

Strategic Planning

Source of Evidence 1

Describe and demonstrate how nursing's mission, vision, values, and strategic and quality plans reflect the organization's current and anticipated strategic priorities.

Context for Vanderbilt Nursing Mission, Vision, Values and Strategic Plans

Vanderbilt is a complex academic medical center. The detail about the organizational structure is comprehensively reviewed in Organizational Overview 1 however, there are some important organizational relationships to consider related to alignment of mission, vision and strategic and quality plans. Vanderbilt University Medical Center is comprised of four entities. These include Vanderbilt University Hospital, The Monroe Carell Junior Children's Hospital, Vanderbilt Psychiatric Hospital and the Vanderbilt Medical Group and Clinics and all are part of the Vanderbilt Magnet designation. The Chief Executive Nursing Officer provides leadership for the provision of nursing care across all of these entities. Thus, the nursing mission, vision and strategic plan must be relevant in each of the entities. An extremely important strategic alliance is with the Vanderbilt Medical Group which is the physician practice portion of the organization. Alignment of physician and nursing professions within each entity is critical to maximizing patient outcomes.

This source of evidence demonstrates the alignment of the nursing mission, vision, values and strategic plan within the context of the broader organization and within the Vanderbilt Medical Group. The CEOs of the entities described above as well as the Executive Chief Nurse report as peers to the Vice Chancellor of Health Affairs and thus have equal influence over the organization's strategic and quality plans.

Nursing and the Organization Vision and Mission Alignment

Vanderbilt provides us a stimulating, intellectually rich and supportive environment to develop the science and art of nursing and to bring the full potential of nursing practice to bear on patients and families. The mission, vision and values of nursing are driven by the philosophy of nursing represented in Table TL 1-1 as well as the principles set forth in the Vanderbilt Nursing Bylaws Table TL 1-2. (*Complete copy of Nursing Bylaws in OO 3*). The content of these foundational documents ensure that nursing is clear in its focus for strategic planning and integrates within a complex organization. Fully grounded in a deep understanding of, and

commitment to the discipline of nursing, the profession of nursing at Vanderbilt is leading the way in innovation and excellence. To that end, the nursing vision, mission and values have been developed and then integrated into the strategic vision and planning for Vanderbilt University Medical Center.

The CNO is engaged and involved in the planning process for the system and brings the message of professional nursing to the executive table. Likewise nurses across the organization in all roles and all settings are part of the planning and implementation of this strategic vision as they are included in many of the planning and implementation teams. (*Committee information in OO 15*) It is this process of matrix decision making and inclusion of all disciplines in clinical testing of new ideas and processes to improve patient care that makes Vanderbilt a system that continues to grow, and strive to meet all aspects of its mission and vision.

Table TL 1-3 demonstrates the relationship between the University mission statement, the Medical Center mission statement, The Vanderbilt Medical Group and the nursing mission statements. The process of strategic planning for nursing and the organization is reviewed in TL3.

Table TL 1 – 1: Philosophy of Nursing

PHILOSOPHY OF NURSING VANDERBILT UNIVERSITY MEDICAL CENTER
<p>We believe that the provision of highly skilled and specialized nursing care is essential to the fulfillment of Vanderbilt University Medical Center’s mission of improving health care outcomes through quality in patient care, education and research. Nursing embraces the responsibility to provide patient centered, high quality, and cost effective nursing care for all patients and their families.</p>
<p>We believe nursing is an applied art and science with the focus of professional practice being to assist individuals, families and communities in achieving optimum health and well-being. This assistance includes preventive health care, education, facilitating recovery and continued support through illness, disability, or death. Professional nurses collaborate with physicians and other disciplines to deliver coordinated and comprehensive patient care. This collaborative care takes place in a variety of settings.</p>
<p>We are guided by a philosophy that recognizes the inherent worth, dignity and uniqueness of every individual. We promote participation of patients and significant others in decisions regarding the patients’ health care and work toward their optimal level of wellness.</p>

We are committed to providing an environment that continually seeks to improve delivery of patient care, facilitates rapid changes in practice, and encourages flexibility throughout all levels of care providers. We believe in the concept of Shared Governance whereby staff participates in decisions affecting nursing practice and the clinical work environment. We believe in the enhancement of an environment that fosters effective communication at all levels, provides recognition of nursing staff for excellence in clinical practice and promotes the recruitment and retention of clinically competent staff. We support the roles of nurses in advanced practice as clinical experts and resources for the enhancement of patient care throughout the care continuum.

