpful. I relayed to her that we felt she is doing a great job; the feedback received from the charge nurses, the senior nurses and the care partners all indicated the she is doing well and is a positive team member."

Peer Review Process Example from 9 South Surgical Unit – VUH

The method for the peer review process on 9 South incorporates an open ended call for feedback about performance and areas for improvement. The difficulty in getting a large group of staff together for the amount of time needed to complete the evaluation process proved to be a challenge, so we came up with a system that allowed peer feedback while not being over burdensome in a time requirement.

To accomplish this we used the groups for self scheduling in VandyWorks as a template for how to assign the peer evaluations. The charge nurses names were added to each list to get a broader field of input for their performance; so the list that each staff member was assigned included a total of 21-22 staff members mixed between both day and night shift employees. This was an improvement based on staff feedback from the previous year where every staff member had the opportunity to comment on every other staff member which was about 64-65 people. The staff felt that it was too daunting to work on that many, so we went with the smaller assignments of about one-third of the staff on the unit.

Another change from the previous year is that rather than listing out every key function and every credo statement, we left the comments more open ended because again the staff felt that going through each of the points under each key function and credo statement was too burdensome. The staff seemed to like it better that their comments were confidential when they either turned them in or returned them electronically to the management team. The evaluation statements garnered from the staff members were then incorporated into the management evaluation.

We also got the charge nurses together as group (split between dayshift and nightshift) to complete the management evaluation in order to get feedback from the supervisory perspective. The evaluations of the charge nurses were largely congruent with the evaluation statements collected from the staff. Where there were specific issues addressed by the charge nurses and managers to which other staff members were not privy, that was also considered in determining overall performance and affect on the team.

Table EP 16 – 3: Examples

Nurse 1	• Efficient, always willing to help others. • Really good nurse, always willing to help • Kind of high strung in the AM during reporting time. Anything and everything throws her off • Takes patient care serious, answers call light and phone calls promptly • Quiet, gets her job done. Her patients are always ready for discharge. Good teacher • Good nurse, very friendly with patients and family • Great nurse, knowledgeable and efficient • Great resource for RN's. She works hard to get what patients need and her care is very thorough. She manages time well with high activity patients. • Great with patients. Have heard many good remarks from her patients regarding her care during her shift. I remember a vascular patient in room XXXX who was a DNR; the patient and family told me that A took great care of their father and that they felt she really cared for the patient. The son was FNP from Atlanta, was in town during Thanksgiving one year and camp up to 9 South and left A a thank you note and gift card to a restaurant. • Never leaves things to be done, patients are never left in a mess. Always on time for report and report is always thorough and informative.	• Needs to communicate more with CP's • Needs to keep her nerves under check in the AM • Not always friendly to night nurses in the morning • Can sometimes be a little intimidating, especially to new-comers and students. Her attitude changes a lot.
Nurse 2	• Keeps busy, always willing to help me. Answers questions • Really liked working with her as a CP • Better than last year during taking and giving reports. Tries to complete her work before leaving • Attitude is 100% better. A is a good nurse, enjoy working with her	• Can let her frustrations show through her attitude. She sometimes

Mid-Year &VPES Annual Evaluation and Goals Example from Neuro ICU – VUH

Mid year conversation fall 2009 and annual performance review spring 2010 with nurse K identified in the review that K is a strong informal leader in the unit. She has over 5 years of experience on the unit and fills in as team leader on the weekends in the absence of the charge nurse. She is strong clinically and is utilized as a resource person on the unit.

K was unaware of her leadership potential and the avenues available to her. At her mid-year conversation in the fall of 2009 she stated she had been thinking about the idea of unit board chair. K was encouraged to explore the role and in January 2010 B began her Shared Governance leadership role as the Unit Board Chair.

In her annual performance review – K and I discussed her growth in this new role. K was encouraged to take the CCRN certification course. She did and passed the exam in July 2010. K has been very involved in Staff Council and brings her enthusiasm back to the Unit Board meetings every month. She has brought many ideas for improvement which includes:

- Maximum Number of preferred off shifts/schedule: as a result, the unit passed a maximum number of preferred off shifts at 6 per 6 week schedule for all staff. The response from the staff has been positive – much better than the previous "first come/first receive" approach.

- Drink Stations for the Neuro ICU: this was to keep us compliant with EOC, but at the same time have staff feel like they could take a break and remain in close proximity to their patients due to the size of the unit. The process was presented at Unit Board and other areas were investigated to determine practice. MICU had approved "Drink Stations" so we adapted their process and identified 3 areas in the unit as "Drink Stations", in addition to the break room. The "stations" were located in cabinets so drinks would be visible and were for covered drinks only. We are trialing this now and there have been no issues with compliance. On the EOC survey in July – there were no drinks found outside of approved areas.

Our coaching/mentoring process has not only helped one staff member find her leadership potential, it has also benefited the unit and the staff. Unit Board attendance is up and great things are happening in many areas.

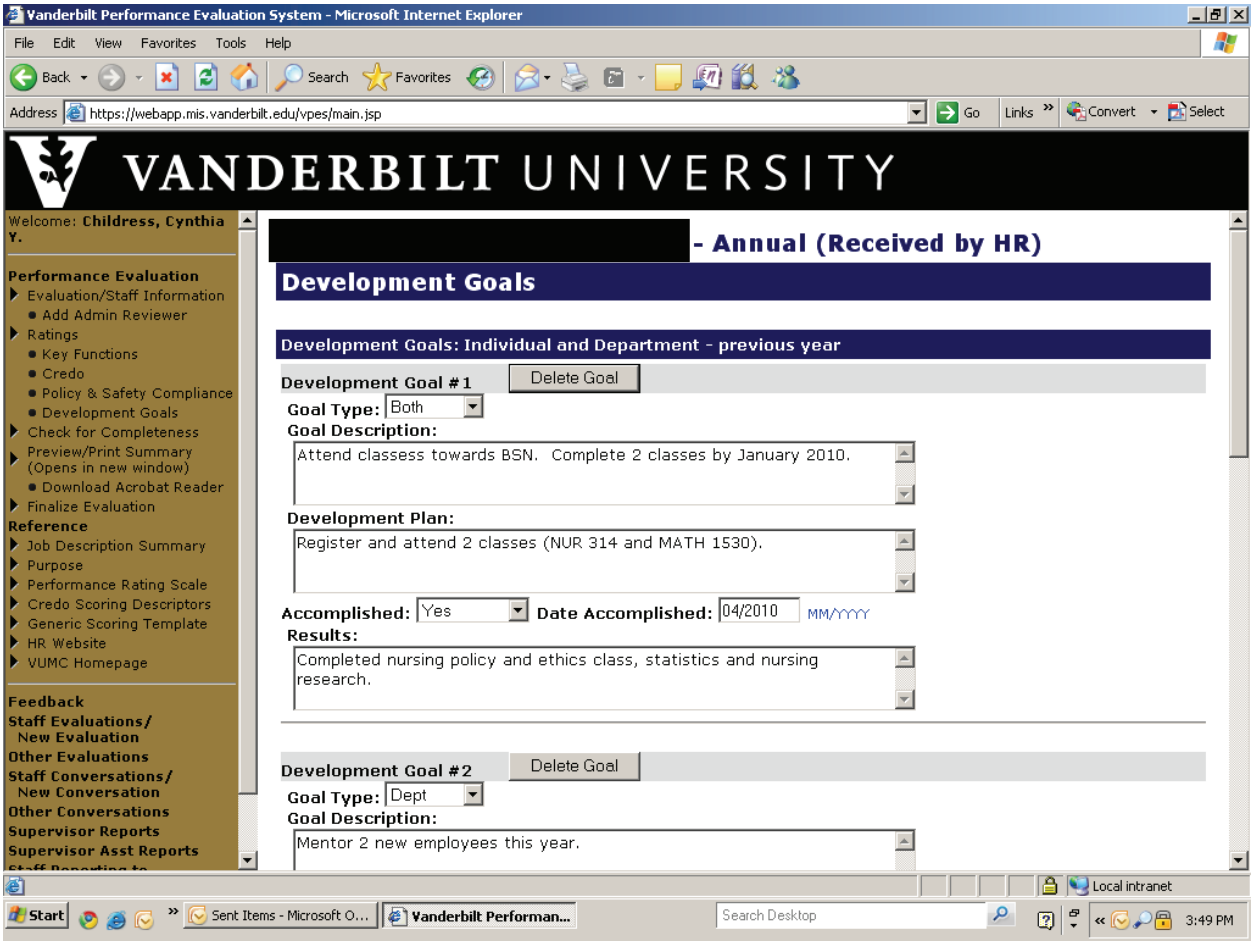
Setting and reaching goals example from Colorectal/General Surgery Unit – VUH

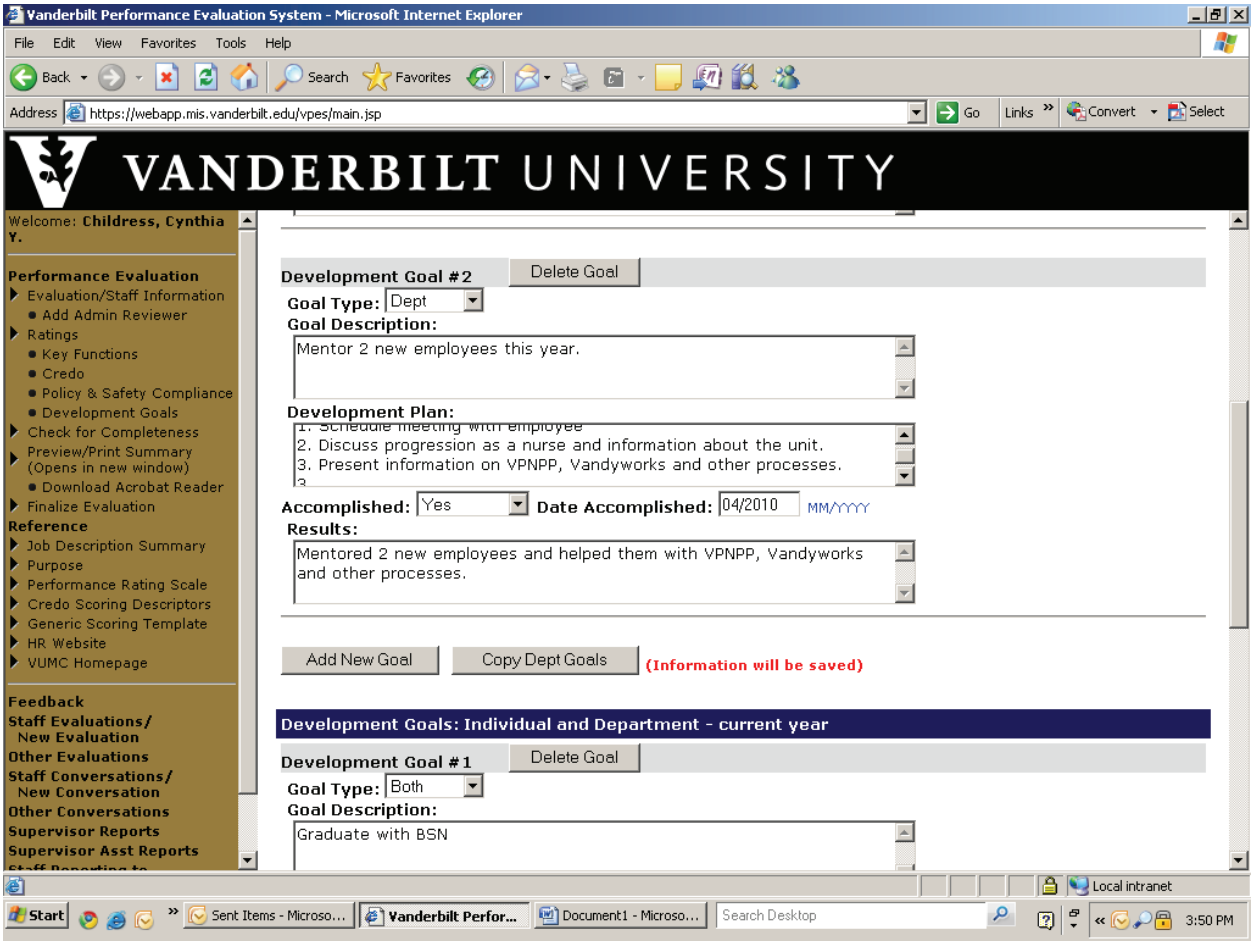
During annual performance conversation, A set goals to:

1) Complete her BSN (will graduate the end of this year)
2) Mentor and coach 2 new employees
3) Coach new staff on the VPNPP Process
4) Present topics of education

Below are copies of the VPES Goals.

Table EP 16 – 4: Screen Shots VPES


Vanderbilt Performance Evaluation System - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address https://webapp.mis.vanderbilt.edu/vpes/main.jsp
Go Links Convert Select
VANDERBILT UNIVERSITY
Welcome: Childress, Cynthia Y.
Performance Evaluation
Evaluation/Staff Information
Add Admin Reviewer
Ratings
Key Functions
Credo
Policy & Safety Compliance
Development Goals
Check for Completeness
Preview/Print Summary (Opens in new window)
Download Acrobat Reader
Finalize Evaluation
Reference
Job Description Summary
Purpose
Performance Rating Scale
Credo Scoring Descriptors
Generic Scoring Template
HR Website
VUMC Homepage
Feedback
Staff Evaluations/ New Evaluation
Other Evaluations
Staff Conversations/ New Conversation
Other Conversations
Supervisor Reports
Supervisor Asst Reports
[redacted] - Annual (Received by HR)
Development Goals
Development Goals: Individual and Department - previous year
Development Goal #1
Delete Goal
Goal Type: Both
Goal Description:
Attend classess towards BSN. Complete 2 classes by January 2010.
Development Plan:
Register and attend 2 classes (NUR 314 and MATH 1530).
Accomplished: Yes
Date Accomplished: 04/2010 MM/YYYY
Results:
Completed nursing policy and ethics class, statistics and nursing research.
Development Goal #2
Delete Goal
Goal Type: Dept
Goal Description:
Mentor 2 new employees this year.
Local intranet
Start
Sent Items - Microsoft O...
Vanderbilt Performan...
Search Desktop
3:49 PM


Vanderbilt Performance Evaluation System - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address https://webapp.mis.vanderbilt.edu/vpes/main.jsp
Go Links Convert Select
VANDERBILT UNIVERSITY
Welcome: Childress, Cynthia Y.
Performance Evaluation
Evaluation/Staff Information
Add Admin Reviewer
Ratings
Key Functions
Credo
Policy & Safety Compliance
Development Goals
Check for Completeness
Preview/Print Summary (Opens in new window)
Download Acrobat Reader
Finalize Evaluation
Reference
Job Description Summary
Purpose
Performance Rating Scale
Credo Scoring Descriptors
Generic Scoring Template
HR Website
VUMC Homepage
Feedback
Staff Evaluations/ New Evaluation
Other Evaluations
Staff Conversations/ New Conversation
Other Conversations
Supervisor Reports
Supervisor Asst Reports
Development Goal #2
Delete Goal
Goal Type: Dept
Goal Description:
Mentor 2 new employees this year.
Development Plan:
2. Discuss progression as a nurse and information about the unit.
3. Present information on VPNPP, Vandyworks and other processes.
Accomplished: Yes
Date Accomplished: 04/2010 MM/YYYY
Results:
Mentored 2 new employees and helped them with VPNPP, Vandyworks and other processes.
Add New Goal
Copy Dept Goals
(Information will be saved)
Development Goals: Individual and Department - current year
Development Goal #1
Delete Goal
Goal Type: Both
Goal Description:
Graduate with BSN
Local intranet
Start
Sent Items - Microso...
Vanderbilt Perfor...
Document1 - Microso...
Search Desktop
3:50 PM

VCH

Direct Care Nurse BC from VCH – 6 Hematology/Oncology

B had set a personal/professional goal to achieve RN 3 status. This goal was set and a plan developed in her annual evaluation. She was already on the road to success as a strong clinical nurse with a positive approach and was a great team player. B had already been instrumental in bringing the two day Association of Pediatric Oncology Chemotherapy and Biotherapy Workshop to VCH. She had also begun the development of an in-service for a complicated antibody study by collaborating with the physician and bringing the information back to the staff. She went on to develop an informational sheet in order to simplify the process for the staff.

The manager and B met two other times to discuss her progress and prepare the documentation. Her evaluation was converted to an advancement packet and submitted for advancement review. Successful in her challenge for RN 3, she has now been asked to serve on the VPNPP Central Committee. B has also helped coach two of her peers through the advancement process. [*EP20-Exhibit C-1-VCH Hem-Onc Feedback, EP20-Exhibit C-2 VCH Hem-Onc Goals*]

Children's Hospital – Director

From Barbara Shultz RN, BSN, Director Integrated Service Line

A was the Assistant Manager in the Pediatric Emergency Department. She and Barbara (her manager at the time) identified a couple of her strengths as being analytical and skilled at reviewing situations or problems in a root cause analysis manner. Over a two year period of time, A identified what her long-term goals were. She was interested in quality work – either as trauma program coordinator or nursing quality. As A was finishing her master's degree, they developed a career path that would give her exposure to the right people and the right work experience to build her skills.

A lead many initiatives in the PEDS ED including, trauma documentation quality review, policy and procedure development, CHCA Collaborative, back to the bedside initiatives, and many others. Many of these initiatives reached outside of the PEDS ED. As a result, she enhanced her skills and quickly established herself as a resource for analysis of evidence-based nursing practice. Peer feedback showed that A had become a "go to person". As a result of the self-appraisal performance review and annual goal setting, A is now the Manager of Nursing Quality for Children's Hospital.

Peer Review and Mentoring for Advancement

Several areas have instituted mentoring groups/committees to support their peers advancing in the Vanderbilt Professional Practice Program (VPNPP). Some examples are below:

Children's Holding Room and PACU

Leighann Chadwell, RN 3 CC, BSN formed a mentor committee to enhance peer feedback and support advancement through the Professional Practice Program. Meeting monthly, the group fosters formal mentoring by RN 3's and 4's for the staff. A VPNPP notebook was designed by one of the RN 3's to assist in understanding and organization. Journaling was also encouraged as a way to track progress. VPNPP question reviews and mock interviews provided practice for those advancing. Since the formation of the committee, 12 nurses have advanced and 3 are currently on track.

In addition, the mentoring committee has now broadened their scope to include unit culture, orientation, quality and hospital committees. This peer review and mentoring committee play an important role in several initiatives in VCH HR and PACU.

The Quality Patient Care and RN 3 model is a tool developed to describe the expectations the committee has for all RN 3's on our unit. The model includes behaviors such as teamwork, customer service and skill set.

The Mentor Committee plays an active role in unit socialization. Mentor committee members are paired with new staff to facilitate socialization into the unit. Evidence supports that socialization and group cohesion are significant in nurse satisfaction and retention.

Since the creation of the Mentor Committee, vacancy rates for our unit have decreased. VCH Holding Room and PACU nurse satisfaction scores in the area of Job Enjoyment have increased. On the Community Survey, overall satisfaction scores have improved by 10% from 2007 to 2009.

The Mentor Committee plays an important role in our unit. The success of the group has impacted the number of staff that has completed the advancement process.

Changing the Peer Review Process – 7th Floor VCH

Creation and implementation of a **group peer evaluation process** that meets the needs of both staff and management team and spreads across the organization

The nursing staff and managers were dissatisfied with the process for doing peer evaluations. The task was a time consuming one that the staff had difficulty completing and which yielded inaccurate results. Each RN was assigned 4-5 co-workers on whom to complete a peer evaluation. These were done independently via an on-line forum and then submitted to the management team electronically. The evaluations were reviewed by a member of the management team, with scores being compared to the examples given. If the examples did not adequately support the generated score, the evaluation would be sent back to the evaluator for revisions. This led to increased frustrations for the staff nurses and a lack of trust for the process and in their management team. There was also an extraordinary amount of time spent on each individual evaluation.

The leadership team created, planned and implemented the first group peer evaluations with input from the staff. The charge nurses and staff nurses participated in the first pilot group peer evaluations and offered feedback (including positives and opportunities for improvement). Most importantly, they were committed to improving the process and finding a solution that would work. After the first try, the group assessed and revised the process.