We believe that research is a vital component for the advancement of evidenced-based clinical practice. Systematic evaluation of the effectiveness of nursing practice contributes to the improvement of patient care and the expansion of nursing knowledge. Excellence in nursing practice is enhanced by creating an environment that provides opportunities for advanced nursing education as well as stimulating personal and professional growth. We seek to foster innovation by working collaboratively with other disciplines to develop new models of clinical practice to improve quality patient outcomes.

We believe that the future of the profession rests upon developing collaborative models between nursing service and nursing education. Nursing facilitates the education of patients, families, nursing peers, colleagues from other disciplines and students of the various health professions. Each nurse serves as a role model of quality professional practice.

We are accountable for our practice in accordance with recognized professional standards and ethical codes. We accept the challenge of providing high quality nursing care as a member of the total health care team in a complex and dynamic health care environment.

Table TL 1-2: Nursing Bylaws Preamble - below

Preamble to the Nursing Bylaws
<p>The nursing staff of VUMC is responsible for the nursing care administered to our patients, with the Board of Trust having the ultimate authority. In order to effectively fulfill this obligation, the nursing staff conforms with the Bylaws, which are formulated upon the following principles:</p> <ol style="list-style-type: none"> 1. All patients are entitled to safe, effective, evidence-based nursing care. 2. Nursing care of the patient is enhanced by use of an evidence-based care delivery system tailored to the uniqueness of each patient and provider. 3. The continuing measurement, evaluation, and improvement of nursing practice are essential to the provision of safe, effective, evidence-based nursing care. 4. The patient is best served by the nursing staff's collaboration with other hospital staff, participation in educational and research programs, and use of evidenced based practice. 5. All nursing staff is accountable for our mission of continuous quality improvement, patient safety, customer satisfaction, and cost effective, evidence-based, value added care. 6. Patients are best served in a healthcare environment that fosters learning, stimulates professional growth and promotes nursing research and innovation in nursing practice.

Table TL 1-3: University, Medical Center and Nursing missions, vision and values

Vanderbilt University Mission	Vanderbilt Medical Center Mission	The Vanderbilt Medical Group and Clinics	Vanderbilt Nursing Mission, Vision and Values
<p>Vanderbilt University is a center for scholarly research, informed and creative teaching, and service to the community and society at large. Vanderbilt will uphold the highest standards and be a leader in:</p> <ul style="list-style-type: none"> • the quest for new knowledge through scholarship, dissemination of knowledge through teaching and outreach, • Creative 	<p>Vanderbilt University Medical Center (VUMC) is a comprehensive healthcare facility dedicated to patient care, research, and biomedical education. Its reputation for excellence in each of these areas has made Vanderbilt a major patient referral center for the Mid-South. Each year, people throughout Tennessee and the Southeast</p>	<p><u>MISSION</u> The Mission of VMG is to improve the health of the people in the communities we serve through evidence-based personalized compassionate care research, ad education.</p> <p><u>VISION</u> The Vision of VMG is to shape the future of</p>	<p><u>MISSION</u> Advance health and wellness through excellence in nursing care, education, and research throughout the lifespan and across the continuum of care.</p> <p><u>VISION</u> To be the national leader in nursing practice, education and research in all nursing roles,</p>

<p>experimentation of ideas and concepts.</p> <p>In pursuit of these goals, Vanderbilt values most highly</p> <ul style="list-style-type: none"> Intellectual freedom that supports open inquiry, equality, compassion, and excellence in all endeavors. 	<p>choose Vanderbilt for their health care needs, not only because of its excellence in medical science, but also because the faculty and staff are dedicated to treating patients with dignity and compassion.</p> <p><i>Vanderbilt's mission is to advance health and wellness through preeminent programs in patient care, education, and research.</i></p>	<p>healthcare through discovery and innovation.</p> <p><u>VALUES</u></p> <p>We make those we serve our highest priority.</p> <p>We respect privacy and confidentiality</p> <p>We communicate effectively with our patients and colleagues</p> <p>We conduct ourselves professionally, with respect and compassion.</p> <p>We have a sense of ownership for the health of our communities</p> <p>We have a high commitment to our colleagues</p>	<p>specialties, and settings.</p> <p><u>VALUES</u></p> <p>We value:</p> <ul style="list-style-type: none"> patient safety and quality Having strong interdisciplinary collaboration and communication. having effective shared decision making and support a continuous learning environment. providing meaningful rewards and recognition highly specialized nursing care and influencing the nursing practice patient and family centered care improving the health of the community through outreach, research and wellness initiatives.
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Behavioral Alignment of Nursing and the Organization