The nurses came together in one location at the same time and were grouped by pod and by shift (ex. 7A dayshift nurses met together; 7A nightshift nurses met together). With the guidance of a facilitator, the group collectively completed the on-line evaluation tool on each nurse from that pod and shift. Charge Nurses then met separately to evaluate staff, utilizing the CN/Manager Tool. The facilitator was carefully chosen and her role was specifically designed to educate the staff on the evaluation process, performance evaluation (i.e. competent and independent vs. proficient and role model), framing opportunities for improvement in a positive manner and to keep the process moving to ensure completion of all evaluations.

Outcomes

The staff:

- Reported greater satisfaction with the process
- Reported that it was helpful to share opinions/observations and come to a consensus rather than doing the evaluation alone
- Expressed their trust in the process and the feedback obtained/given on them personally

- Voiced a better understanding of the evaluation tool and their ability to differentiate between varying levels of performance (i.e. what an RN 2 "looks like" vs. an RN 3 or 4)

Currently, the process has been expanded to include Care Partner evaluations.

The group process was duplicated by the 6th and 8th Floors in VCH. Group peer feedback was also introduced to the rest of VCH and VUH. The 7th floor of VCH has served as mentors to adult counterparts to educate them and answer questions on the group feedback process. *(See clinic example in this section)*

Goal set for RN 3 Advancement by nurse on 6th floor – VCH

R expressed a desire to challenge the clinical ladder in her annual evaluation. Her manager discussed the process with her and outlined a plan for the areas that she would need to work on over the next 6 months. R and her manager held regular meetings to check her progress. During the mid-year conversation, R was ready to begin finalizing the process of advancing to RN 3.

R completed her self evaluation and two peers evaluated her performance for advancement. R challenged the ladder for RN 3 and was successful in February 2008. She continues to function at this level. [*EP20-Exhibit D-1-VCH Hem-Onc Peer Eval 2-14-08, EP20-Exhibit D-2-VCH Hem-Onc Peer Eval 2-13-08, EP20-Exhibit D-3-VCH Hem-Onc Mid Year Conversation 12-18-07*]

VPNPP and Certification Moves in the PCCU

In the PCCU professional growth was identified as a goal that improves staff satisfaction and quality of care. Staff conversations showed that many of the staff believed the VPNPP advancement process was cumbersome or they just did not understand it and they really wondered about the value or CCRN certification. A plan was developed to address these issues.

First on the agenda was basic education. Education to increase the understanding of the VPNPP advancement process and remove perceived barriers. For the CCRN certification, staffs were supported to attend the CCRN Review Course provided by VCH on-site.

Once a couple of staff had advanced and received their CCRN, then they acted as resources and mentors for the other staff. That was an even bigger motivator than the words of encouragement that came from the leadership team.

PCCU went from 1 RN3 to 10 RN3s. Thirteen PCCU staff received their CCRN over the last year and others are currently preparing to take the exam. Excellent results from leadership and peer professional development mentoring.

Vanderbilt Psychiatric Hospital/Respond

None of the nurses in Respond had advanced through VPNPP. A group came together as a mentoring group for each other. They completed their in-depth self-evaluations and conducted peer reviews for each other as in the annual evaluation process. They set annual goals for improvement. They met 1-2 times monthly and attended the 3 hour VPNPP training program. All 4 members of the group advanced to RN 3 and continue to mentor others. Two of the group have become members of the VPNPP Central Committee and participate in RN 3 and 4 advancement interviews. Members of this initial group included: Barbara Holmes, RN, MSN, Susan Russell, RN, MSN, PhD, Marilyn Henning RN, Shirley Qiao, RN, MSN assisted by Lori Harris, RN, BSN, Nurse Manager at VPH.

Clinics

Children's Clinic (DOT) Nurse sets and reaches advancement goal

Nurse A in one of our Children's Clinics set her goal to advance to RN 3 in 2009. She was already working toward that level, so she and her manager were able to start her on the path to her goals. At her 2010 evaluation, she had accomplished her goal. [*EP20-Exhibit E-1-VCH DOT Goals 2009, EP20-Exhibit E-2-VCH DOT Goals 2010, EP20-Exhibit E-3-VCH DOT Letter*]

Nursing Manager A in VMG Clinic

One of the clinic managers identified during the initial 6 month (mid-year) evaluation the need for further training in relationship building, particularly with physician colleagues. Supervising multiple sites was challenging because the physician assignment varied daily as well. She wanted further training that would improve her confidence in her role performance and enable her to address issues proactively rather than reactively which in turn reinforced with physician staff a lack of confidence in her ability as a manager. The specific key functions this addressed are below.

Building Relationships: Team Building, Showing Support, Conflict Prevention and Management

- **Builds, maintains and supports a culture that fosters effective working relationships**

- **Utilizes and models Credo behaviors to build relationships and mange conflict within scope of responsibility**

- **Identifies service recovery strategies the preserve individual dignity**

At this time, not unique to this manager, VMG Williamson had embarked on a series of training modules designed to enhance the leadership skills of all managers. Example of content included: Leading through Change and Transition, Improving Team Performance, and Asking Questions –A Powerful Leadership Tool. This leadership series demonstrated not only Vanderbilt's investment in the manager, but a corresponding investment expectation by senior leaders toward the target audience. Content matter experts delivered content and at the close of each module, a senior leader presented real time examples to the group with the demonstration of how the content applied to their role in the organization.

The decision to develop and offer this leadership series was based on the type of feedback from managers as noted above during self appraisal and goal setting. Another driver for this program was feedback from managers on the community survey and deficits identified by senior leaders. Feedback from this leadership series was positive with a significant level of satisfaction with the content and its applicability to the manager role.

Manager A, as discussed above, also indicated a high level of satisfaction and improved ability to provide leadership which impacted this manager's self-appraisal of her strengths and weaknesses. For this particular manager, the Leadership Investment Series prompted a level of self assessment that led to her re-evaluation of her role as a manager. She ultimately decided that leadership was not her career path.

Changing the Peer Review Process in Outpatient Cardiology (Lessons learned from Children's Hospital)

From the results of the Community Survey, the Cardiology Clinic nurses were dissatisfied with the process of peer review for evaluations. One of the problems identified was that peer evaluations when assigned to individuals were lacking constructive examples and feedback for improvement. They decided to take the learnings from Children's with group peer review and apply that process. Working with Connie Ford RN, MHA, CPON, who has an outpatient clinic in Children's and is part of the VPNPP committee, the Cardiology Clinic revamped their peer review process.

For Cardiology, the subgroups were naturally divided into related work groups; Interventional clinic, General Cardiology clinic, etc. a total of 7 subgroups. The staffs were given hard copies of the Credo, the peer evaluation for review prior to the meeting. We also used a "safety contract" that was signed to ensure that what was said during evaluations was not shared outside of the meetings. One person would step out of the group and the remainder would answer the peer evaluations. Also, the team was asked for a focus to work on.

Initially, some of the staffs were uncomfortable with the process. As we continue to refine the process, their comfort level has improved. One of the successes has been that 4 staff members have achieved RN 3 status. [*EP20-Exhibit F-1-Peer Feedback Tool, EP20-Exhibit F-2-Ground Rules for Feedback, EP20-Exhibit F-3-Giving-Receiving Feedback, EP20-Exhibit F-4-Eval Scoring Descriptors, EP20-Exhibit F-5-Suggestions for Giving-Receiving Feedback, EP20-Exhibit F-6-Overview of Performance at Level, EP20-Exhibit F-7-Rephrasing Negative Feedback, EP20-Exhibit F-8-Credo Behaviors*]

Ethics, Privacy, Security, and Confidentiality

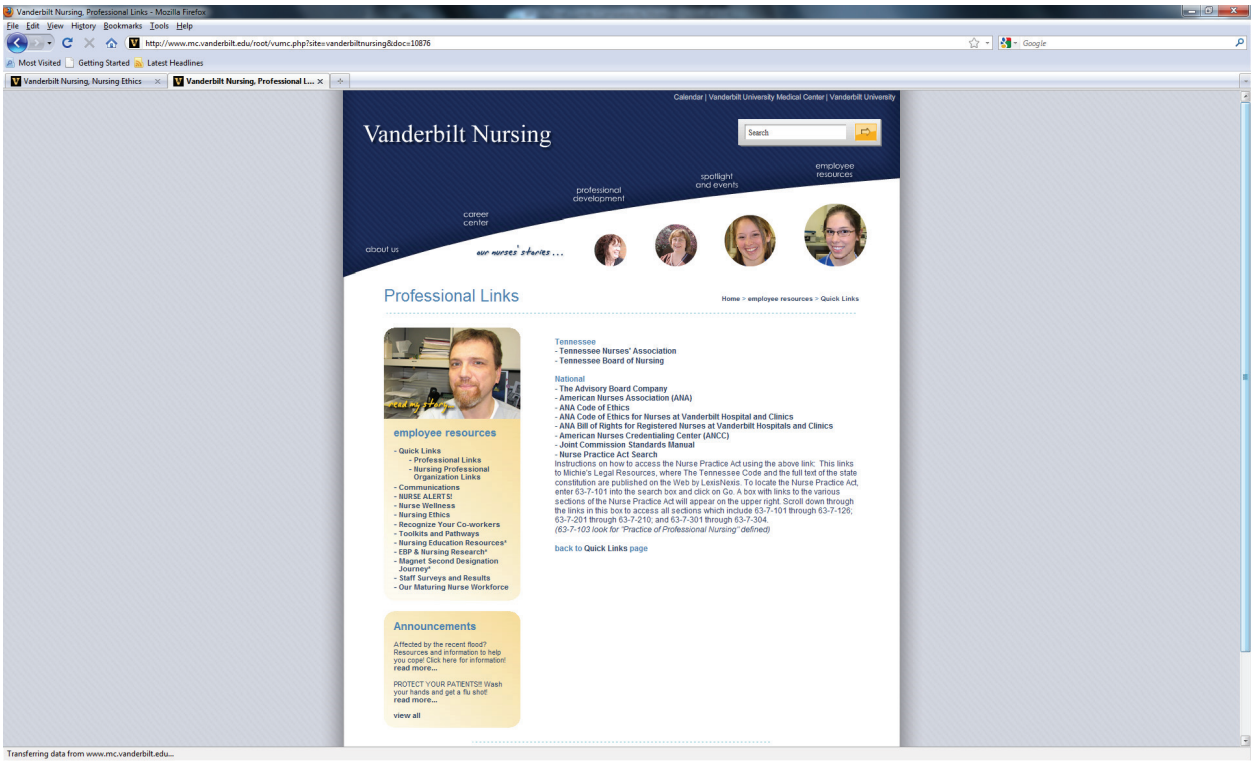
Source of Evidence 23

Describe and demonstrate how nurses use available resources, such as *the ANA Code of Ethics for Nurses (American Nurses Association, 2001b)*, to address complex ethical issues. Provide examples from different practice settings.

As the acuity of our patients has increased and advancements in technology have improved, the health care team is faced with questions that can create moral distress. At VUMC we have worked to create structures, processes and resources to support the nursing staff and the healthcare team. Please refer to Organizational Overview – Question 19 for policies, procedures and resources that are in place to assist staff in addressing ethical issues. Information was provided about our Clinical Ethics Consultation Service and Ethics Committee.

In addition, the *ANA Code of Ethics for Nurses with Interpretative Statements (American Nurses Association, 2001b)* and other professional resources, such as the Tennessee State Nurse Practice Act are readily accessible to the staff from Professional Links on the Nursing website.

Table EP 23 – 1: Screen Shot Nursing Website



Nurses at all levels across the Medical Center take part in activities sponsored by the Medical Center Ethics Committee and access services provided by the Center for Biomedical Ethics and Society, including the Clinical Ethics Consultation Service (CECS). The consult service provides 24/7 coverage for the Medical Center. The committee, which includes several members from nursing, provides input on institution-wide policy and practice related to ethics, as well as education on clinical and organizational ethics and related professional issues. The Center provides education and consultation services and has members which serve on the Medical Center Ethics Committee. Other services which provide support for staff in regard to ethical principles/support include Patient Affairs, Social Services and Pastoral Care. [*EP23-Exhibit A-1-20.10.19 Ethics Consultation Policy*]

Table EP 23 – 2: Ethics Committee Member List

Name	Role
Margaret G. Rush, MD Children's Hospital	Co-Chair
Elizabeth Heitman, Ph. D. Biomedical Ethics	Co-Chair
Carol Eck, RN, MSN Cancer Institute	Member
Keith Wrenn, MD Emergency Medicine	Member
Mark J. Bliton, Ph.D. Biomedical Ethics	Member
Larry R. Churchill, Ph. D. Biomedical Ethics	Member
Joshua Perry, JD, M.T.S. Biomedical Ethics	Member

Janie Parmley, RN Homecare Services	Member
Nancye Feistritzer, RN, MSN Hospital Administration	Member
Josette Bianchi-Haynes, MD House Staff	Member
Kelley E. Melvin, MD, M. Ed. House Staff	Member
Amy E. Schindler, MD House Staff	Member
Jan Zolkower, BS, CTR, CIP IRB	Member
Susan K. Hannasch, JD Office of General Council	Member
Julia C. Morris, JD Office of General Council	Member
Jeffrey P. Bishop, MD Medicine	Member
Lindsey Robertson, RN Nursing/SICU	Member
Cindy Vnencak-Jones, Ph. D. Molecular Lab	Member
Marcy Thomas, M. Div. Pastoral Care	Member
Charles W. Stratton, MD Pathology	Member
Kyle Brothers, MD Pediatrics	Member
Brian Carter, MD	Member

Pediatrics	
Ellen Wright Clayton, MD, JD Pediatrics	Member
Mary B. Taylor, MD Pediatrics	Member
Susie Leming-Lee, RN, MSN Quality Resource Services/Perioperative Services	Member
Rita Fie, MSSW Social Work	Member
Dan Ramage, LCSW Social Work	Member
Kimberly Lomis, MD Surgery	Member
John L. Tarpley, MD Surgery	Member

The official purpose of the Ethics Committee is spelled out in the Medical Staff Bylaws (Article VIII - Functions and Committees), page 45 of 80 at http://mcapps03.mc.vanderbilt.edu/E-Manual/HPolicy.nsf/AllDocs/B44025AAF168A0E58625771900519AC5

8.3.5 Ethics Committee

The Ethics Committee is a multi-disciplinary committee with members representing emergency medicine, geriatrics, home care services, hospital administration, house staff, medical ethics, neonatology, nursing, pastoral care, pathology, pediatrics, social work, surgery, the legal office and other services and/or departments as appropriate:

A. To review existing and pending Medical Center policies regarding ethical issues, and to recommend for the Medical Center Medical Board's consideration any policies and/or changes in policy deemed necessary to promote ethical practice in health care;

B. To be available to Medical Center personnel, patients, and their families for advice and appropriate referral for consultations on moral and ethical issues; and

C. To foster awareness of moral and ethical issues within the Medical Center by sponsoring educational and informational programs and activities.

Table EP 23 – 3: Screen Shot Ethics Website

Faculty from the Center for Biomedical Ethics and Society and Clinical Ethics Consultation Service participate in our Hearts and Mind orientation to introduce our Credo Behaviors and to introduce new staff to the Clinical Ethics Consult Service. Other examples of faculty work with the nursing staff and health care team include:

- Nursing Case Managers and Social Workers – Quarterly case-based presentations/discussions
- Nurse Residency/1st year graduate nurses – a series of 3 workshops twice yearly
- Entity Nursing Staff councils – twice yearly case-based discussions
- Weekly rounds have been started in some of the critical care units with nursing and the health care team, and they are working on expanding that practice

- Ethics Grand Rounds (which always includes at least one nurse presenter)– semi-annual
  Recent topics have included:
  - Decision-making about high-cost, lifelong therapies
  - Ethical Issues Caring for patients with limited English proficiency
  - Quality improvement and the IRB
  - Privacy, confidentiality and the electronic media
  - Ethical issues in the pandemic flu [*EP23-Exhibit A-2-Pandemic Ethics*]
  - Caring for family, friends and VIPs

Perhaps the work of the Clinical Ethics Consultation Service (CECS) is one of the most supportive things in place to help the nursing staff answer questions. They provide two kinds of services:

1. Discussions and conferences with care providers, unit staff, or departments focused on personal, professional, patient care and/or other policy issues
2. Individual clinical ethics consultations with nurses, physicians, patients and families

Table EP 23 – 4: Ethics Consult Service Member List

Name	Role
Mark j. Bliton, Ph. D.	Associate Professor, Department of Medicine; secondary appointments in the Departments of Obstetrics and Gynecology and Philosophy
Kyle B. Brothers, MD	Instructor, Department of Pediatrics
Ellen Wright Clayton, MD, JD	Rosalind E. Franklin Professor of Genetics and health Policy and Director of the Center for Biomedical Ethics and Safety
Larry R. Churchill, Ph. D.	Ann Geddes Stahlman Chair of Medical Ethics

Joseph B. Fanning, Ph. D.	Assistant Professor, Department of Medicine, Associate Director of Clinical Ethics Consultation Service
Jill A. Fisher, Ph. D.	Assistant Professor, Department of Medicine
Elizabeth Heitman, Ph. D.	Associate Professor, Departments of Medicine and Anesthesiology, Director of the Clinical Ethics Consultation Service
Walter M. Robinson, MD, MPH	Associate Professor of Pediatrics
David Schenck, Ph. D.	Research Associate Professor

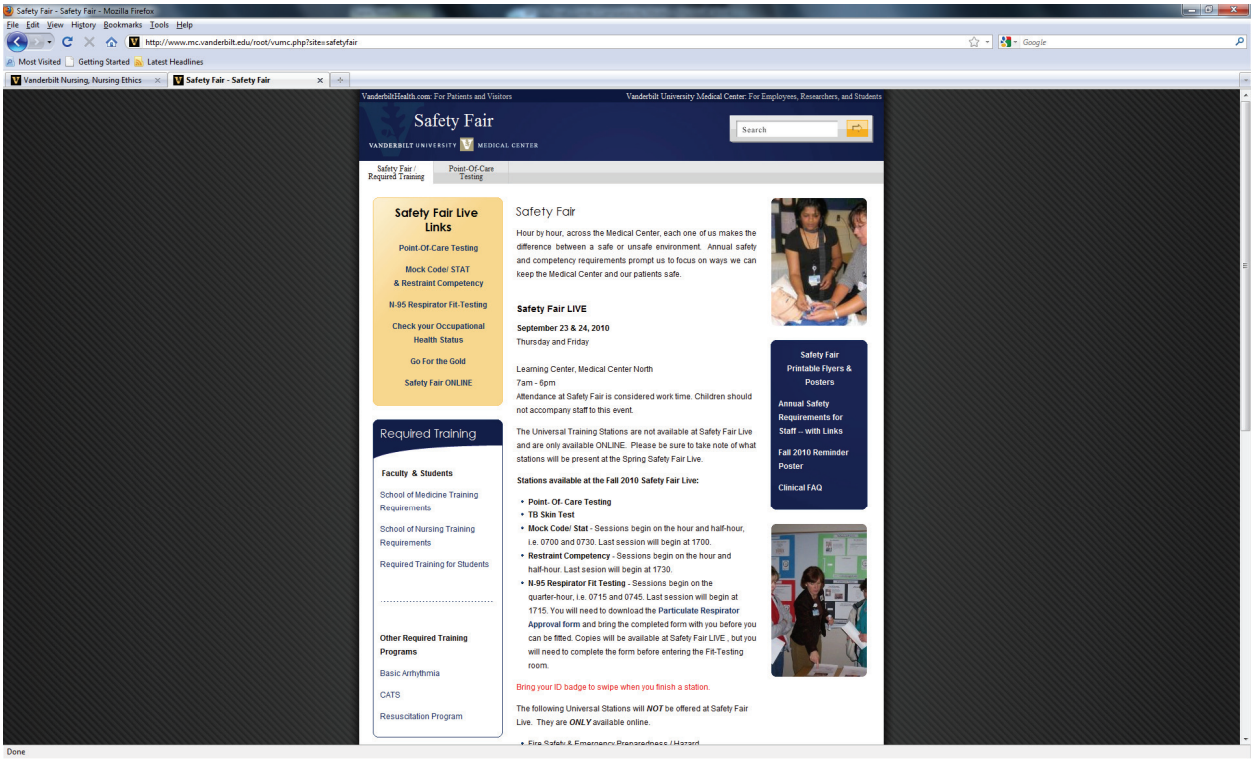
Annual Education/Competency Requirements

1) Standards of Conduct – Viewing of PowerPoint information and post-test

2) Privacy and Security – Viewing of PowerPoint information and post-test

3) Conflict of Interest Document – Policy Review and signature of document

Table EP 23 – 5: Screen Shot Safety Fair Website



Understanding and Meeting Ethical Needs of the Nursing Staff (IRB Study)

We recognize that our diverse patient population can present unique ethical questions and dilemmas for our nursing staff. To more clearly identify some of the needs of the nurses and their perception of the issues they encounter in daily practice, nursing partnered with members of the Center for Biomedical Ethics to conduct an IRB approved online survey about potential ethical issues nurses face. [*EP23-Exhibit B-1-Nurse News 10-09-V4 FINAL, EP23-Exhibit B-2-ethical issues in nursing survey questions, EP23-Exhibit B-3-IRB Exempt Approval Letter 5-4-09]*

The Table below shows the 5 issues identified as those most frequently raising questions.