An important part of the foundation for Vanderbilt that aligns nursing and all disciplines is the Vanderbilt Medical Center Credo. The credo translates the mission and vision into foundational behaviors for all faculty and staff. It is commonly referred to as describing “It’s *Who We Are*”. Regardless of the role at Vanderbilt, all faculty, staff, nursing and other disciplines, are held accountable through performance management for demonstrating

behaviors described by the credo. The credo provides consistency, accountability and a shared understanding of behaviors that optimize patient outcomes and staff satisfaction. The Credo is presented in Table TL 1-4.

Table TL 1 – 4: VUMC Credo

Vanderbilt University Medical Center Credo
<ul style="list-style-type: none">• We provide excellence in healthcare, research and education.• We treat others as we wish to be treated.• We continuously evaluate and improve our performance
<p>I make those I serve my highest priority:</p> <ul style="list-style-type: none">• promote the health and well being of all patients who seek care at Vanderbilt• support trainees in all of their academic endeavors• respect colleagues and those we serve who differ by gender, race, religion, culture, national origin, mental and physical abilities and sexual orientation and treat them with dignity, respect and compassion• recognize that every member of the Vanderbilt team makes important contributions• ensure that all team members understand overall team goals and their roles• answer questions posed by patients, trainees or staff to ensure understanding and facilitate learning <p>I have a sense of ownership:</p> <ul style="list-style-type: none">• take any concern (real, perceived, big, or small) seriously and seek resolution or understanding - ask for help if the concern is beyond ability or scope of authority• approach those who appear to need help or be lost and assist/direct them appropriately• clean up litter, debris and spills promptly or notify the best resource to keep the medical center environment clean and safe• remain conscious of the enormous cost of health care, teaching and research and optimize resources while delivering exemplary service <p>I conduct myself professionally:</p> <ul style="list-style-type: none">• recognize the increasing diversity of our community and broaden my knowledge of the cultures of the individuals we serve• adhere to department and medical center policies such as smoking, attendance and dress code• refrain from loud talk and excessive noises - a quiet environment is important to heal,

learn and work

- discuss internal issues only with those who need to know and refrain from criticizing Vanderbilt in the workplace and in the community
- continue to learn and seek new knowledge to enhance my skills and ability to serve
- strive to maintain personal well-being and balance of work and personal life

I respect privacy and confidentiality:

- only engage in conversations regarding patients according to Vanderbilt policies and regulatory requirements
- discuss confidential matters in a private area
- keep written/electronic information out of the view of others
- knock prior to entering a patient's room, identify myself, and ask permission to enter
- utilize doors/curtains/blankets as appropriate to ensure privacy and explain to the patient why I am doing this, ask permission prior to removing garments or blankets

I communicate effectively:

- introduce myself to patients/families/visitors, colleagues
- wear my ID badge where it can be easily seen
- smile, make eye contact, greet others, and speak in ways that are easily understood and show concern and interest; actively listen
- recognize that body language and tone of voice are important parts of communication
- listen and respond to dissatisfied patients, families, visitors and/or colleagues
- remain calm when confronted with or responding to pressure situations

I am committed to my colleagues:

- treat colleagues with dignity, respect and compassion; value and respect differences in background, experience, culture, religion, and ethnicity
- contribute to my work group in positive ways and continuously support the efforts of others
- view all colleagues as equally important members of the Vanderbilt team, regardless of job, role or title
- promote interdepartmental cooperation
- recognize and encourage positive behaviors
- provide private constructive feedback for inappropriate behaviors

Alignment of Strategic Planning

The strategic planning process for nursing is described in TL 3. This section responds to the question of how the nursing strategic plan reflects the organization's current and

anticipated strategic priorities. The most recent nursing strategic planning process was completed in May of 2010. The organizational pillar goals, the Vanderbilt Medical Group’s strategic plan and the known information related to healthcare reform provided the context and foundation for the nursing strategic plan. On completion of the draft nursing strategic plan, Marilyn Dubree, the Executive Chief Nursing Officer met with the CEO’s of the Vanderbilt Medical Group, Vanderbilt University Hospital, Monroe Carell Junior Children’s Hospital, the Vice Chancellor of Health Affairs and the Dean of the Vanderbilt School of Nursing to ensure they perceived the nursing strategic plan aligned with those entities plans and that the strategic plan was relevant to the future of the Medical Center.