Table EP 23 – 6: Ethical Issue Frequency and Need for Educational Activities

Educational Activities

Rank & Order of Ethical Issue Frequency and Need for Educational Activities

Variable	Rank Q 1: Ethical issues that arise at VUMC (Top 5 out of 20)	% Responding "YES" to Q 1	Rank Q 2: Ethical issues where additional educational activities are needed	% Responding "YES" to Q 2
Caring for non-English speakers	1	72	1	55
Communication/conflicts among caregivers	2	61	3	45
Family disagreements	3	57	4	37
Caring for patients with different cultural or ethnic beliefs about health care	4	53	2	46
End of life	5	46	4	37

We currently continue to analyze the information from the survey. In response to the first broad review of the data, the following have been implemented:

1. Vanderbilt Cultural and Linguistic Council has been developed: [*EP23-Exhibit C-1-Vanderbilt Cultural and Linguistic Council*]

    - Interdisciplinary, including community representative
    - Provide a 'clearinghouse' where all the work to address issues related to caring for non-English speaking patients, cultural diversity, health literacy and education/training can be coordinated
    - New issues and initiatives can be addressed and recommendations made to executive leadership
    - Create a partnership with the Nursing Diversity Committee and the Ethics Committee
    - Partner with other groups to provide education & training for staff
    - Establish, plan & monitor to provide culturally & linguistically appropriate services

2. Incorporate resources education for all nursing orientation groups (not just the nurses in the residency program)

3. Launched Nurse Alert! for ethics information and education

4. Improved access to resource information connection from the nursing website to ethics website/by creating an ethics webpage on the nursing website

http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=30731

Table EP 23 – 7: Screen Shot Nursing Website

5. Improve notification of Ethics Grand Rounds to the nursing staff.

6. Showcase nursing ethics during Octoberfest (CEN) to further share survey results and plans

7. Continue efforts to reach frontline leaders through our established programs such as: S3 Series, Frontline Leadership Program & charge nurses

Examples

Adult Medical Intensive Care Unit

Nurses in the medical intensive care unit face end-of-life issues on a daily basis, but one case will always stick out, said David Kornguth, RN. The patient was an accomplished

equestrian who sustained a C2 fracture after being thrown from her horse during a competition. Against all expectations, she survived, but as a quadriplegic on a ventilator. After almost four years of experiencing an increasing number of complications related to her quadriplegia, she made the decision in collaboration with her family and physician to be taken off the ventilator. She was well aware this action would result in her death.

Three to four weeks before her planned admission the attending physician, Dr. Miller came to the MICU manager to make her aware of this patient and seek her help in preparing the staff for this patient's situation. The manager initiated a consult with the Ethics Service to assist her and Drs. Miller and Karlekar to help the MICU staff and resident physicians work through this ethical dilemma. Involved in the planning were:

- Robert Miller, MD, attending physician – coordinated admission; oversight of patient care
- Mohana Karlekar, MD, medical director of Palliative Care Team – co-managed patient care
- Julie Foss, MSN, RN, NE-BC, MICU manager – facilitated preparation of nursing, respiratory therapy and physician staff
- Larry Churchill, PhD., Stahlman Professor of Medical Ethics – ethics consult – facilitated preparation for procedure especially for the nursing staff

Per the MICU nursing staff:

This situation was truly an ethical dilemma. The ANA Code of Ethics includes several statements that are important in this situation, including: "*The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems*." "*The nurse's primary commitment is to the patient, whether an individual, family, group, or community*." "*The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient*." "*The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal professional growth*."

While the MICU nurses routinely participate in withdrawal of support, these patients have usually been ill or hospitalized for a long period of time, have run out of treatment options, and have not made a decision to die on a specific day. The purpose for involving the ethics service was to help the manager and physicians provide the support and resources

needed by the nurses, respiratory therapy, and physicians to not only meet the needs of the patient but also of the staff and physicians.

A meeting was held with the MICU manager and Drs. Churchill, Miller and Karlekar to decide on content for planned staff meetings. Several staff meetings were held and while Respiratory Therapists do not report up through the MICU manager they were included in the invitation to these meetings. At the staff meetings Drs. Miller, Karlekar, and Churchill joined manager, Julie Foss, in a discussion that included the following:

- information about the patient, her situation, the steps she had taken to get to this decision, including family support for it
- anticipated plan of care
- information about her psychiatry consult, which determined that she was competent and had no underlying issues and was of sound judgment
- review of the VUMC policies involving ethical dilemmas and decision-making
- acknowledgement of respect for decisions by staff and physicians to not participate in this patient's care

There was time allotted for questions. Staff nurses who were uncomfortable with this situation were encouraged to let the MICU manager know so that they would not be expected to participate in this patient's care and especially not with the withdrawal of support.

The nurse assigned to the patient on the day of withdrawal volunteered to take the patient as part of his assignment. The patient had a peaceful death. Her husband was appreciative of all of the care provided. One nurse who had taken horse riding lessons from the patient prior to the accident was scheduled to work the day of the planned withdrawal. She requested to have her schedule changed and her request was accommodated.

Dr. Karlekar from Palliative Care and the MICU manager held a debrief session for all of the staff and physicians involved with this patient. All of those involved felt that the patient and husband were comfortable with this decision therefore making them feel like they made a difference for this patient. Staff nurses who were uncomfortable with this patient's decisions had their opinions and beliefs respected and were not involved in this patient's care.

This patient's situation was shared with all nursing staff as an example of ethical dilemmas and ethical decision making. It was used to encourage nurses to participate in an upcoming ethics survey.

"In their own words":

"*It was difficult because in this situation, some people think it borders on euthanasia. But we do this all the time in the hospital. The only difference was she got out of the hospital*," Kornguth said.

"*We were going to do this up front," Dr. Miller said. "We were not going to lie about her admission or her reason. She was coming into the hospital, and we got the ICU bed reserved."* Some questioned how this was different from physician-assisted suicide.

"*If you go on life support, you have the right to come off*," Miller explained. "*This is not suicide. You use life support for a defined purpose. It's either to save a life or to preserve the quality of life that you expect. If it doesn't meet that need, you're not obligated to stay on it. That doesn't mean it's easy for you or for your family or for your physician to take you off it, but that's part of the obligation*."

Kornguth said the situation was personally challenging because of his religious beliefs. "*I prayed a lot over this situation and found it difficult for myself. But the reality is she had no quality of life. Her quality of life was riding horses, and all she could do now was look at them*," he said. "*It is hard to look at a person and talk to them, and then let them pick the time they are going to die. But she was adamant that she didn't feel any fear in making the decision and her attitude about it made me feel comfortable."*

Kornguth said that the Palliative Care Team and Ethics Consult Service are integral to the end-of-life decision they make daily on the unit. The biggest issues arise when a patient's wishes are unclear.

"*People don't talk about their wishes beforehand, then unexpected health issues come up and no one knows what they would have wanted*," Kornguth explained.

"*We give each individual person the right to make decisions about their life. We try to give people the best quality of life they want. Sometimes that quality of life means the end of their life, and then we give them the best death possible."* [*EP23-Exhibit D-1-Vanderbilt Medicine-winter09, EP23-Exhibit D-2-Nursing July09v6-FINAL]*

Clinical Research Center

In planning for a new multi-center research study that would involve enrolling a vulnerable pediatric population, research protocol reviewers (nurses) identified the staff's need for clarification and guidance for a potential moral distress question – what behavior constitutes dissent. The specific question was: "*Is it ethical to hold or swaddle subject*" volunteer pediatric research population, particular to Angelman Syndrome protocol and "*what behavior constitutes dissent*." Angelman Syndrome is a genetic disorder resulting in children being non-verbal and having a varied potential of developmental delays.

Discussion among the nursing staff and the sleep study technicians generated similar concerns of safety and protection of subject (CFR 50.51 children, not involving greater than minimal risk). Peter Howard, sleep technician, communicated with the study team to learn that holding would be essential but received no clear answer to how "restraining" versus holding would be defined. The CRC staff has a strong sense of responsibility to provide a safe environment and uphold that research will not cause undue stress or danger to participants. Particularly, their commitment to pediatric subjects is strong and they do receive additional protection under federal guidelines. Subjects would require holding during lead placement, however restraining children via swaddling with sheets is unacceptable in minimal risk studies, which this was. In light of these important questions/issues, an expert from IRB/Ethics was invited to a Unit Board meeting.

After discussion, a resolution was reached which included a standard of care approach for all pediatric patients in the study.

- Reduce stimulation to the child by having two sleep technicians place the EEG leads with the regular caregiver (parent) holding and distracting the child.
- If two attempts fail, the study would be stopped and parents would have the option to re-schedule.
- Modification of admission – admission to occur early in the afternoon to allow the child and parents to become comfortable with the environment.
- Caregiver (parent) given control for identifying stress behavior and signaling when the study should stop.

Staff now has significant comfort in dealing with this non-verbal vulnerable population, identifying unique indicators of stress which support providing appropriate individualized care during data collection. Since the beginning of the study, 16 patients have been enrolled with 16 successfully completing the prescribed 4 hours for the sleep study. The staff is hopeful this study will lead to a better understanding of Angelman Syndrome.

Staff involved in the coordination/resolution of this particular situation:

- Christa Hedstrom, EdD RN, Nursing Director VICTR-CRC acted as resource to unit board chairs
- VICTR-CRC Unit Board Co-Chairs Deloris Lee RN CCRP and Diane Anders RN contacted ethics office and requested expert consultation. They also facilitated the called Unit Board meeting on 5/14/08

- Peter Howard, certified sleep technologist and manager sleep study core, sought input from research team and shared information during meeting

- Eugene Gallagher, MS, CIP presented & lead discussion of special ethical issues pertaining to children in research, assent and dissent examples

Key players were present at the 5/14 2008 unit board meeting which was held at a time convenient to late shift.

Case Managers

A member of the Ethics Consultation Service attends the Case Manager's Council Meetings at scheduled intervals. They use an open floor forum for case managers to present ethical issues. [*EP23-Exhibit E-1-Case Manager Council 11-03-09]*

In their own words: examples of recent case discussions include:

TRAUMA:

"*Balancing the needs/requests of grieving families sometimes presents ethical dilemmas for staff. Our Ethics consult service helped us navigate through a challenging situation in the trauma unit where a brain dead patient's parents requested their son's sperm so they could have it injected into his 17 year old girlfriend. Ethics supported our trauma staff and this family and helped us be able to respond appropriately to this request. Ethics also consulted our fertility clinic who said the request was unethical and would not provide this kind of service. The parent's request was respectfully denied*."

INFECTIOUS DISEASE

"*In this case the health care team was faced with an incredibly complex, dying AIDS patient admitted many time with multiple infections that had finally affected her mental capacity. This patient had no Power of Attorney (POA) and Adult Protective Services (APS) was involved due to claims of patient abuse by her daughter. Ethics, along with legal, helped us appoint a surrogate decision maker and obtain clarification of her code status based on patient*

preferences which had been expressed when she was of sound mental capacity. Patient was transferred to inpatient hospice."

"*We had an illegal immigrant with a new AIDS diagnosis with multiple brain lesions. The patient was from Guatemala and spoke only Spanish. Child Protective Services was involved as the patient had 2 young children and there was a suspected abusive home situation and/or possible child trafficking. The patient's father was in Guatemala. There was no Power Of Attorney so a physician was appointed as surrogate. At the time of this writing, we are unsure if patient will regain function physically or mentally, although she is showing minimal improvement. Ethics and Social Work is helping team sort through many complex issues."*

WOMENS HEALTH

"*Ethics helped one of our patients find their voice and be able to express final wishes to both her family and the medical team. In this instance, our nursing case manager consulted the ethics consult service regarding a patient that did not want to avail themselves of continuing cancer treatment. The patient perceived that her family, and to a lesser extent, even health care providers, were wanting her/pushing her to continue therapy in the hope that chemo might help. The patient told the case manager that she was very tired and "did not want any more of this" and wanted to go home to die, but felt that she had to continue to meet the needs of her family by continuing with "chemo". With the patient's and medical team's approval, the Women's case manager contacted the ethics consult service to sit down with the patient to outline her desires and help her communicate this to her family. Although the patient was not able to go home to die, as she would have preferred, she moved from being completely non-communicative with family, and even with the broader health care team, about her wishes and was more relaxed and less angry at her family. The patient and family were able to spend their last few days together without the animosity that had existed prior to this point*."

CHILDREN'S HOSPITAL

"*The staff on the oncology unit had been providing care for a 25 year old young man with progressive disease with multiple recurrences. He was post stem cell transplant for Ewing's sarcoma and had not had appropriate blood count recovery and he had developed myelodysplastic syndrome which was evolving into leukemia. The family and the patient wanted aggressive measures. When the Palliative Care Consult Service talked to the patient and his family, they refused hospice care. They also "fired" the stem cell transplant physician. The health care team struggled with "what was right for this patient" and experienced much moral distress. The entire team, physicians, nurses, Case managers, etc were concerned about the treatment plan. The intensive care physicians wanted to make the patient a DNR and address*

his status at the time of deterioration. However, the patient and his family refused DNR and palliative care treatment plan.

The Ethics Consult Service was brought in to assess and help with this difficult situation. Their assistance with resolution provided a better end result for all involved. After very careful listening and working with the patient, family and staff, the patient was discharged with palliative care and died at home."

VANDERBILT PSYCHIATRIC HOSPITAL

"A 13 yr old female initially presented to VCH as a transfer from another hospital with severe malnutrition and major depressive symptoms with catatonic features. Her history stated that she had gradually declined in health over a year's time when she experienced three deaths in the family including a grandmother she was particularly close to. Three weeks prior to admission she had become completely non-verbal and had stopped eating or drinking. She was admitted to Children's Hospital at this time and was placed on tube feedings. There she remained mute and in a fetal position for much of the day, only walking to the bathroom. Though family and sitters were by her side, she attempted to hurt herself several times over the several days. The Psychiatric Consult team was called in for assessment and suggestions for treatment. Medication management targeting her depression and behavioral management initiatives were started. While she was managing to gain some weight, she remained non-verbal, aggressive with staff, restless, and unable to care for herself. It was felt she would still harm herself if given the opportunity. She made little or no eye contact and shunned interaction. After 2 ½ weeks, she still did not speak or eat on her own.

In full agreement the pediatric team and the Psychiatric Consult Team felt that she might make progress in a psychiatric setting where the emphasis would be on behavioral interventions. She would also be part of a milieu with patients her own age, with the ability to engage in group therapy and school activities within the hospital. She was transferred to Vanderbilt Psychiatric Hospital Adolescent Program. On transfer, she presented as young, fragile, and unhappy. She had her hair pulled over her face and eyes and immediately went to bed, refusing to walk, even to the bathroom. She was placed on 1-1 care around the clock for risk of fall and potential suicide. For the next several days and nights, she regressed into non-ambulatory status. She was carried to the bathroom and was no longer able to perform her own ADL's. She was frequently agitated, aggressive to staff, kicking them or attempting to bite or scratch them when they were in proximity. Even with sedation, she was not calm for long, if at all. She repeatedly pulled out her feeding tube which needed to be replaced on a regular basis and became dehydrated and medically compromised. Her heart rate became irregular and she

was transferred back to Children's Hospital to receive IV fluids and to stabilize her deteriorating physical status.

Even though her physical condition stabilized she still would not communicate .The Psych Consult Service made regular visits and she was prescribed a course of anti-depressants and anti-psychotic medication. The patient remained mute and troubled, aggressively lashing out and requiring frequent sedation. She remained on the medication for several weeks without a noticeable change in behavior.

The Psychiatric Consult Team after much thought and deliberation consulted the Ethics Consult Service to discuss the treatment of electroconvulsive therapy (ECT). It was felt that this consideration was a necessary step in providing the ultimate care for a particularly challenging patient presentation, especially due to her young age. A team comprised of a board certified child psychiatrist, a psychiatrist not in the practice group, a pediatrician, a social worker and a nurse reviewed the case with recommendations for treatment. The family was carefully apprised of the risk-benefits of ECT. A Guardian ad litem was appointed to protect the patient's interests. The judge agreed with the premise that ECT treatments would be beneficial.

The choice of electing to administer ECT treatments to an adolescent patient is controversial and is certainly not a common treatment of choice. Each case is considered individually and after other treatments failed or have not rendered a positive outcome. ECT in this age group is not widely performed or as well researched as it is in the adult population. There is not as much data to evaluate what the long term effect of brain functioning might be. At the time, we had never treated a VPH adolescent patient with ECT

Most of the staff had some preconceived concepts of what ECT might do to a child at this age, were fearful and had misgivings. Having the Ethics Consult Service involved in the decision provided the interdisciplinary team the ability to discuss and weigh the benefits and risks of such action. As this patient was one of the most fragile the staff had seen, they were skeptical that ECT would help and were afraid they could make matters even worse for her in the future. The staff was very concerned for this young girl who was mired in a depression that rendered her mute, suicidal, unable to relate to others.

Dr. Michael Sherman was the attending child psychiatrist who headed the team of multi-disciplinary clinicians who cared for the patient. Along with Fellows, Drs. Cheryl Cobb and Jessica Ford, Josh Chestnut, Social Worker, a nutritionist, Shelley Alexander, Educator, nurses Georgia Burdick, Carolyn Forrest, Suzanne Boyles, and mental health specialists. They met daily to discuss and monitor her progress, which seemed slow and marginal at best.

The outcome was that the patient who had once been mute, non-ambulatory, catatonic, not eating or drinking , who was at major risk for suicidality and a persistent Major Depressive Disorder was able to leave the hospital , months later with much improved functioning. She was active and verbally expressive, returning to her home and family.

It is not possible to measure the extent and degree each intervention played in the recovery of this patient. It is likely that each component played a part in her improved functioning. Prior to her treatments of ECT, it seemed as if pharmacological and psychological modalities were inadequate and insufficient in this unusual case.

The VPH nursing staffs have treated two other pts on the Adolescent Program who have had ECT treatments. The experience taught us that it is a viable form of treatment for adolescents who do not respond to other treatments. We were educated and experienced firsthand that it can be a tool toward successful and positive outcomes. Having the Ethics Consult Service involved in this situation provided a format for safe conversation and exploration of all issues for the interdisciplinary team in this particular situation."

Children's Hospital

Professional and Personal Boundaries

Mary Murray, LCSW, Manager, Social Services Children's and Kristen Denmon, RN, BSN, direct care nurse Children's Cardiac Cath Lab and the Pediatric Intensive Care Unit have partnered together for education on professional and personal boundaries. One of the challenges for some of the Children's Hospital staff has been maintaining a healthy work/life balance -the concept is providing quality care for patients and families without crossing the line of becoming too involved.

Identified problems with personal relationships with patients/families included but were not limited to:

- Taking patients or parents to lunch outside Children's Hospital
- Buying food or gifts for patients/families to whom the staff feel a special connection
- Coming in to work on days off to spend time with parents
- "Friending" patients or parents in social media such as FACEBOOK or MYSPACE

Mary and Kristen created an evidence-based education module [EP23-Exhibit F-1-Discussion of Professional Boundaries] that has been presented to the staff and leadership of

Children's Hospital. They are now presenting to all new nurses and care partners at the Children's Hospital. The goal of the presentations and subsequent discussions is to generate thought regarding how to be caring while concurrently remaining professional as they care for children and their families. The message to the staff is – "*you are a nurse first*".

Leaders and staff in Children's use parts of the learning module when they have issues arise. Mary and Kristen are frequently consulted about singular complex issues that arise. Feedback has been positive and staff has reported that they have changed their behavior based on the information provided. Mary and Kristen have also presented their information at 4 national conferences. [*EP23-Exhibit G-1-Ped Critical Care Nsg Conf 1, EP23-Exhibit G-2-Ped Critical Care Nsg Conf 2a, EP23-Exhibit G-3-Evaluations-Feedback*]

Diversity and Workplace Advocacy

Source of Evidence 26

Describe and demonstrate how nurses use resources to meet the unique and individual needs of patients and families.

Patients/families are at the center of our PPM. In support of our model, nurses at VUMC have a large number of internal and external resources readily available to them to assist with meting the unique and individual needs of patients and families. Based on their autonomous decision-making, nurses can utilize these easily accessible resources quickly, without delay.

Summary of selected available resources:

Language Services

In a year over 60,000 limited English proficient (LEP) patients visit our clinics and that does not include hospital admissions. Vanderbilt Interpreter Services is one of the most utilized resources that we have. Overall, they have an average of 1,500 requests a month just for the onsite interpreter services. We have 7 full-time interpreters (6 Spanish and 1 Arabic) plus 20 plus temporary interpreters for various languages. All of the interpreters are trained and assessed before they can practice at Vanderbilt and follow the National Standards of Practice for Healthcare Interpreters. [*EP26-Exhibit A-1-Arab Pregnancy Book Cover, EP26-Exhibit A-2-Arabic Asthma Plan, EP26-Exhibit A-3-Chinese Asthma Plan, EP26-Exhibit A-4-Breast Feeding Information-Spanish, EP26-Exhibit A-5-VMC Book Cover Arabic, EP26-Exhibit A-6-Arab Pregnancy Book Final*]

In addition to onsite interpreters, we have over 15,000 calls to our Telephonic Language Line interpreters in a year. Our Language Line has 154 languages with 24/7 coverage. We have signage assuring patients that they are entitled to interpreters at no cost and this is included in our Patient Rights document that all patients receive copies of. Our Interpreter Services also provides translation of documents and services for the hearing and visually impaired.

Interpreter Services can be reached by 2-Serve (2-7378) or by their website www.mc.vanderbilt.edu/interpreter. [*EP26-Exhibit B-1-Presentation Interpreter Services*]

Table EP 26 – 1: Screen Shot of Interpreter Services Website

Center for Women's Health Example:

The Center for Women's Health (CWH) at Vanderbilt is always a humming place. Women of all ages and with a variety of needs enter our doors each day. Many of these patients have specific cultural needs, which our staff makes every attempt to meet.

One recent example of this came when a family who was new to the country and who had not yet established care with a provider presented to CWH. This particular family was in need of obstetrical care, since the patient was new to the clinic, no history had been obtained prior to the visit. Nadia, who has been our in-house Arabic interpreter for the past year, was able to sit with the patient and complete the necessary forms and accompany the patient through triage. She then escorted the patient to the ultrasound appointment. Sadly, this young family suddenly found themselves in the midst of dealing with the loss of a pregnancy. The couple and their two small children were attended closely throughout the duration of the imaging and provider visits by Nadia. She was able to provide thorough information about all that was being done to care for them in their own language. All of their questions were answered about treatment that would be provided during the visit and in future days. The usefulness of the service cannot be underestimated. The ability to provide interpreter services

to meet patients' needs is a blessing to any woman from another culture. It is of particular significance to those finding themselves in unusually stressful circumstances like this family.

The use of interpreter services to provide solid patient and provider communication throughout the spectrum of care enables the patient and their family to understand all that is going on around them, calming what may feel like chaos. When we partner together with wonderful people like Nadia, we succeed in providing open and thorough dialogue, thus ensuring the highest standards in patient care, communication, and outcomes are accomplished at the Center for Women's Health at Vanderbilt. [*EP26-Exhibit C-1-Language Breakdown in Inpatient Women's*]

Jennifer Layman Young, RN, MSN
Center for Women's Health at Vanderbilt

"In their own words"

"The Ob/Gyn recently had a retreat to discuss Ob care at Vanderbilt. Several times during the retreat, individuals discussed the excellent service from our Medical Interpreters. I thought you should know what a great job they are doing. They are truly appreciated."

Dr. Bruce Beyer – Medical Director for Women's Health at 100 Oaks, Assistant Professor OB/GYN

"One of the challenges that we faced on 4 East is that when we needed a "Language Line" to communicate with a patient, we spent an incredible amount of time going from room-to-room to find where the portable phone had been used last. We have a total of 36 patient rooms, and only 3 portable language line telephones.

As a result of talking about this frustration during a unit board meeting this spring, our department came up with the idea of ordering a speaker phone to place at each patient's bedside. The current telephones were in need of replacement and this was a great opportunity to work on this challenging situation. Having the telephone number for the "Optimal" Language Line service directly on the speaker phone helped ease the situation. Now, when the nurse, physician, case worker, etc, enters the room, they can immediately dial the language line interpreter while having the phone on speaker.

The patient and staff can communicate without the delay of running all over the unit to find the phone."

Anisha Fuller, RN, BSN
4 East; OB/GYN

"On a daily basis in Labor and Delivery we have non-English speaking patients that come in. Whether they are Burmese, Chinese, Somalian, or Sudanese, we are always calling the language line to make sure they know what is going on with their care. Anesthesia usually comes in as soon as they arrive and we get all of their health history and answer any questions so they feel comfortable right from the start. Oftentimes we have a Spanish and Arabic interpreter in-house that does rounds on our unit to make sure the patients are taken care of personally and promptly.

We also have menus for each patient to customize their own meals just like a restaurant. This is very much a patient satisfier. They have so many options and the food is really good. The patient knows they can always ask their nurse for something and we can call dietary and get it for them."

Emily S. Guess, RN, Charge Nurse
Labor and Delivery-4N

"Johannie,

Thank you to you and your great team. You all make such a difference to the overall quality of our patient care in the ED

Thank you,
Kate

From our Charge Nurse report: 4/16/2010: "We would love to elevate our interpreter-Mel-he sang to a sweet child without parents who only spoke Spanish--team player. "

Kate Copeland, RN, BSN
Manager
Monroe Carell Jr. Children's Hospital at Vanderbilt, Emergency Department

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"Darien,

Thank you very much for your help in translation !! We appreciate interpreter services for all that you provide to improve the quality of care for our patients and families.

Thank you."

Kate Copeland, RN, BSN
Manager
Monroe Carell Jr. Children's Hospital at Vanderbilt, Emergency Department

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"Hi Ms. Resto,

I work in MCE South Tower at the Voice Center and frequently have need of your department's services in working with my patients. Yesterday Sarah Rodriguez was assigned to a 7 year old patient of mine that I had a lengthy and difficulty evaluation with, and I wanted to let you know that not only did I find her services excellent, but she was on time, affable and great with both the patients and with us (the clinicians). I know that this is your department's goal with every patient interaction, and your interpreters have never been anything but professional, but Ms. Rodriguez stood out and I wanted to let you know. I would be delighted to work with her any time. Thanks to her assistance, I believe that my patient and her mother left with a great understanding of the necessity of the tests we conducted yesterday, comforted by an attentive and personable interpreter.

Have a nice day"

Sincerely,

Jennifer

Jennifer C. Muckala, M.A., CCC-SLP
Senior Speech-Language Pathologist III
Vanderbilt Voice Center

"*Dear Johannie,*

This is Dolores Smith the Vanderbilt Bill Wilkerson Center pediatric social worker writing once again to commend one of your employees. Yesterday, I was working on a difficult case and needed to contact a family quickly and provide them with detailed information from a list of written material. Sarah was between appointments when I approached her for assistance. She offered to assist me without reservation. In between the cases she was working here at the Center, she would come to my office and assist me with attempting to contact the family and translating messages the family was leaving on my phone. We were unable to make contact with the family by the end of the day and Sarah kindly offered to come in this morning before beginning work to provide interpreter services for the family. With Sarah help this morning, I was able to contact the family and provide the detailed information they needed.

Again, I commend Ms Rodriquez for her dedication."

Sincerely,

Dolores

Dolores A Smith, LCSW
Social Worker II
VWBC/NCCDFC

"*Hi Johannie,*

I am writing to give kudos to one of the interpreters, Nabila Mikhiel. Nabila is always wonderful to work with. She provides great interpreting services to the families we serve, and she is very helpful to clinic staff as well. I feel that Nabila is very devoted to her role here at Vanderbilt.

I want to highlight a particular experience that I had with Nabila last week, in which the clinic team was working with a family which posed to be a challenging situation. The entire clinic visit lasted around two hours, the environment in the room was very chaotic, and mother was angry and expressed her concerns for quite a while. Nabila was very patient with the mother and provided interpretive services throughout the entire process. As the clinic social worker, I had a lot of involvement with mother on that day in order to provide supportive services, and it was a stressful and chaotic situation. However, Nabila remained calm and poised and continued to help the family and clinic staff in a very professional manner.

Nabila is an asset to the clinic and to Vanderbilt, and we are very happy she is here! I also want to thank you for everything that interpretive services do for Vanderbilt and the families we serve."

Thank you!

Melissa (Primary Care Social Worker)

Melissa Bowles, LMSW
Pediatric Social Worker
Monroe Carell Jr. Children's Hospital at Vanderbilt

Unique ICU SMART (Stryker) Beds

In the new Critical Care Tower that houses the adult MICU, NICU and SICU, are SMART Beds. These "SMART" beds are equipped with language translation software. The beds have 24 languages for translation. They are programmed to ask/translate specific questions; examples below:

- Can you squeeze my hand
- Can you wiggle your toes
- Are you having trouble breathing
- Are you in pain
- You are in the hospital

Using the SMART Beds

"In their own words"

"For a patient who was intubated and spoke only Arabic, I used the bed to help assess my patient's neuro status by using the Arabic translations for 'squeeze my hand' and 'are you in pain. Very helpful."

Jordan Frenz, RN, BSN
Surgical Intensive Care – University Hospital

"Recently we had a Spanish only speaking patient and family. I used the SMART bed to see if the patient was able to understand and if the bed would really work for us. I choose the command to take a deep breath and cough and "he did it"! I was so excited as pulmonary toilet was a high priority for this patient and it also provided me with the knowledge that he could follow commands."

Donna Sabash, RN, BSN, CCRN
Surgical Intensive Care Unit – University Hospital

"We had an intubated Spanish speaking patient. He was awake, but unable to talk due to the ET tube and could not write due to edema in his hands. He was able to nod his head yes and no. The Language Line was not an option as he could not speak to them. Needing the ability to communicate immediately (before interpreter came), we used the translation option on the SMART bed and it worked wonderfully. With this tool, we determined that the patient

was having pain and the location of the pain. We were able to appropriately assess and treat the problem. This was a great help for this patient's care."

John Paulley, RN
Surgical Intensive Care Unit – University Hospital

"Early summer of 2010 I cared for a Laotian gentleman whose home was somewhere in/near the Buddhist temple in Nashville. He came on a Friday evening with an interpreter the ED had contacted and she stayed for several hours assisting with questions the day of admission and the following morning. A "cousin" also visited the following morning, but was not going to be returning for a few days. From what the interpreter shared, the monks helped him with his care, although I never saw or heard from any of the monks. We were able to get responses from yes/no questions and even get through the entire CAM-ICU assessment. He was CAM negative.

I released the interpreter since we were doing so well on the second day. I checked the *Stryker Intouch* bed to see if Laotian was available - yes, it is. There are different categories of questions: neuro assessment, pain assessment, and I believe another one or two categories. I told him "I have a surprise for you" and programmed the bed to ask him to "wiggle his toes". I remember the look of joy on his face when he heard his native tongue. He looked from side-to-side to see where the voice was coming from. We went through all of the options (except detailed pain assessment since he said he was not in pain). We smiled and laughed through the entire exercise. It was helpful in bonding and building trust."

Denise Gamary MSN, CCRN, RN 4, MICU -VUH

Cultural and Linguistic Council

As discussed in EP 23, in response to a nursing ethics survey where the nursing staff indicated one of their major concerns was "caring for non English speakers", a Cultural and Linguistic Council has been launched. The chair of the council is Terrell Smith, RN, MSN, Director of Patient/Family Centered Care. The work of that council is:

- Interdisciplinary, including a community representative
- Providing a 'clearinghouse' where all the work to address issues related to caring for non-English speaking patients, cultural diversity, health literacy and education/training can be coordinated
- Providing a place for new issues and initiatives to be addressed and recommendations made to executive leadership

- Creating a partnership with the Nursing Diversity Committee and the Ethics Committee
- Partnering with other groups to provide education & training for staff
- Establishing a plan to monitor to provide culturally & linguistically appropriate services

[*EP26-Exhibit D-1-Cultural and Linguistic Workplan, EP26-Exhibit D-2-Vanderbilt Cultural and Linguistic Council*]

Cultural Religious Manual

This is an online manual that provides basic information regarding potential cultural and religious issues to address for the major ethnic groups seen at Vanderbilt. The information contained in the Cultural Religious Manual is not to serve as a complete resource, just as beginning point for staff for information. The information includes:

- an overview
- dietary considerations
- transplant/organ donation
- end of life issues
- reproductive issues
- autopsies
- drugs and blood products
- death and burial practices
- specific religious/cultural practices

[*EP26-Exhibit E-1-RC 006 Hinduism-example, EP26-Exhibit E-2-RC 010 Mennonite-example, EP26-Exhibit E-3-Cultural and Religious Handbook Intro, EP26-Exhibit E-4-Cultural and Religious Handbook Quick Reference*]

Examples:

From VUH - Adult Trauma Unit

"This past year we had an orthodox Jewish patient who died following an accident. The patient was to be transported to the morgue and to the Medical Examiner's office. Shannon Godby, RN was asked how we could make arrangements for someone from the synagogue to stay with the body. She was extremely concerned, because she had never heard of this. So, she consulted the Religious and Cultural Resource Handbook." **See info below:**

Death/Burial Practices: Body is to be buried as soon as possible after death. A fetus may be buried. Cremation is not in keeping with Jewish law. Not all funeral homes are "approved" to prepare a body for burial. Consultation with the Rabbi is advisable.

IMPORTANT REMINDER: Because of the community orientation of Judaism, the presence of family and friends should be anticipated. This will be especially true of a child, or a critically ill or dying patient. In the case of death, Jewish law requires that the body not be left alone.

"Shannon and one of our Chaplains called the medical examiner's (ME) office and explained the situation. Permission was granted for the designated family member to ride with the body and stay at the ME's office and proceed to the Funeral Home of their choice."

From Burn Unit

The Burn Unit in VUH realized they were having an increased number of Kurdish patients on their unit (large Kurdish population in Nashville). Caroline Goedicke, RN did some research, which include the Cultural/Religious Manual on their medical practices and beliefs. Using the Muslim, she did a poster on the information for Islam for the unit. This was helpful for the staff to see specific information.

VCH – Periop Services

Raye Nell Dyer, Children's Hospital Chaplain, did an update for Holding/PACU/OR staff and 77 people attended. The update was to address the many different religious and cultural issues they provide care for. The format of discussion and dialogue was effective. Raye Nell

used information from the online Cultural Religious Manual and covered acceptance of blood products, medication and nutrition. This was a reminder for our group of this excellent online resource. [*EP26-Exhibit F-1-Religious cultural Reference OR*]

Rebecca Arndt MSN, RN, CNOR
Nurse Educator Perioperative and Procedural Services, Children's Hospital

Age Specific Needs

Geriatric Interdisciplinary Team / ACE Unit (Acute care for the Elderly)

The Acute Care Unit for the Elderly/Vanderbilt Senior and Special care treats high acuity patients age 65 and older. The unit has 14 beds on the third floor of Medical Center North's Round Wing and is staffed by nurses who have had specialized training. Each patient is screened by and cared for by the Geriatric Interdisciplinary Team which includes physicians, nurses, physical, occupational, speech and respiratory therapists, dietitians, pharmacist and wound care and safety specialists. In addition, the Geriatric Interdisciplinary Team will consult and follow patients on other units throughout the Medical Center. [*EP26-Exhibit G-1-Delerium Management, EP26-Exhibit G-2-Geriatric Admission Pathway, EP26-Exhibit G-3-Geriatric Opiod Management, EP26-Exhibit G-4-Pain Assessment for Dementia Patients]*

Office of Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) Life at Vanderbilt

Available as a resource for questions and issues related to gender and sexuality and serves all members of the Vanderbilt Community. Available for staff to consult about any patient issues.

Project Opportunity

Under the direction of the Director for Patient/Family Centered Care, Terrell Smith, RN, MSN, we have a special, grant supported program called Project Opportunity. Project Opportunity trains high school students with developmental disabilities to work at Vanderbilt. The outcome goal of this transition program is employment. Notably, several of the graduates (now, productive staff members) are actually previous patients of Children's Hospital.

This is a win/win/win for students, who are now productive staff members; for departments who are filling a business need for some high turnover positions; and for families

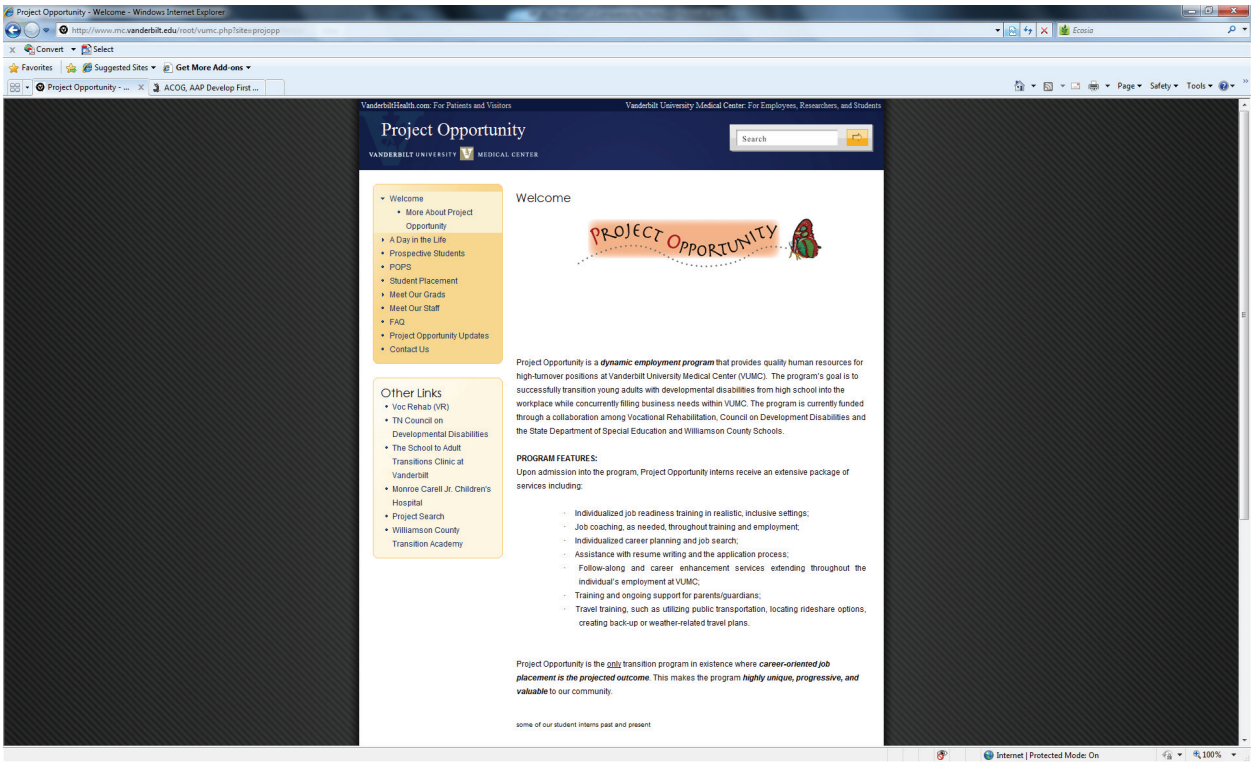
of current patients who are being treated at the hospital and see that their baby can have a meaningful future.