Several tables are presented that demonstrate alignment of the Vanderbilt Nursing Strategic plan with the organization. Table TL 1-5 demonstrates the alignment of Vanderbilt Medical Group Strategies and Nursing Strategies. (*Nursing Strategic Plan in OO 3*)

Table TL 1 -5: Alignment of Goals and Strategic Plans Fiscal Year 2010

VMG Strategies	Nursing Strategies
Continuously improve patient outcomes using evidence-based medicine: and innovative, reliable, coordinated care practices.	Lead the nation in producing evidence that will drive nursing practice, recognizing and legitimizing the evolution of knowledge in a rapidly changing environment. Create passion and discipline for the translation of evidence into practice that will optimize patient outcomes.
Promote wellness and disease-prevention in our communities.	
Provide an exceptional personalized patient experience through family-centered care and value creation.	Transform the way in which health care is delivered across the continuum in order to ensure highly reliable personalized care, taking advantage of the capabilities and unique contributions of the entire care delivery team.
Be the healthcare employer of choice.	Create a leadership model that will provide current and future leaders the environments, tools, evidence and skill development to be innovative and transformational during a time

	of health care reform and transition.
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The Strategic Plan for Nursing outlines goals that support each strategy. Strategies and supporting goals are outlined in Table TL 1-6. The crosswalk of the alignment of these goals with the VMG strategic goals is presented in Table TL 1-7.

Table TL 1 – 6: Nursing Strategies and Goals

Nursing Strategies and Goals	
I. Vanderbilt Personalized Patient Care Model	
1 Statement of Strategy: Transform the way in which health care is delivered across the continuum in order to ensure highly reliable personalized care, taking advantage of the capabilities and unique contributions of the entire care delivery team.	
<u>GOALS</u>	
1.1 Determine what brings value to patients, makes a difference and creates breakthroughs	
1.2 Understand the impact of who brings the right skill set and resources to achieve a personalized healthcare model	
1.3 Understand and design systems to maximize the benefit and utilize the full talents of the healthcare team	
II. Evidenced Based Practice and Effective Processes	
2 Statement of Strategy: Lead the nation in producing evidence that will drive nursing practice, recognizing and legitimizing the evolution of knowledge in a rapidly changing environment. Create passion and discipline for the translation of evidence into practice that will optimize patient outcomes.	
<u>GOALS</u>	
2.1 Establish/create nursing infrastructure dedicated to driving the cycle of EBP	
2.2 Develop and implement core training systems for evidenced based practice processes targeted to role requirements	
2.3 Ensure the alignment of evidenced based practice with internal and external benchmarking and quality improvement priorities	

<p>2.4 Complete gap analysis for evidenced based practice and create a work plan for moving forward</p> <p>2.5 Disseminate and publish; broadcast to mark what is being accomplished in evidenced based practice</p> <p>III. Transformational Leadership and Professional Development</p> <p>3 Statement of Strategy: Create a leadership model that will provide current and future leaders the environments, tools, evidence and skill development to be innovative and transformational during a time of health care reform and transition.</p> <p>GOALS</p> <p>3.1 Develop transformational leaders who can create and transform programs/products/environments to meet the patient population needs and VUMC organizational goals (People, Quality, Safety, Finances, Growth, and Innovation).</p> <p>3.2 Develop a recruitment and retention philosophy that supports flexible standard and consistent requirements for leadership practice.</p> <p>3.3 Provide organizational learning opportunities for the individual leaders and leadership teams to learn together and obtain or create tools to meet their desired objectives</p> <p>3.4 Define the leadership model that is transformational and flexible with leadership competencies and a menu of tools</p>

Table TL 1 - 7: Cross walk of alignment of VMG strategic goals and Nursing Strategic Goals

Vanderbilt Medical Group Strategic Goals	Nursing Strategic Goals
<p>Clinical Growth & Capacity Establish clinical service capacity, infrastructure, and desired growth in support of VUMC goals.</p>	
<p>Operational Efficiency Achieve optimal service and care coordination by improving the operational efficiency and effectiveness of the Vanderbilt clinics through</p>	<p>1.2 Understand the impact of who brings the right skill set and resources to achieve a personalized healthcare model</p> <p>1.3 Understand and design systems to</p>

<p>the design and implementation of a consistent and measureable operational platform that meets patient/family expectations, simplifies work processes for physicians and staff, supports future growth, and creates an environment of innovation.</p>	<p>maximize the benefit and utilize the full talents of the healthcare team 2.4 Complete gap analysis for evidenced based practice and create a work plan for moving forward</p>
<p>Continuous Improvement of Outcomes Demonstrate continuous improvement of patient outcomes through the use of evidence-based medicine and quality and safety science best practice</p>	<p>2.3 Ensure the alignment of evidenced based practice with internal and external benchmarking and quality improvement priorities</p>
<p>Development & Training Improve team effectiveness, care, and service outcomes in patient care through organizational development and training programs targeted to leadership development, support staff education, clinical team training, and orientation.</p>	<p>2.2 Develop and implement core training systems for evidenced based practice processes targeted to role requirements 3.1 Develop transformational leaders who can create and transform programs/products/environments to meet the patient population needs and VUMC organizational goals (People, Quality, Safety, Finances, Growth, and Innovation). 3.3 Provide organizational learning opportunities for the individual leaders and leadership teams to learn together and obtain or create tools to meet their desired objectives</p>
<p>Maximize Value Maximize the value of VMG to the organization (internally), locally, and nationally.</p>	<p>1.1 Determine what brings value to patients, makes a difference and creates breakthroughs 2.5 Disseminate and publish; broadcast to mark what is being accomplished in evidenced based practice</p>
<p>Management & Governance Align management and governance of the</p>	<p>2.1 Establish/create nursing infrastructure dedicated to driving the cycle of EBP</p>

<p>VMG/TVC for execution of the strategic plan and the meet the interests of the VUMC in the transformation of practice.</p>	<p>3.2 Develop a recruitment and retention philosophy that supports flexible standard and consistent requirements for leadership practice.</p> <p>3.4 Define the leadership model that is transformational and flexible with leadership competencies and a menu of tools</p>
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We have adopted an approach to operations based on the five pillars of people, service, quality, finance and innovation. Annually, the organization develops pillar goals to guide operational focus for the coming year. A Blueprint for Quality that has been collaboratively developed for the entire organization and the Nursing Quality Performance Plan guide the creation of the annual quality pillar goals which are represented in Table TL 1-8. Both of these documents are available in Organizational Overview – Question 3. Table TL1-8 represents our approach to annual 5 pillar goal establishment and the crosswalk of organizational pillar goals and nursing pillar goals.

Table TL 1 – 8: Crosswalk of organizational pillar goal targets with nursing pillar goals

2011 Organizational Pillar Goals	2011 Nursing Pillar Goals
<p>People</p> <ul style="list-style-type: none"> Retention at 18 months after hire – 67.5% Overall turnover (all employees) – 11.5% 	<p>People</p> <ul style="list-style-type: none"> Retention at 18 months after hire – 67.5% Overall turnover (all employees) – 11.5% Nursing Turnover – 11.8%
<p>Service Pillar (Patient Satisfaction)</p> <ul style="list-style-type: none"> Overall Quality of Care – perform at 95 percentile Overall Teamwork between doctors, providers, nurses and staff – perform at 95 percentile Patient engagement – perform at 95 percentile Improve VMG access to level of 60% of 	<p>Service Pillar (Patient Satisfaction)</p> <ul style="list-style-type: none"> Overall Quality of Care – perform at 95 percentile Overall Teamwork between doctors, providers, nurses and staff – perform at 95 percentile Patient engagement – perform at 95 percentile Improve VMG access to level of 60% of