The website outlines the program and has photos of some of or graduates and video that gives a glimpse into their work days. This program has been cited by the mayor of Nashville as the model program for high school transitions.

www.mc.vanderbilt.edu/projectopportunity

[*EP26-Exhibit H-1-A Day in the Life-Project Opportunity]*

Table EP 26 – 2: Screen Shot Project Opportunity Website



Examples

(Please also note that many of the stories in EP 16 regarding Interdisciplinary Collaboration illustrate how the nurses use resources to meet the unique and individual needs of patients and families)

VUH

4 South GYN Surgery – Meeting a Unique Need that Could Compromise Quality of Patient Care

We were faced with a challenge to see how we could change our delivery of nursing care or procedures that would be able to accommodate this patient safely and within the guidelines of nursing standards of care.

"One of our URO-GYN physicians spoke to me about a patient that had a phobia that her genital area or breasts could not be seen naked by anyone (while awake). In his opinion she desperately needed surgery in order to rule out a malignant pelvic tumor, that she had been "sitting on" for several years, because of her phobia. He had submitted a list of her requests to see if we could accommodate them.

Her requests were:

- *No one could see her naked while she was awake.*
- *She wanted to wear her bra and panties into the OR and PACU*
- *She wanted to insert her Foley*
- *She wanted to prep her abdomen and pubic area*

She had seen other physicians who could not meet her wishes and Dr. XX and 4 South was her last resort. At first I was cautious about compromising our standard of care, or placing nurses at risk. I spoke with Risk Management initially and they agreed with me.

After re-thinking her requests, I felt there was a way to accommodate this patient without compromising our standard of care or putting nurses at risk. I thought it would benefit both parties if we could at least meet the patient. Through Dr. XX's office a meeting date was set.

In the meantime, I met with the staff (and the 4 East Manager) and briefed them. Our meeting with the patient went exceptionally well and she was open to our suggestions/negotiations. We were also able to give her a tour of the unit and let her meet some of the staff.

Dr. XX was notified that the meeting had gone very well and what our suggestions and ideas were. He was agreeable to all except the panties, which we later worked out the day of surgery. I informed Risk Management what we had decided on and they were in agreement.

The day of surgery, the patient arrived on our unit with her Foley already in place. She was allowed to keep her bra on (no metal – all cotton) and panties were pulled down to her knees in the OR. She was then instructed on how to perform her abdominal prep by her circulator and performed that herself while their backs were turned. The window into the OR room was covered and there no medical students were allowed to be present. These are a few of the ways her needs were met.

The patient's needs and wishes were accommodated without compromising any standards of care. The admission process, surgery (benign mass), and post operative course all went smoothly, and the patient was discharged home. Afterwards, the patient thanked everyone and told Dr. XX she was so impressed that Vanderbilt and the staff went to such lengths to respect her as a person and make her feel comfortable enough to have her surgery at Vanderbilt."

Karen Hickey, RN, BSN, Manager
4 South Patient Care Service-University Hospital

VCH

NICU – Collaborative Partnership with Mothers to Improve Babies' Health

The Neonatal Intensive Care Unit (NICU) demonstrates how nursing formed a collaborative partnership with patients and families for two reasons:

- to provide easy access to supplies for breast feeding mothers while the babies are in the NICU
- to support their goal of increasing the number of breast fed infants

Nursing leaders and lactation consultants collaborated with families to create the "Baby of Mine" Lactation support store to support breast feeding moms in the NICU. Organizational, state, and national goals have been identified to increase the number of breast fed infants. Our Children's NICU is a level III, 77 bed regional care center that receives patients from southern

KY, northern AL as well as Memphis and Knoxville. Parents often travel to be closer to their babies as soon as they can be discharged from the outlying hospitals. Mothers frequently come unprepared for breastfeeding and/or expression of breast milk.

Prior to the creation of the Baby of Mine store, the NICU had a vendor which provided a breast pump to mothers eligible via certain insurance groups. There was no vendor to provide other needs such as a good supportive nursing bra. Private insurance or self pay mothers had difficulty renting or buying supplies. Although there was a lactation store located near the Newborn Nursery, it was not easily accessible for parents of infants in the NICU. An assessment showed that an easily accessible location for providing items to support breast feeding as well as breast pumps and parts would help promote and support breastfeeding.

In October 2008 a small underutilized space was identified along the route every parent has to pass when they are coming to visit their baby. Throughout October 2008 and November 2008 we worked with the department of finance to set up the finance/cost structure for the store. We also identified vendor contacts and inventory lists for products.

Breastfeeding goals in the NICU include increasing breast feeding support and increasing the number of patients in the Neonatal Intensive Care Unit who are provided breast milk as a source of nutrition. These goals support state and national initiatives to improve the health of mothers and children. The Tennessee Initiative for Perinatal Quality Care (TIPQC) 2009 goals include efforts to foster improved health for babies in the NICU by increasing the percentage of any human milk provided to babies in the Neonatal ICU and increasing the number of babies in the Neonatal ICU who receive human milk at their first feeding.

In addition, the Centers for Disease Control (CDC) has adopted increasing the number of breast fed infants as a key strategy to improve the health of mothers and their children. In 2009, the CDC created a report card to show how breastfeeding is being supported by each state. [*EP26-Exhibit I-1-CDC Breastfeeding Report]* Only 58% of TN mothers have ever breastfed and only 12.8% of infants in TN are exclusively breast fed at 6 months. The Healthy People 2010 initiative includes goals to improve breastfeeding rates. The goal is to increase the

number of mothers who breastfed from birth to 75% as well as increasing duration of breast feeding to 50% over 6 months and 25% for 12 months.

We believe with the opening of the Baby of Mine store, we have put support in place to help our mothers meet theirs and their babies' needs. In the first 6 months, the Baby of Mine Store had $3,261.40 in sales. Merchandise is sold at cost, plus sales tax. We are in the process of collecting data to evaluate the impact on the percentage of breast fed infants and the number of infants who receive breast milk as a first feeding in the NICU. [*EP26-Exhibit J-1-Baby of Mine Brochure]*

VPH

Staff are challenged to keep patient safe while trying to address their own discomfort

VITA had a pre-op transgender patient (male to female) on the unit for suicidal ideation and drug/alcohol issues. The patient spent nearly two weeks on the unit and slowly began adding more feminine clothing; eventually wearing a wig and makeup. Our staff often felt uncomfortable on the best way to provide care for the patient.

Since the patient did express active suicidal ideation, he was on 1:1, with a staff member assigned to stay with him at all times. Daily hygiene was often an issue as he was physically male, but identified as female. Providing care for this patient proved to evoke many emotions for staff and patients.

To try to begin to identify and help address questions, a professional development seminar with the Vanderbilt Psychological and Counseling Center (PCC) was initiated. Two psychologists and one pre-doctoral intern came to the unit for an in-service on the differences between sexual and gender identity and possible counseling techniques for future patients. The presentation also included Q&A session, role play, review of definitions/terms, and counseling techniques.

The in-service was very valuable in terms of overall information, but more importantly it provided a dialogue among nurses, mental health specialists, and even nursing students who were visiting the unit that day on providing care to complicated patients.

The dialogue and information helped us to develop a plan of care that respected this patient's special needs, but enabled us to keep him in a safe environment.

Clinic

Obtaining resources for patient with limited means

"*One of our very established patients found herself in a very difficult situation. She forms a type of stone called Cystine stones that are very serious. These aren't stones that can be dissolved, or stones that can be prevented by dietary measures, these stones form fast and in multiple numbers inside the kidney at a very rapid pace. Cystine stones require not only a gross amount of fluid intake but two different types of medication to be taken multiple times a day.*

My patient is a young, otherwise healthy woman. She was able to work for several years until her stone problem became so overwhelming that she began struggling with her job. She was requiring multiple clinic and ED visits due to passing stones. She developed frequent urinary tract infections and had several surgeries to try to clear the stones out of her kidneys. The problem was that she could almost form them as fast as the physician could take them out. Not only were we treating her physically, we were also trying to determine metabolically what medications to place her on to at least try to slow the progression.

During this process, she was having difficulty with poor attendance at work due to her many medical needs. She is single, with a limited income and was now losing job. She needed medication specific to her stone disease and had no means to pay.

I contacted the Mission Pharmaceutical Company and inquired about any programs they may have to help patients in this situation. They did and she was able to receive her initial Rx as directed by the physician for Thiola and Urocit K, specialty medications.

We have been able to supply her medications free of charge with the help of Mission Pharm since March 2008. We submit an application every 3 months and they send the medication here for her to pick up."

Dana Teasley, RN 3
Urology Clinic

Dayani Center

Welcome to my "Moving Clinic" on the Cumberland River

'*On certain days, Teresa Roberts' office is a 140-foot twin engine towboat with a 4,200 horsepower engine. Teresa is the executive physical nurse for the Vanderbilt Dayani Center and this awesome "office" floats down the Cumberland River.*

Ingram Barge Company and the Dayani Center are partners in an innovative program, called Partners in Towboat Wellness. These towboat employees present unique healthcare challenges due to their schedules, routines, eating habits; essentially how they make their living. Issues contributing to potential health problems include: erratic sleeping schedules, unhealthy/erratic meals, being sedentary, and being "on the job" for three straight weeks at a time.

The captains, pilots, and other personnel from Ingram Barge get comprehensive physicals, treadmill test and healthy living guidance all under the watchful eye of Roberts and a team (Robert Workman, MD; Mark Jacokes, MD; Zafer Karabultu, PhD, Exercise Physiologist; registered dietitians) from The Dayani Center. As Dayani's first certified health coach, all of Teresa's time is dedicated to this program. She has been with them since the beginning. She works closely with the National Maritime Center in West Virginia and the U.S. Coast Guard (USCG).

Captains and pilots of riverboats have to meet specific health standards to renew their USCG licenses every 5 years. They must have a comprehensive medical and physical evaluation. Through Partners in Tugboat Wellness, Teresa works with them on implementing interventions to decrease and/or control health problems that could cause them to lose their license as mariners. Adhering to a strict health promotion plan ensures that the mariners can perform their jobs without fear of underlying medical conditions that could potentially cause them to lose their licenses or lead to unsafe practices on the water. This program benefits the employees, the company and keeps water travel safe."

Teresa reports the success of this program:

"We are seeing a reduction in the risk factors and improved health among the Ingram Barge associates." Statistics from the program support her claim.

- 40% have improved their exercise tolerance as measured by treadmill time
- 23% have reduced their blood pressure
- 35% have reduced their cholesterol levels
- 20% have reduced their fasting blood sugar

- 10% have quit smoking

"Our priorities are safety, prevention and reducing risk factors so they can get out there, be healthy, and be safe," Teresa says.

With this program, Ingram Barge provides exercise equipment (treadmill or elliptical machine) on all boats. The Dayani Center provides exercise prescriptions for all the employees. Additionally, the cooks are in the program. Teresa has worked with the cooks by taking recipes and making substitutions which make them heart healthy, yet still filling and delicious.

Quotes from Ingram Barge Employees:

"This program is fabulous. Ingram would be so far behind where we should be without it. And it's the personal relationships that make the difference."

"Since I have come to work at Ingram, the quality of my life has definitely improved. Nurse Teresa makes you feel like part of the family. I just can't say enough about what she does for us."

The next phase of the partnership will be determining not only the effectiveness of the program and the wellness interventions, but to discover the relationship of health to boat safety.

Teresa calls this work her passion; challenging, but rewarding. *"I consider it an honor, and definitely a pleasure, to be their partner in towboat wellness. It's just the coolest thing".* [*EP26-Exhibit K-1-Life on the Cumberland-House Organ]*

Trauma Survivors Network

"Just being able to "go to the bathroom" by yourself can make all the difference in the world"

Vanderbilt is a very busy regional Level 1 Trauma Center. The nurses are faced with new challenges every day to find ways to meet the unique needs of their patient population. The Trauma Survivors Network is part of a solution that they had a hand in creating as part of an interdisciplinary team that included trauma survivors and their families. [*EP26-Exhibit L-1-Trauma Survivors Network Brochure]*

Below is just one story of how the staff have utilized this important network of trauma survivors and their families to meet the needs of their patients. Trauma nurses recognize the power of "peer" and "having been there".

Even in trauma it is unusual to have a double arm amputee. Jason Koger is a peer mentor (seen in the brochure walking with his 2 daughters) who did lose both his arms in an accident. When the Trauma Unit had another man who had to have both of his arms amputated, they knew who to call.

When Jason came for the peer visit, he brought a pair of pants with him. He said that no one had actually shown him how to open his pants and use the bathroom. He was determined to make sure that this guy did not leave the hospital worried about that. Jason brought the pants to show him the Velcro replacement for the zipper and the loop sewn on, so that he could get his hook through the loop and open the Velcro. This helps the staff to recognize the value of peer support. The patient's wife said she could immediately see the relief on her husband's face.

Diversity and Workplace Advocacy

Source of Evidence 28

Describe and demonstrate the organizational structure(s) and process(es) that are in place to identify and manage problems related to incompetent, unsafe, or unprofessional conduct.

In *Organizational Overview Questions 20 and 21* we have provided many policies and procedures that address the issues of incompetent, unsafe, or unprofessional conduct. Information on policies and procedures for safety are also provided in *Organizational Overview Questions 24 and 25.* Below is a summary of the structures and processes we use. Following the summary is Table EP 28 – 1 which provides specific information about our programs.

Summary

Our processes that address the identification and management of problems related to incompetent, unsafe, or unprofessional practice or conduct are interdisciplinary. They involve multiple policies, processes, individuals and departments.

The procedure is to identify and manage incompetent, unsafe or unprofessional practice or conduct through early reporting and identification. Early identification can occur at the individual supervisor level, in the Office of Patient Affairs, or in Risk and Insurance Management. Once incompetent, unsafe, unprofessional practice or conduct is identified, leadership works with the appropriate team members.

The programs which support both system and individual compliance with our guidelines for safe and ethical practice include:

- Environment of Care rounds conducted by interdisciplinary teams in every medical center site of care at least twice each year to identify potentially unsafe or unethical practices.

- Rounding for outcomes conducted by area managers and their designees.

- Tracer rounds designed to monitor our compliance with external standards as patients move across the care continuum.

Our Vanderbilt Professional Nursing Practice Program (VPNPP) focuses on the individual practice of each direct care nurse. Each nurse is expected to use problem solving skills to identify and resolve patient, unit or system issues, using the appropriate chain of command. As

nurses advance in the program, their skills and leadership in quality improvement and change management expand and improve.

Several departments work together to identify and address lapses in compliance with our guidelines and expectations for safe, competent and ethical practice as well as professional practice and conduct. This is accomplished through defined and organized processes within each department and interdisciplinary collegiality.

In sum, the nurse managers and leaders and other organizational leaders are responsible for setting the expectations for a professional environment for patients/families and staff. They set the tone in their areas, monitor and provide feedback and discipline as required. Supporting expectations for professional behavior is our ***Professional Conduct Policy, OP 30-10-13***, that applies to all staff and faculty at VUMC. [*EP28-Exhibit A-1-Professional Conduct Policy*] Our Credo Behaviors serve as an excellent benchmark for holding staff accountable. The Credo is also used as a concrete tool when counseling staff.

Table EP 28 – 1: Structure and Process Related to Conduct

VUMC Structures and Processes to Identify and Manage Incompetent, Unsafe, or Unprofessional Conduct

VUMC Structure	Processes/Issues Addressed
Human Resources	• Conducts background checks to prevent hiring of staff with known violations • Provide guidance in the development of a performance improvement plan or termination when indicated for violations *(Information in OO 21)*
Evaluation Process	• Staff receive either a 3 month or 6 month probationary period evaluation depending on their job classification • Direct care nurses have 30, 60 and 90 day evaluation discussions with their managers • All staff have annual evaluations • Nurses at all levels participate in a peer review process at the time of their annual evaluation (*see Organizational Overview Question 17 for examples of tools and Exemplary Professional Practice Question 20 for examples of goal setting)*
Counseling and Progressive Discipline	• All performance issues are addressed at the time of occurrence through our Performance Improvement Counseling (PIC) Program • Disciplinary action is determined in conjunction with the leader

	and Human Resources Employee Relations Staff
VERITAS II	Electronic Database that all employees have access to for reporting • Medication Errors • Patient Safety issues • Adverse patient events • Near Misses • Sentinel Events • Patient/Family Complaints • Unprofessional Behavior/Conduct • Any issue they question When VERITAS II report is done, an alert if generated to the manager and to Risk Management for follow-up. Manager completes follow-up and documents in the system. Employee receives confirmation their report has been received.
PYXSIS Dispensing and ADMIN RX Medication Administration System	Automated medication dispensing system and bar-coding medication administration system • Nursing leaders, pharmacy and informatics track issues related to medication overrides, failure to follow appropriate administration scan procedures and irregular dispensing patterns • Pharmacy works with nursing leaders to further analyze trends or concerns • Issues are addressed by nursing leaders as appropriate in conjunction with Employee Relations • Trend reports are provided to Patient Safety Committee, Nursing Quality Committee and Medication Use, Safety, Improvement Committee (MUSIC) – all interdisciplinary committees with nursing representation • House-wide trends are addressed when identified
Risk Management	• Receives all VERITAS II Reports • At system level, the reports are aggregated and shared with Risk Management, Patient Safety Committee, Nursing Quality Committee and individual nursing leaders as appropriate. • When a significant near miss or adverse event occurs, a team is assigned to conduct a root cause analysis (which includes all staff involved) and those results and improvement recommendations are reported to Risk Management, Patient Safety Committee and other groups and individuals and groups as appropriate including

	nursing leaders. *(Information in Folder Reporting & Event Analysis – OO 21)*
Corporate Compliance Office	• Develops/reviews Standards of Conduct and conducts audits • Accepts calls (anonymous if desired) about any concerns employees may have and investigates • Issues that need to be addressed are brought to the appropriate group and /or manager as needed • Corporate Compliance Office follows trends and reports to Executive Leadership *(Information in OO 20)*
Information Management/Network Computing Services	• Monitors use of clinical computers for any accessing of inappropriate sites or other misuse • Utilizes auditing capabilities • Issues that need to be addressed are brought to the appropriate group and/or manager as needed • Trends are followed and reviewed and reported to Executive Leadership
HIPPA and Privacy Office	• Monitors and addresses all issues related to HIPPA and Privacy for patients and staff. • Utilizes an ongoing audit system. • Staff can also make reports anonymously to this office • When it is determined that a violation has occurred, the HIPPA and Privacy office works with the manager and Employee Relations to take appropriate action • Trends are followed and reviewed and reported to Executive Leadership *(Information in OO 19)*
Center for Patient and Professional Advocacy	• In conjunction with Patient Affairs and other departments addresses issues and complaints related to unprofessional conduct by physicians and staff • Works with appropriate manager and Employee Relations to address specific issues as they arise • Trends are followed and reviewed and reported to Executive Leadership *(Information in Complaint Resolution OO 21)*
Occupational Health	Purpose is to support staff health and safety in the work environment. Programs include: • TB Screening and compliance • Influenza vaccinations

	• Ergonomics • Smooth Moves • Many others • Work with individual managers and departments as issues arise • Track and analyze trends and report to Safety Committee and Nursing Leadership Board with recommendations for improvements as needed
Employee Assistance Program	• Provides services for staff including: o Stress incident debriefing o Workplace relationships o Counseling o Outside referrals as needed o Many others • Work with individual managers as appropriate (all services are confidential) • Keep leaders apprised of uses of services and make recommendations for changes and additions.
Safety Officer and VUMC Environmental Health and Safety	• Promotes safety & environmental management as well as addresses problems *(Information in OO 24 & 25)* • Receives and addresses any complaints • Conducts Environment of Care Rounds with interdisciplinary teams in all medical center sites at least twice each year and as identified by need to identify potentially unsafe, incompetent or unethical practices. • Reports through the Safety Committee and to the Executive Leadership • Tracks and analyzes trends and makes recommendations for changes • Conducts interdisciplinary root cause analysis for sentinel events or significant near misses
Patient Complaint Monitoring System for Physicians (PARS)	• Any complaint about a physician is assessed and follow-up is taken • Follow-up can include: counseling, education, corrective action and/or referral to the Physician Wellness Program
Office of Patient Affairs	http://www.vanderbilthealth.com/main/13777

	• Purpose is to serve as the patient's intermediary and to facilitate the flow of information between visitors and the medical center community and to create a caring environment. • Patient advocacy in the Office of Patient Affairs is available to assist patients in any way with questions, needs or concerns they have about their visit/care at VUMC.
Manager Resources	• Vanderbilt Nursing Website Resources http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=23175 • Credo Conversations Training – part of our Leadership Development work – "Giving and Receiving Feedback on Non-Credo Behaviors"
Workplace Violence Interdisciplinary Committee	• Identifies and addresses any violence reported in the Medical Center • Reviews every VERITAS II report with potential or actual violence involving staff • Follow-up information and trends are reported to Nursing Leadership, Vanderbilt Police, Employee Assistance and Risk and Insurance Management

Table EP 28 – 2: Examples of Structure and Processes Related to Conduct

Examples from Structures & Processes that Identify and Manage Incompetent, Unsafe, or Unprofessional Conduct

Process	Examples
Evaluations	Compliance with the evaluation process is centrally monitored by Human Resources and all Medical Center evaluations are completed in the month of April. Merit raises are tied to evaluations.
Performance Improvement Counseling (PIC)	Employee Relations staff are excellent partners with nursing in this process. *(Information can be provided on-site)*
VERITAS II & Risk	2008-2010 – Reported "Credo Behavior/Unprofessional Conduct for

Management	staff was 221 and for physicians was 195.
Admin RX – (Bar coding medications)	Total current scanning rates for VUH and VCH are above 95% (benchmark is 80%). This includes: patient's ID band scanned and patient's medications scanned when administered. Nurse Managers get a composite report showing scores for all units. Units that fail to meet the 80% benchmark on any day receive a second report for their unit only that includes a breakdown by individual staff member for scanning performance. [*EP28-Exhibit B-1-Scan History AdminRx Children's and Adult Hospitals, EP28-Exhibit B-2-Scan Rate* Summaries] [*EP28-Exhibit C-1-FELDOTT-ADE Overview Nursing Quality, EP28-Exhibit C-2-06-04-10 NQC Minutes*] *(Detailed Scanning reports are provided in 00 23 and EP 32 EO)*
Corporate Compliance Reports	In the last two years, the Corporate Compliance Office has received a total of 7 reports related to incompetent, unsafe, or unprofessional behavior. *(Records available on-site)*
Monitoring access & inappropriate computer use (IT) and HIPPA & Privacy Office	In summary, per quarter there are approximately 95 issues reported and approximately 40 of those come out as actual violations. [*EP28-Exhibit D-1-2009 4th Quarter-Final*]
Center for Patient & Professional Advocacy and Patient Complaint Monitoring System for Physicians (PARS)	Report information is provided in supporting document [*EP28-Exhibit E-1-PARS Progress Report Data*] Serves as an advocate for staff and/or patients who might be the recipient of unprofessional conduct.
Occupational Health	Detailed information provided in OO 24 and EP 30 & 30 EO.
Employee Assistance Program	Detailed information in EP 29: New cases program use Totals for FY 2009: • Faculty & Physicians - 180 • EAP – Staff - 796 • Nurse Wellness - 211

Environmental Health and Safety	Details in OO 20, 21, 24 & 25. [*EP28-Exhibit F-1-EOC 2009 Annual Report, EP28-Exhibit F-2-EOC Inpatient, EP28-Exhibit F-3-EOC-Outpatient, EP28-Exhibit F-4-EOC-Ped Inpatient, EP28-Exhibit F-5-EOC-Public Area*]
Manager Resources	Please see information below.
Workplace Violence	Please see information below.

Manager Resources

1. Per the Vanderbilt Nursing Website we have a section dedicated to supporting Professional Behavior. http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=23175 This serves as a resource for both staff and leaders. This resource provides information about our Professional Conduct Policy, reference articles, definitions and other helpful information.

Table EP 28 – 3: Screen Shot of Nursing Website

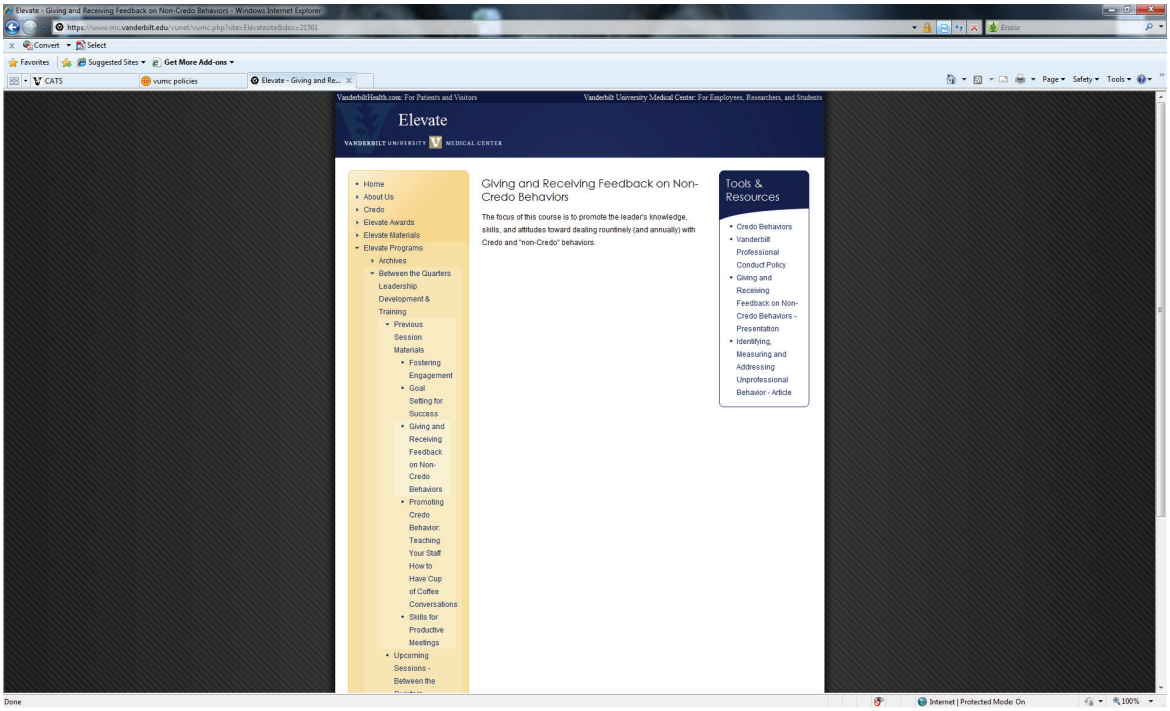
In addition, in November 2008, a four hour education program entitled: **Professional Behavior and a Healthy Workplace Culture,** was mandatory for all clinical leaders in patient care areas. The program was attended by approximately 200 leaders and provided for learning, practice sessions and feedback. [*EP28-Exhibit G-1-Prof Behv in the Workplace Results*] The materials from that workshop are linked to the website and managers and staff utilize those for education sessions and information. Probably one of the most useful tools is a comprehensive list of resources that can be accessed throughout the Medical Center. Some examples of information include:

- Examples from other leaders on how they have addressed unprofessional behavior
- Power Point presentations for Promoting Professional Behavior and PPB Tools and Resources for Clinical Leaders
- Starting Points for Addressing Professional Concerns
- References Grid and Books and Websites

[*EP28-Exhibit G-2-VUMC Resource List, EP28-Exhibit G-3-VUMC Resource List Additional, EP28-Exhibit G-4-Prof Behv Starting Points]*

2. Through our Elevate Leadership Development initiative, a course is offered to assist leaders with potentially challenging conversations – Giving and Receiving Feedback on Non-Credo Behaviors. This 4 hour program offers instruction on how to approach and have a conversation with any staff member who is exhibiting unprofessional (non-credo behavior). Due to the direct connection to the Credo and practice time, this program has proven to be an excellent resource for leaders.

Table EP 28 – 3: Screen Shot of Elevate Website



Workplace Violence

The Nurse Manager of the Trauma Unit, Sarah Hutchison, RN, BSN was approached by a group of staff members about a growing intolerance and anger building from repeated incidents of potential/actual/perceived workplace violence on 10 North Trauma. They felt like there continues to be an increasing number of violent acts on the streets of surrounding areas. Because Vanderbilt is a Level I Trauma Center, 10 North is receiving the victims of these trauma incidents, and thus potentially bringing the originating violence into the hospital. The Trauma staff is committed to treating each patient/family/visitor with dignity. However, the staff have found that many of the patients/families and friends push their limits and they sometimes find it challenging to work with these individuals. The Trauma staff created a survey, administered it to all staff, and the results were "eye opening" and enlightening.

Table EP 28 – 4: Survey Questions and % of Staff that Answered Yes

Survey Question	Percentage of staff that answered yes
Have you ever been the victim of workplace violence	50%
Has a patient/ patient's family ever hit, kicked, pinched, or in any way physically abused you/	66%

Have you ever felt intimidated to enter a patient's room because of the way the patient/ patient's family spoke to you?	50%
Have you ever had an injury, caused intentionally by a patient/family member that required medical attention?	16%
Have you ever reported any act of abuse (verbal, physical, or implied) that you have been the victim of?	Less than 50%

In addition to the survey questions, there were many enlightening comments, many of which focused on how do we put patients first, but still address this issue.

Sarah went to Work Life Connections/Employee Assistance Program (WLC/EAP) and shared the findings from the survey with Director, James Kendall. He had been helpful in the past with specific cases and issues surrounding similar fears. One of the biggest issues was that the fear and anger were growing. Due to the results of the survey and Jim's insight, a group was formed to start addressing these issues.

The survey information was shared and the team set the course for the work. A decision was made to address the issues that affected the staff most and where the team believed they could make the biggest impact for the staff. The team noted the many occurrences of workplace violence, identified the definition of the term, the reactions by staff and the long term effects we were seeing. The team looked at the evidence and contacted other Trauma Centers. They found that other Trauma Centers were facing the same issue, but few had real solutions for dealing with the issues.

The team had a one day working retreat in May, 2009. They discussed the research and training ideas, for what would be phase I of the program. Materials would address:

- Defining the issue
- The issues leading to/ cause workplace violence
- Identification of those at risk
- Training staff how to make their area safer
- How to diffuse escalating discussions

Training for the 10 North staff actually began in late October, after the major Trauma Season. The training was mandatory for all the staff and the compliance rate was 90%. The staff evaluations were positive for all areas. They reported that the discussion and the realization that all of their peers felt similar and worried about the possibilities acts of violence, was helpful to know. They were pleased with us taking the first steps.

A second survey was done in December to measure post training. The results were very similar, except more of them felt they knew how to report occurrences, and felt safe in doing so and by reporting what they witness from others (i.e. from 35 % to > 50%). Many were still extremely worried about how we can prevent the acts by developing better protocols for handling agitated and violent patients or provide better control of visitation by others. Although this team continues their work, they have already shared this information with:

- Vanderbilt Nurse Wellness Committee in December 2009
- The District Tennessee Nurses Association Meeting March 2010

The team has been asked to think about how to share this with Ohio State University after a recent incident on their campus. They are looking to possibly create a webinar or sponsored talks where needed.

Table EP 28 – 5: Team Members

Sarah Hutchison, RN,BSN	Manager, 10 N Trauma- Chair
Pat Morrow, RN3	Direct Care Nurse, Trauma Unit
Sondra Blount, RN 4	Direct Care Nurse, Trauma Unit
Pam Askins, RN 2	Direct Care Nurse, Trauma Unit
Alicia Woodall, RN 2	Direct Care Nurse, Trauma Unit
Jamie Gutshall, RN 2	Direct Care Nurse, Trauma Unit
Shirley Smith, LCSW	Trauma Social Worker
Margie Gale, RN, MSN, CEAP	Work Life Connections/Employee

	Assistance Program
Betty Barrow, RN	Risk Management
Diane Moat, RN, JD	Risk Management
Nola Brown, Lieutenant	Vanderbilt Police Department
Terrell Smith, RN, MSN	Director of Patient/ Family Care
Cathy Anderson	Guest Services

Current/Ongoing Work

The group has started reviewing VERITAS reports to see if they can identify any major trends. This is in development as to how any issues might be addressed.

After the release of the JCAHO sentinel event notice for "Preventing Violence in the health care setting", the team added some new work to their list:

- The staffs are looking at checklists to be used by bedside nurses to assess their areas for violent hazards (i.e. equipment, instruments, cables, etc.)

- The Charge Nurses are looking for another checklist for CNs to have to assess hallways for loose equipment and room safety issues

- VUPD is working on area assessments for violence in the ED and Trauma

- VUPD is working with plant operations to make sure we can, as a hospital, close and lock different access entries at night

- ED and Trauma are looking how to better lock down their areas for gang or violent events

- ED and Trauma will use similar codes and key phrases for violence (after we get our keypads replaced with possibly badge swipes)

- The Crisis Prevention Program is being reviewed by the managers of Trauma and the ED for possible advanced training of staff

- Jim Kendall shared the power point with us that is on VandySafe to tweak and mix with 10 Trauma Workplace Violence Prevention PowerPoint to take out to floors and staff for education.

This information was taken to the VUH Nursing Leadership Board and further discussion was about future plans:

- To have Charge Nurse specific training in both de-escalation and response to acts of violence

- To examine the possibility of having drills for the areas and the entire hospital (the group has already talked to Pam Hoffner, RN, MSN, Director, Emergency Preparedness to join us with her experience in hospital response for emergency preparedness)

- To make lists for staff and Charge Nurses to use for assessing and making plans in their area--- we have already started on this project

[*EP28-Exhibit H-1-10 N Workplace Violence Prevention Committee, EP28-Exhibit H-2-Behavioral Universal Precautions, EP28-Exhibit H-3-What You Should Know about Workplace Violence, EP28-Exhibit H-4-CPI Prospectus, EP28-Exhibit H-5-Training Prog Interview, EP28-Exhibit H-6-Trauma Workplace Violence Task Force-Template, EP28-Exhibit H-7-Value Statements for Educators(1), EP28-Exhibit H-8-Veritas Workplace Violence Screens, EP28-Exhibit-H-9-Workplace Violence Prevention References, EP28-Exhibit H-10-Workplace Violence Survey]*

Diversity and Workplace Advocacy

Source of Evidence 29

Describe and demonstrate the organization's workplace advocacy initiatives for:

- **Caregiver Stress**
- **Diversity**
- **Rights**
- **Confidentiality**

Vanderbilt University Medical Center as an organization offers many programs that address issues related to caregiver stress, diversity, rights and confidentiality. Organizational Overview Question 29 provides policies and procedures that address interdisciplinary conflict. VUMC/Nursing was, if not the first, then one of the first organizations to do a Nurse Wellness Conference.

Caregiver Stress

As is to be expected, VUMC offers a variety of services to support staff including a comprehensive benefits package for employees and family members including same-sex partners. This benefit package includes a free fitness and wellness counseling center which offers many exercise, wellness and counseling incentive programs.

Perhaps the most comprehensive support comes from our WorkLIfe Connections/Employee Assistance Programs (WLC/EAP). WLC/EAP takes a comprehensive approach to employee wellness and caregiver stress. A comprehensive look at WLC/EAP is provided.

Work/Life Connections-EAP

1. **Work Life Connections – EAP** (WLC) provides psychological Support to the Vanderbilt faculty and staff, promoting problem solving and stress resilience through individual counseling, group education, and manager consultations. It has services devoted to the special issues encountered by faculty, physicians, and nurses in addition to those provided other staff.

    - **FPWP**: In 1999, Vanderbilt began a specialized Faculty and Physician Wellness Program (FPWP) that utilizes a work based internal EAP model. The program was established to meet the growing needs of professionals coping with stress, depression, addiction and other emotional and behavioral issues. The keys to

success are easy accessibility, proximity, confidentiality, and compassion. The Faculty and Physician Wellness Program is available to psychological support to the Vanderbilt faculty of all ten University Schools as well as housestaff, spouses and domestic partners.

- **EAP**: The Employee Assistance Program focuses on psychological support for the Vanderbilt staff.

- **NWP**: The Nurse Wellness Program was launched in 2002 with the goal of providing psychological support to nurses. The components of the Nurse Wellness Program include counseling, workplace outreach, and promoting wellness. The Nurse Wellness Program is available to our Vanderbilt Nurses including: registered nurses, advanced practice nurses, graduate nurses, licensed practical nurses and their spouses or domestic partners. The Nurse Wellness Program champion (Margie Gale, RN, MSN, CEAP) is intricately involved in the nurse Wellness Committee activities supporting the wellness of nurses. This year the Nurse Wellness Traveling Fair has gone to the many worksites to promote wellness efforts, increase awareness of resources and services.

    - The Nurse Wellness Committee is one of the 7 committees for our Be the Best Work (details in NK). As part of their work, this committee has done an annual Nurse Wellness Fair. This past year, the group decided to "take it on the road." The traveling Nurse Wellness Fair was a big hit. (Please see specific information in below.)

Table EP 29 – 1: Summary Nurse Wellness Fair Activities 2009

Connections	Connected with over 500 nurses
SmartCart	Mobile display cart with handouts, information, materials on nurse wellness topics
Locations	Various areas in VUH, VCH, VPH, & various clinic locations, including those off-campus - (essentially every nurse would have had some opportunity to "pass by". Also, went to many individual units and clinics.
Exhibits & Information	• VUPD Safety • Victim Advocacy Program (Includes Domestic Violence) • Nurse Wellness Committee

	• Nurse Wellness Program • EAP • Smooth Moves • Health & Wellness • Vanderbilt Farmer's Market • Vanderbilt Go for the Gold • Heart Health info from VHVI • Information about musical 'Hey Florence' • University Hardship Fund (WLC – EAP) • Domestic Partner Benefits
In Addition **(Over 1,000 nurses contacted)**	During Nurses Week 2009 – Nurse Wellness Specialist – Margie Gale, RN, MSN, CEAP took an entire week out of the office & made rounds on every unit, in every department and in every clinic (including off-sites). Theme was promoting Stress Resilience with card handout on Stressages (messages on how to copy positively with stress).

2. Individual Counseling Services: Work/Life Connections-EAP confidential counseling services were provided to 1461 faculty and staff (260 faculty and physicians; 314 nurses; and 887 staff) representing a 6.5% utilization rate (based upon approx. 22,309 employees as of 6/30/2009).

- 1187 new cases were opened this year FY 08-09. On average, 93 faculty and staff new cases were opened each month

Table EP 29 – 2: Program Use-New Cases

	Cases 2008-09	Cases 2007-08
FPWP: Faculty and Physicians	180	176
NWP: Nurses	211	228
EAP: Staff	796	617

- Faculty: 73% of 140 new Faculty and physician clients seen for individual counseling represent the School of Medicine and the School of Nursing; 27% of the faculty represent the other University Schools

- Nurses: 164 new nurse clients seen for individual counseling

- Staff: 720 of the 887 staff (81%) seen for individual counseling were Medical Center employees. Approximately 77% of the Vanderbilt staffs are Medical Center employees and 23% work at University Central

3. Organizational Services

- Psychological First Aid is provided to individuals and groups following traumatic incidents

    - 33 Critical Incident Stress Interventions were provided surrounding 25 tragedies - the deaths of 2 MC Faculty, 8 Vanderbilt nurses, 5 staff members, the murder of a University faculty member and 9 difficult patient care situations

- Management Consultations to assist leadership with employee behavioral concerns

    - NWP and EAP: 16 managers sought organizational consultation services. Managers reported that the contact resulted in an improved plan to deal with issues in their departments

    - FPWP: 40 consultations with leadership around faculty and physician issues

- Departmental Workshops focused on topics such as stress resilience, conflict resolution, coping with stress, building a civilized workplace, cash flow management and dealing with change

    - Work/Life Connections-EAP provided 96 departmental in-services (stress resilience, conflict resolution, coping with stress, building a civilized workplace, cash flow management and dealing with change). More than 2450 employees participated.

- Promoting Professional Boundaries: 196 of the 200 Nursing Leaders attended the Nurse Leadership Academy including the WLC presentation on "Building a Civilized Workplace"

    - <u>Promoting Professional Behavior: Building the Civilized Workplace: It Starts with ME!</u>
      Presenter: Margie Gale, RN, MSN, CEAP

      This presentation focuses on staff responsibility in creating and building a civilized workplace that promotes a positive work environment. Current information about lateral violence in nursing and its impact on practice and patient care is provided as the basis to improve workplace civility. Specific communication techniques are recommended for addressing and resolving several forms of unprofessional behavior patterns. Resources are identified for staff to promote professional behavior in nursing.

- Eight-eight presentations were made to nurses in various media forms concerning stress resilience, professionalism and improved communication through Nurse Residency orientation, New Nurse Orientations, podcasts, unit boards, and department meetings.

- Addiction Recovery Support and Monitoring for Faculty and Staff who been treated for an addiction and have returned to work.

    - Recovery Support: 47 monitored Addiction agreements: 13 MC Faculty; 4 Housestaff; 1 University Faculty; 11 Nurses; 18 staff; one nurse and two staff members were terminated due to non-compliance. No faculty or physician on Addiction agreement was terminated from VU due to non-compliance.

- WLC administers the Faculty and Staff Hardship Fund which helps faculty and staff with financial assistance through a fund for small unexpected needs.

    - $32,531.80 was disbursed to faculty and staff in need. 87 employees were assisted with utility bills, rent, and other necessities following an acute event and 139 received $50 emergency food cards.

- 34 Vanderbilt families were assisted during the holidays through the Partnering with Parents program.

Impact

1. Retention

- The retention rate among faculty and physicians who participate in the program is not statistically different than that of all faculty and physicians at VU. No faculty or physician on Addiction agreement was terminated from VU due to non-compliance.

- The retention rate among nurses who participate in the program is similar to all nurses at VMC.

- The retention rate among staff who participated in the program is only slightly lower that staff who did not seek services at VMC.

2. Clinical Outcomes

- There was a 46% improvement on standardized inventories one month following initial WLC intake in those presenting with depression.

- At intake 65% of the clients reported that their problems interfered with their work performance and 60% reported improvement in productivity due to interventions.

- Following interventions, 63% stated that their performance, productivity and coping abilities improved.

3. Community Survey Results

- The Medical Center Community Survey score increased to 4.07 in 2008 from 3.99 in 2007 on awareness of Vanderbilt resources to deal with personal problems. 81% of respondents giving a favorable response

- The Community Survey score by nurse respondents increased to 4.05 in 2008 from 4.03 in 2007 on awareness of Vanderbilt resources to deal with personal problems.

Work/Life Connections-EAP Confidentiality

Confidentiality is critical in the success of the counseling relationship. Our counselors are legally required to maintain the confidentiality of client information. Confidential requirements are subject to State mandatory reporting issues. Information concerning your use of Work/Life Connections-EAP are not in any University medical or personnel record. Records are kept in the Work/Life Connections-EAP office and protected according to confidentiality protocols. At your first visit, you will be given an intake form that includes the following:

STATEMENT OF UNDERSTANDING

The Vanderbilt Work/Life Connections-EAP (Employee Assistance Program, Faculty and Physician Wellness Program and Nurse Wellness Program) offers assessment, referral, short-term counseling and follow-up. Services provided by Work/Life Connections-EAP are provided at no cost to the individual.

Referrals to Vanderbilt or other health care providers may be recommended to help you resolve problems. Those services may be covered under your medical benefit plan offered by Vanderbilt. We will try to always refer to providers covered by your insurance. However, it is your responsibility to determine whether or not services are covered under your plan and to pay any charges not covered.

CONFIDENTIALITY

Your counselor will not share information with any persons outside of the Work/Life Connections-EAP without your permission, except as required by law. Generally, legal rules do not require a release of such private information except where life or safety is seriously threatened. However, the following situations are the exceptions:

- If, in the professional opinion of the counselor, the client is actively homicidal or suicidal, Work/Life Connections-EAP has a duty to warn/intervene.

- If, in the professional opinion of the counselor, the client possibly poses a threat to the health and safety of patients, students, customers or co-workers, resulting from an emotional illness or substance use, Work/Life Connections-EAP has a duty to intervene/protect.

- In situations of child or domestic abuse, the law requires reportage to appropriate authorities.

- If there is suspected fraud or abuse, Work/Life Connections-EAP, in accordance with The Legal Compliance and Integrity Plan, is required to report to the Corporate Compliance Department.

- The individual signs a release of information.

In addition, information concerning your use of Work/Life Connections-EAP services will not be made part of your personnel record. Audits of the program may be conducted, but the auditors will not disclose information identifying your participation in the program.

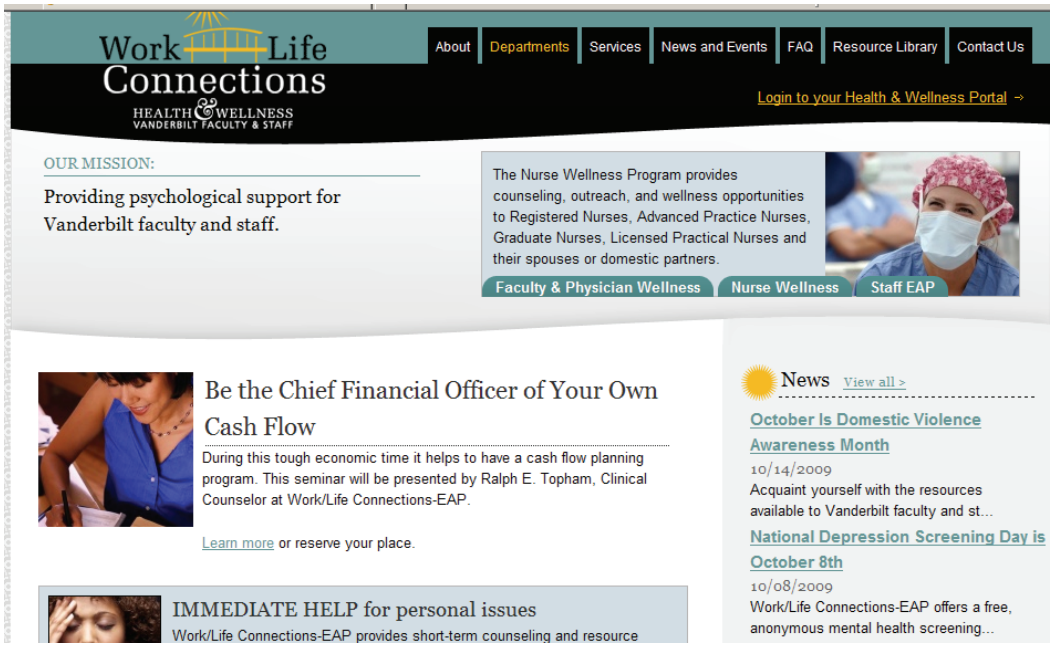
- **Self-Referral**: If an employee comes in for assistance, no one will be notified of the individual's use of Work/Life Connections-EAP unless the individual permits/requests it, except as noted above under confidentiality.

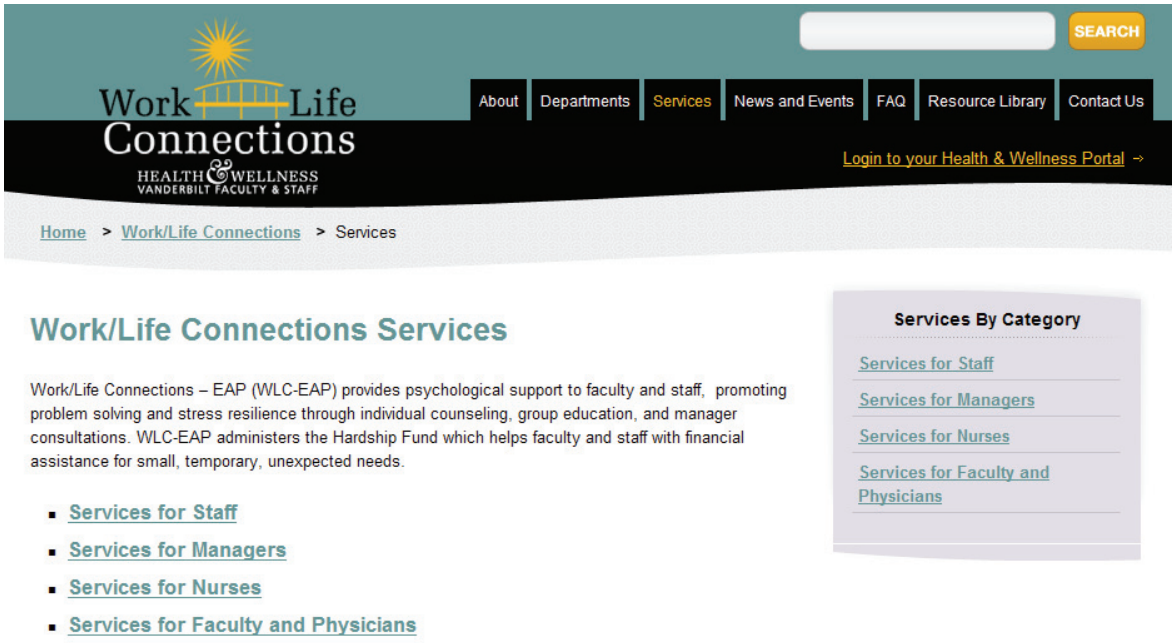
- **Mandatory Referral**: If an employee contacts Work/Life Connections-EAP as the result of a supervisory requirement, the supervisor will be notified that the employee has kept appointment at Work/Life Connections- EAP and whether their participation is satisfactory or not satisfactory. Information from the supervisor will be requested to clarify the issues and expectations in order to best assist the faculty or staff member.

Website: http://worklifeconnections.vanderbilt.edu/

Work/Life Connections-EAP, one of the four Vanderbilt Faculty and Staff Health and Wellness programs maintains a website geared toward easy access to information about services, access, information, resources, and program.

Table EP 29 – 3, 4 & 5: Screen Shots Work Life Connections/Nurse Wellness Website


Work Life Connections
HEALTH & WELLNESS
VANDERBILT FACULTY & STAFF
About
Departments
Services
News and Events
FAQ
Resource Library
Contact Us
Login to your Health & Wellness Portal
OUR MISSION:
Providing psychological support for Vanderbilt faculty and staff.
The Nurse Wellness Program provides counseling, outreach, and wellness opportunities to Registered Nurses, Advanced Practice Nurses, Graduate Nurses, Licensed Practical Nurses and their spouses or domestic partners.
Faculty & Physician Wellness
Nurse Wellness
Staff EAP
Be the Chief Financial Officer of Your Own Cash Flow
During this tough economic time it helps to have a cash flow planning program. This seminar will be presented by Ralph E. Topham, Clinical Counselor at Work/Life Connections-EAP.
Learn more or reserve your place.
IMMEDIATE HELP for personal issues
Work/Life Connections-EAP provides short-term counseling and resource
News
View all >
October Is Domestic Violence Awareness Month
10/14/2009
Acquaint yourself with the resources available to Vanderbilt faculty and st...
National Depression Screening Day is October 8th
10/08/2009
Work/Life Connections-EAP offers a free, anonymous mental health screening...


SEARCH
Work Life Connections
HEALTH & WELLNESS
VANDERBILT FACULTY & STAFF
About
Departments
Services
News and Events
FAQ
Resource Library
Contact Us
Login to your Health & Wellness Portal
Home > Work/Life Connections > Services
Work/Life Connections Services
Work/Life Connections – EAP (WLC-EAP) provides psychological support to faculty and staff, promoting problem solving and stress resilience through individual counseling, group education, and manager consultations. WLC-EAP administers the Hardship Fund which helps faculty and staff with financial assistance for small, temporary, unexpected needs.
Services for Staff
Services for Managers
Services for Nurses
Services for Faculty and Physicians
Services By Category
Services for Staff
Services for Managers
Services for Nurses
Services for Faculty and Physicians

PUBLICATIONS

- Kendall, J; Rice, T; Gale, M; Trice, E; and Yarbrough, M *The Creation of a Specialized University EAP Program— A Nurse Wellness Program* Journal of Workplace Behavioral Health, Volume 22, Issue 2 & 3 January 2008 , pages 111 – 126

- Kendall, J *Loss in the Workplace: Traumatic Event Response* The Journal of Employee Assistance, 1st Quarterly 2007, Vol. 37 No 1 pg 19

- Kendall, J and Gatrell, L *Reducing the Risk of Substance Abuse*, The Journal of Employee Assistance, Vol. 37 No 2, 2nd Quarterly 2007, pg25-36

- Silberman, A; Kendall, J; Price, A; and Rice, T *University Employee Assistance Program Response to Traumas on Campus* Journal of Workplace Behavioral Health, Volume 22, Issue 2 & 3 January 2008 , pages 91 – 109

- Kendall, J; Brady, D *Matters of the Heart: A program Support Medical Marriages for Residents at an Academic Medical Center* Journal of Workplace Behavioral Health, Volume 24, Issue 3 July-September 2009, pages 320 – 325

Table EP 29 – 6: Work/Life Connections Staff

Staff Member	Role
Margie Gale, RN, MSN, CEAP *Nurse Wellness Specialist*	Margie is a Mental Health Clinical Nurse Specialist with over 30 years of nursing experience. She has been a nursing instructor at the Vanderbilt School of Nursing, MeHarry Medical College and at Columbia State Community College. In 1988, Margie worked for the PASS, an Employee Assistance Program for the Nashville Police Department. She is president of the Tennessee Nurses Association. Margie joined Work/Life Connections-EAP in September, 2002. Margie is a key member of the Nurse Wellness Committee.
Mary Yarbrough, MD, MPH *Director of Health and Wellness Programs*	Dr. Yarbrough earned an M.D. from Vanderbilt and an MPH from Johns Hopkins. She completed residencies at Vanderbilt (Internal Medicine) and Johns Hopkins (Preventive Medicine and Public Health)) and is boarded in Internal Medicine, General Preventive Medicine and Public Health, and Occupational Medicine. She is an Associate Professor of Internal Medicine and Preventive Medicine at Vanderbilt. She is the Executive Director of Vanderbilt's Faculty/Staff Health and Wellness Programs, which includes the Occupational Health Clinic; the Child and Family Centers; Work/Life Connections--EAP, including the Faculty/Physician Wellness and Nurse Wellness Programs; and Health *Plus*, Vanderbilt's health promotion program.
Paul Ragan, MD *Medical Director*	Dr. Ragan is a Board Certified Psychiatrist and is Board Certified in Addiction Psychiatry. He is an Associate Professor of Psychiatry in Vanderbilt's School of Medicine, Senior Consulting Psychiatrist for the Adult Psychiatric Consultation Service and Staff Psychiatrist in the PTSD Clinic for the

	Tennessee Valley Health System, Nashville Campus.
Jim Kendall, LCSW, CEAP *Manager*	Jim earned his MSSW at the University of Tennessee in 1978 after completing his undergraduate studies at the University of California at Santa Cruz. He is a Licensed Clinical Social Worker with over 30 years of clinical experience. Jim joined the Vanderbilt staff in 2000. In 2005, he was honored with the "Friend of Nursing" award. Jim serves on the Nurse Wellness and Nursing Diversity Committees.
Stephanie Dean, LPC, CEAP *Assistant Manager*	Stephanie earned her Bachelor's and Master's Degrees from Western Kentucky University in Bowling Green, KY. She is a Licensed Professional Counselor and a Licensed and Certified Employee Assistance Professional. She joined the Work/Life Connections-EAP Team in January, 2008 after working as a Senior EAP for Cracker Barrel Old Country Store. Stephanie has also served as the Director of Employee Assistance Programs for Family and Children's Services in Nashville and was the EAP Director for Northcrest Medical Center.
Ellen Trice, LCSW, CEAP *Recovery Support Coordinator*	Ellen earned her Master's Degree in Social Work from the University of Tennessee, an MBA from Vanderbilt University, and a B.S. Degree in Human Behavior from Peabody. She is a Licensed Clinical Social Worker and a Certified Employee Assistance Professional. Her background in EAP includes starting the first employee assistance program at the University of California at Berkley; staffing the EAP program at Textron Aerostructures; and being Vanderbilt's first full-time EAP Coordinator in 1992.
Ellen Clark, LCSW, CEAP *EAP Counselor*	Ellen earned a Master's of Science Degree in Social Work at the University of Tennessee after completing her undergraduate degree in Psychology at Oakland University. She is a Licensed Clinical Social Worker with over 15 years of clinical experience. Ellen has provided clinical services to Peninsula Hospital, The Village, Children's Psychological Services, and Levi Strauss and Co. She has provided training

	for St. Mary's Hospital in Knoxville, Catholic Charities, Alcohol and Drug Council, Tennessee State University, the Crisis Intervention Center and taught graduate level courses at the University of Tennessee.
Ralph Topham, LPC *EAP Counselor*	Ralph earned his M.Ed. in Educational Psychology (Clinical Track) from the University of Utah, a B.A. in Zoology at the University of Texas, an M.A.T. from Washington University, St. Louis, and spent four years in the Air Force. He is a Licensed Professional Counselor with experience in stress reduction, coaching in leadership communication, and workplace issues. He also taught middle school science in St. Louis for 19 years. While in Utah, he began a private practice working as a communications trainer with executives and physicians. Ralph joined Work/Life Connections-EAP in June, 2008.
David Street, MD *Consulting Psychiatrist*	Dr. Street earned a MD Degree from the Medical College of Pennsylvania in 1991 after completing a B.S. at Pennsylvania State University. He was in private practice in General Otolaryngology, Head and Neck Surgery and Facial Plastic Surgery from 1996-2004. Making a career change, he completed his psychiatric residency at Vanderbilt in 2007 followed by a fellowship in forensic psychiatry at Emory in 2008. Dr. Street joined the Vanderbilt staff in 2008 and is a consulting psychiatrist for the Faculty and Physician Wellness Program of Work/Life Connections-EAP and an Assistant Professor, Department of Psychiatry, with a specialty in Forensic Psychiatry.

Health and Wellness

The Vanderbilt Faculty and Staff Health and Wellness programs support the health and productivity of Vanderbilt faculty and staff, http://healthandwellness.vanderbilt.edu/.

- The Occupational Health Clinic

- Health-Plus
- The Family and Child Centers
- Work/Life Connections-EAP

Health and Wellness Awards and Recognitions

- **The Corporate Health Achievement Award:** The American College of Occupational and Environmental Medicine (ACOEM) selected Vanderbilt University's Health and Wellness Division as a recipient of the 2002 Corporate Health Achievement Award (CHAA). Vanderbilt University is the first institution of higher education and academic medical center to receive this prestigious award. ACOEM, an international medical specialty society of more than 6,000 occupational and environmental medicine physicians, recognizes the best corporate health programs in American through the CHAA competition. The Award honors and provides national recognition to North American corporations and institutions exhibiting excellence in employee health, safety and environmental management, and recognizes the finest health programs in America. Examiners look for measurable results in 23 quality categories covering four areas - healthy people, a healthy environment, a healthy company, and management and leadership.

- **Fortune Magazine's 100 Best Companies:** In 2008, Vanderbilt was named one of the top 100 best places to work in the United States in Fortune magazine's prestigious annual survey; it is the first university ever to be named to the list. The rankings are determined through an extensive survey process and are based on levels of credibility, respect, fairness, pride and camaraderie in the workforce. The survey was conducted by Fortune in conjunction with the Great Place to Work Institute.

- **The C. Everett Koop National Health Award:** In 2008, the Go for the Gold Program received the prestigious C. Everett Koop Award honoring health promotion and disease prevention programs with a demonstrated savings from improving health behavior.

- **The Governor's Council on Physical Fitness and Health Shining Star Award:** Vanderbilt was recognized in 2009 for being a shining star in the workplace setting. The Governor's Council on Physical Fitness has established a Shining Star Awards program that is designed to recognize the efforts of the contribution to the promotion of healthy lifestyles by groups of Tennesseans.

- **The American Heart Association Fit-Friendly Companies Award:** Vanderbilt received the Platinum Award in 2008 and 2009 for recognition of companies that have demonstrated a commitment to fitness and nutrition in the workplace and well as demonstrate at least one behavior change program, one cost-savings outcome and one program that positive return on investment. Visit the American Heart Association's website to learn more.

- **The American Heart Association Worksite Innovations Award:** Health and Wellness received this award on Vanderbilt's behalf in 2008 for recognition of companies that lead the development and implementation of innovative and effective programs that promote physical activity specifically in the workplace. Visit the American Heart Association's website to learn more.

- **Nashville Scene Best of Nashville Award:** In 2008, the Nashville Scene publication voted the Vanderbilt Child Care Program one of the top three centers in Nashville by voters in the reader's poll.

- **League of American Communications Professionals Inspire Award Newsletter and Magazine Competition:** The Health and Wellness Connection newsletter that is mailed to the homes of faculty and staff was awarded the 2006 Honors recognition.

Table EP 29 – 7: Screen shot Work Life Connections Website

Table EP 29 – 8: VUMC Diversity Information and Resources

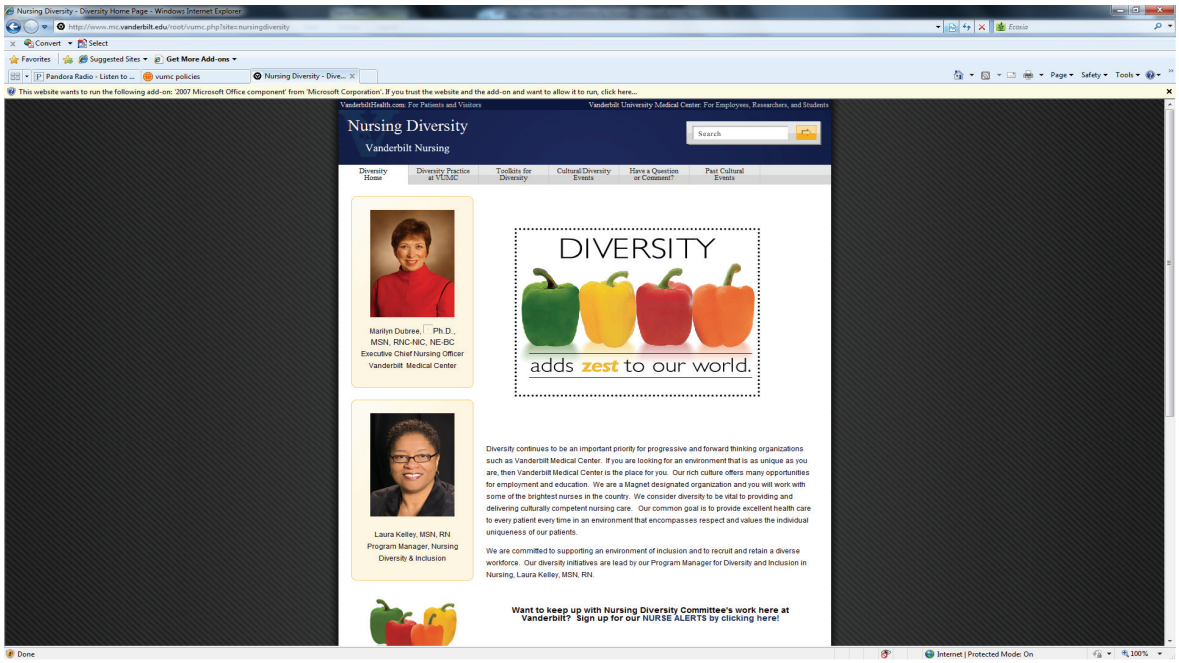
Structure	Processes

Equal Opportunity, Affirmative Action and Disability Services Department (EAD)	• Department website/Brochure
	• Policies (on-line)
	  ○ Domestic Partner Benefit Policy
	  ○ Equal Action and Affirmative Action Policy
	  ○ Anti-Harassment Policy
	  ○ Work Place Violence Policy
	  ○ Grievance Policy
	  ○ Privacy Office
	  ○ Electronic Communication Policy
	[*EP29-Exhibit A-1-EAD Spring Newsletter 2010, EP29-Exhibit A-2-EEO Poster, EP29-Exhibit A-3-Domestic Partner Benefit Policy*]

EAD Training	• Attitudes Towards Differences • Alphabet Soup • Sexual Harassment Workshop/Brochure • Cross-Cultural Communication Workshop

Human Resources	• Recruiting and Hiring Policy • Staff Conduct Policy [EP29-Exhibit B-1-Professional Conduct Policy]
Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) Organization/Department	• Training ○ Safe Zone Training [*EP29-Exhibit C-1-LGBTQI Information*]
Department of Pastoral Care	• Staff • On-line Religious & Cultural Information Manual *(Information provided in EP 26)*
Nursing Diversity Committee *(Chart of ethnic profile for nursing in OO 1)*	• Website: http://www.mc.vanderbilt.edu/root/vumc.php?site=nursingdiversity • Toolkit – online • Dignity and Respect: Showing our Patients Cultural Sensitivity Workshop Laura Kelley, RN, MSN, Program Manager for Nursing Diversity and Inclusion *(More Information on Nursing Diversity Committee Below*)

Table EP 29 – 9: Screen Shot Diversity Webpage



http://www.mc.vanderbilt.edu/root/vumc.php?site=nursingdiversity

Nursing Diversity Committee [*EP29-Exhibit D-1-Nursing Diversity Charter, EP29-Exhibit D-2-Nursing Diversity Committee Member List*]

As one of the seven – Be the Best Committees *(in NK)*, Nursing Diversity Committee as established: To cultivate an inclusive culture encompassing respect and valuing individual uniqueness at all levels of Nursing within Vanderbilt University Medical Center. The committee is co-chaired by Laura Kelley, RN, MSN, Program Manager for Nursing Diversity and Nicole, Herndon, RN, MSN, APN-NP, NEA-BC, Assistant Administrative Director Perinatal Services

Scope of the work:

- Identification of best practices regarding recruitment and retention that will foster a sense of community around the core Elevate Pillars and attract a diverse nursing group.
- Recommendations to address issues related to recruitment and retention.
- Conduct benchmarking activities that support exploration of best practice strategies to enhance minority/diverse workforce.

Still a relatively new committee, the group has accomplished much and continues to try to define their work in nursing and throughout the Medical Center. One of their next projects is a pilot with Nurse Managers. The purpose of the pilot is to determine if targeted training for nurse managers will improve their "comfort level" in providing leadership for a diverse nursing staff. The table below provides some of the accomplishments of the Nursing Diversity Committee and future goals. [*EP29-Exhibit E-1-06-11-10 BTB Minutes-Diversity* Pilot]

Table EP 29 – 10: Accomplishments and Goals Nursing Diversity Committee

Accomplishment	Goal 2010
Mission Statement Diversity Brochure Diversity Recruitment Plan Website Aprilfest 2009: Three one hour Cultural Workshops Nurses' Week 2009: Thank you E-card to all Nursing Staff. Nursing Diversity Website	Continue to collaborate with Recruitment on diversity recruitment Cultural Presentations for: Martin Luther King Celebration Aprilfest Nurses' Week 2010 Employee Celebration Month Oktoberfest Develop communication plan to advertise diversity website Develop plan to increase number of subscribers to nurse alerts for diversity

Octoberfest Diversity Day: Three one hour Cultural Workshops Participated in Attitudes Toward Differences workshops Completed Diversity Gap Analysis of current practices and training for leadership	Continue updates to website Collaborate with LDI, EAD and Nursing Education in an advisory capacity for development of leadership support Implement recommendations from Gap Analysis Develop diversity training for leadership

VCH-Example

"Laura came to our July 1 VCH Nursing Staff Council meeting and presented an update on the work of the Nursing Diversity Committee. We discussed issues around "creating an inclusive culture". She shared the new goals and did an update from what is now on the Diversity Website. Laura also encouraged us to sign up for Diversity Nursing Alerts! to receive updates and information. They are currently sending out helpful hints on different cultural and religious customs, which can be helpful for patients and for working with our peers. She is available to attend staff meetings and/or unit board meetings."

Melanie Foster, RN, BSN, 7th Floor & 4 A Acute Care Medicine & EMU

Table EP 29 – 11: VUMC Rights and Confidentiality Information and Resources

Structure	Processes
Nurses Bill of Rights	Link from the Nursing Website – under Professional Links. Nurses can access the document that lists the seven rights of nurses as outlined by the American Nurses Association and also the document outlining how those rights "live" at Vanderbilt.
Privacy Office	The Privacy Office oversees the institution's HIPAA requirements for the privacy and confidentiality of protected health information. The Privacy Office daily reviews employees viewing employee's medical records to ensure the confidentiality of those records. Staff may also call or email the Privacy Office and request that their protected health information be audited for unauthorized access. The Privacy Office maintains the privacy portion of the Privacy/Security website which provides information for staff members relating to the HIPAA privacy regulations and a link to the Privacy Office email for reporting known or suspected confidentiality violations. Information and Privacy Security Website:

	http://www.mc.vanderbilt.edu/root/vumc.php?site=InfoPrivacySecurity&doc=21566 The Privacy Office also distributes a monthly newsletter among the institution which provides important privacy and confidentiality information and reminders to staff members.
Human Resources/Employee Relations	Serves as an advocate in the monitoring of policies and discipline for all staff in a consistent and appropriate manner Examples include: • Performance Improvement Counseling and Discipline • Federal and organizational leave policies • Many others
Accommodating Employee Rights to Request another Care Giver be Assigned due to Personal Beliefs	Operations Policy 30-10.10 is the Request for Excuse from Staff Assignment (Religious, Ethical or Other Reasons) • Staff submit a written request • Requests are reviewed by the Opportunity Development Center • Each request is evaluated on its own merit • The majority of requests are accommodated • If the requested accommodation is not possible in the employee's current position, the employee is supported to explore a formal transfer through recruitment for posted positions where an accommodation may be feasible [*EP29-Exhibit F-1-Request for Excuse from Staff Assignment*]
Nursing Bylaws provides process for Clinical Dispute Resolution	Nursing Bylaws Article V. Section 5 – Dispute Resolution Procedure for Clinical Practice [*EP29-Exhibit G-1-VUMC Nursing Staff Bylaws-Dispute Resolution*] • Step 1: Discussion with supervisor • Step 2 : Facilitation • Step 3: Nursing Dispute Resolution Committee for Clinical Practice Issues – Clinical experts and peers (if not resolved by Steps 1 & 2)

Unique Example of Wellness Activity in Nursing

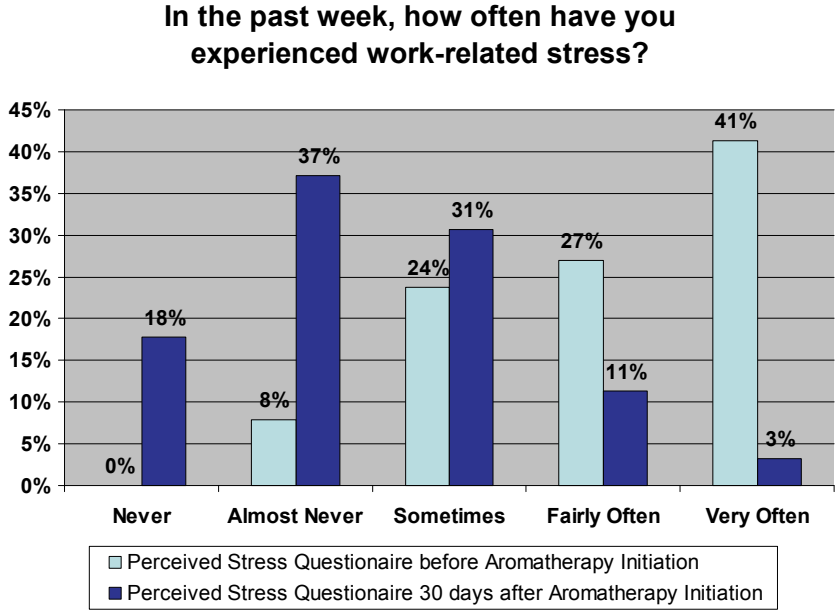
Aromatherapy in the Adult ED

http://www.mc.vanderbilt.edu/root/vumc.php?site=adulted&doc=25041

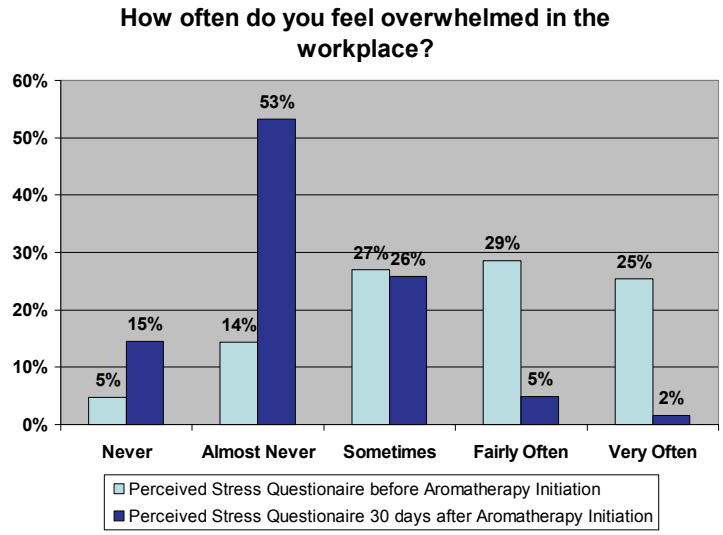
The Adult Emergency Department started their own Wellness Committee. Tonya R. McBride RN and Teresa G. Sturges, RN develop their first project which was the use of essential oils to decrease stress and also the sometimes "not so pleasant odors" in the ED. Through the use of evidence and a well designed study, the Adult ED was able to measure the benefits of "essential oil therapy" for multiple items, including: decrease in work-related stress, decreased feelings of being overwhelmed at work and feeling better equipped to handle stress at work. This new approach to the hectic "ED Life" was embraced by the entire interdisciplinary team. The work of this committee will continue as they look at "nurse wellness" in the Adult ED. On their survey, 93% of the respondents said they would like to see work on a "Quiet Room" for staff. [*EP29-Exhibit H-1-Essential Oil Introduction – ED, EP29-Exhibit H-2-Wellness Committee Standard Roll Out Plan – ED, EP29-Exhibit H-3-Wellness Survey – ED*]

See the graphs below for study results:

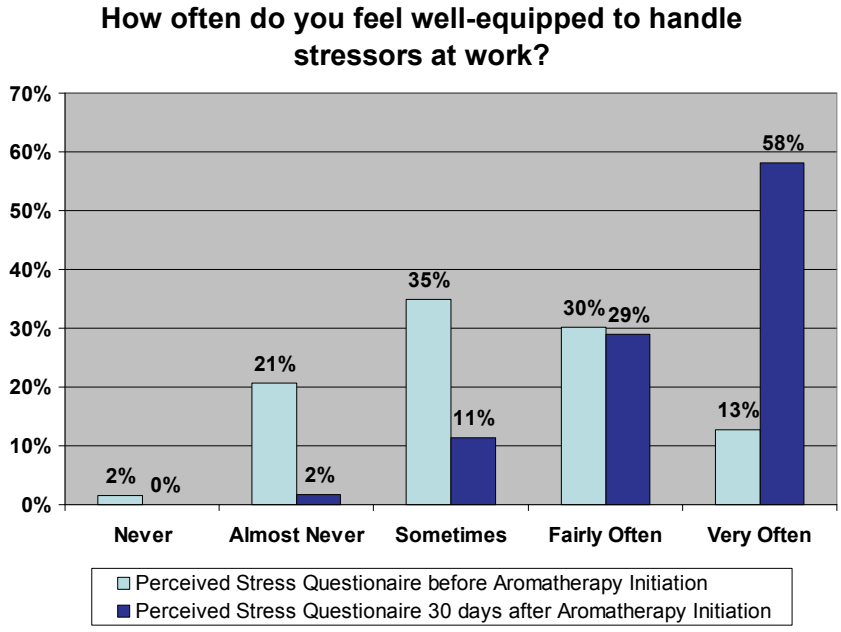
GRAPH EP 29 - 1: Work Related Stress



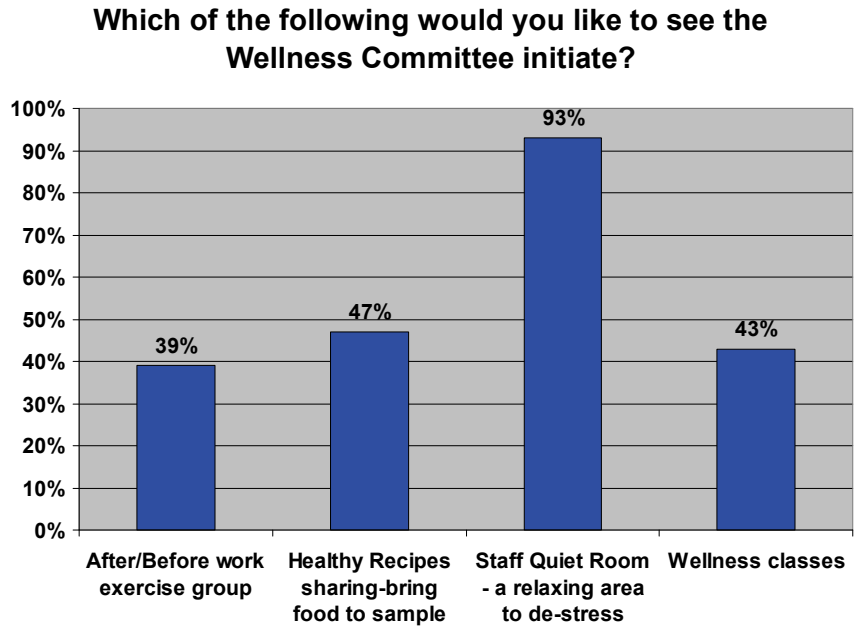
GRAPH EP 29 - 2: Feeling Overwhelmed in the Workplace



GRAPH EP 29 - 3: Feeling Well-equipped to Handle Stressors at Work



GRAPH EP 29 - 4: Wellness Committee Options



VCH – "In his own words"

"In 2001, after 14 years of emergency service work, my EMS career suddenly came to an abrupt end when I was diagnosed with PTSD. The stress that compounded during those years changed my life professionally and personally in the profound ways. At that time, PTSD and severe stress were not often discussed in the health care field. Through my personal experience, I want bring awareness to this subject and to educate providers on how to stay mentally healthy when caring for others in the health care field.

This is a 1-2 hour education presentation that I have presented to several departments within Vanderbilt Medical Center including LifeFlight, the Pediatric Emergency Dept, Neonatal Intensive Care Unit, Children Hospital Nursing Administration, and Children's Hospital Executive Leadership. Large presentations outside of Vanderbilt include: 2008 Update in Acute & Emergency Pediatric Care conference in Nashville TN, 2009 Contemporary Forums National Critical Care Conference in Nashville TN, and 2009 Hampton Roads Trauma Conference, Newport News VA. I have also been invited to present to the International Critical Incident Stress Foundation State Conference in Nebraska. It is scheduled for October."

Description of the presentation:

"Health care workers consistently strive to provide the highest quality of patient care while being bombarded with a variety of external factors including high patient volumes. They are experts in dealing with high stress events and keeping calm during seemingly uncontrolled situations. But who do health care workers call for help when they are the ones in need? The cumulative stress is carried by all providers and affects each of us in different ways. This presentation will share, though one individual's personal journey, that which is often not talked about within the healthcare community. Learn strategies that can help you and your colleagues indentify those at high risk and can show you how to provide the appropriate assistance, ultimately increasing retention and reducing burnout of your team members.

I am currently working on a study format to collect data pre and post course to measure effectiveness. However, my own unofficial data are the comments from staff that have been in the program. Several people have shared their personal story with me following the lecture and several have gone on to seek assistance with EAP and some off campus." [*EP29-Exhibit I-2-Eric's Class Comments*]

Eric Clauss, RN, EMT, ENPC
Children's Emergency Department