<p>new patients being seen within 15 days of requesting appointment</p>	<p>new patients being seen within 15 days of requesting appointment</p>
<p>Quality</p> <ul style="list-style-type: none"> • Observed to expected mortality at 0.70 • 15% reduction in healthcare acquired infections (SIR score of 1.11) as measured by the sum of Central line acquired blood stream infections, ventilator acquired pneumonia, catheter associated urinary tract infections • 15% reduction in preventable healthcare adverse events as measured by the sum of falls, pressure ulcers, medication errors. • Improve intra-professional communications within and across all care settings during transfer and transitions of care and during procedures • Design and establish a coherent quality improvement learning system with defined tools and methods to foster continuous learning for continuous improvement • Achieve top performance in clinical programs <ul style="list-style-type: none"> ○ Stroke – 91% ○ Pneumonia – 90% ○ Heart failure – 95% ○ SCIP – 94% ○ OPPS – 94% ○ Acute MI – monitor ○ Diabetes – to be developed ○ Pediatric asthma – TBD 	<p>Quality</p> <ul style="list-style-type: none"> • Observed to expected mortality at 0.70 <p>Healthcare Acquired Infections</p> <ul style="list-style-type: none"> • Central line acquired blood stream infections SIR score of 1.31 • Ventilator acquired pneumonia SIR score of 1.24 • Catheter associated urinary tract infection SIR score of 0.63 • Surgical site infection SIR score of 1.09 • Hand hygiene – 90% compliance <p>Preventable healthcare adverse events</p> <ul style="list-style-type: none"> • Pressure ulcers per 1000 patient days – 0.86 • Falls per 1000 patient days – 3.00 • Medication errors per 1000 patient days – 3.81. <p>Intra-professional communications</p> <ul style="list-style-type: none"> • Design standardized process and tools for handovers and spread to 3 areas <p>Design and establish a coherent quality improvement learning system with defined tools and methods to foster continuous learning for continuous improvement</p> <ul style="list-style-type: none"> • Develop prototype of standardization process for admission and discharge medication reconciliation <p>Achieve top performance in clinical programs</p> <ul style="list-style-type: none"> ○ Stroke – 91% ○ Pneumonia – 90% ○ Heart failure – 95% ○ SCIP – 94% ○ OPPS – 94% ○ Acute MI – monitor

	<ul style="list-style-type: none"> ○ Diabetes – to be developed <p>Pediatric asthma – TBD</p>
<p>Finance and Growth</p> <ul style="list-style-type: none"> • Results of operations - \$106.4 million • Discharges – 55,360 • Ambulatory visits – 1,557,302 • Surgical procedures – 47,472 • Cost per discharge - \$16,288 • Cost per visit - \$489 	<p>Finance and Growth</p> <ul style="list-style-type: none"> • Results of operations - \$106.4 million • Discharges – 55,360 • Ambulatory visits – 1,557,302 • Surgical procedures – 47,472 • Cost per discharge - \$16,288 <p>Cost per visit - \$489</p>
<p>Innovation</p> <ul style="list-style-type: none"> • Warfarin– proof of concept • MyHealth@VU – results of proof of concept • Achieve reduction in growth of Vanderbilt Health Plan costs – results of proof of concept • Diagnostic Management team – results of proof of concept • Integration of pharmacogenomic information into clinical decision support infrastructures • Presentation of genomic data to individuals 	<p>Innovation</p> <p>Warfarin</p> <ul style="list-style-type: none"> • Improve over baseline INR in-range by 20% (outpatient coumadin clinic) <p>MyHealth@VU</p> <ul style="list-style-type: none"> • Improve to 65% the number of patients with blood pressure in control without adversely affecting satisfaction scores (VMG nurse managed patients through MyHealth@VU)

Strategic Planning

Source of Evidence 2

Describe and demonstrate how nurses at every level – CNO, nurse administrators, and direct-care nurses – advocate for resources, including fiscal and technology resources, to support unit/division goals.

There are a multitude of ways nurses at all levels influence access to resources to meet unit and department goals. Starting at the staff level, all staff have direct access to nurse managers as well as through Unit Board meetings, staff meetings, unit based quality and service meetings. Managers practice leader rounding intentionally asking “Do you have the tools to do your job” and “What resource or systems problems exist that are barriers to effective patient care”. Leaders are expected to actively access required resources and/or to remove identified barriers to support patient care. Staff nurses also sit on organization wide committees and councils providing feedback to managers and administrators in nursing and from across the Medical Center.

Managers meet with the administrator responsible for their area regularly both one on one and with their peers. During these group meetings common resource issues are identified and accountability for access resources defined. Inpatient managers have access to the Medical Economics Outcomes Committee where supply purchases are considered. This committee organizes trials for new supplies and supply replacement and equipment.

Nursing administrators and executives are actively involved in creating and prioritizing the capital list for all entities each year. Nursing leaders are responsible for demonstrating need and return on investment for new items that are not replacement items. Managers and administrators work closely with Clinical Engineering leadership to be certain critical equipment is replaced according to the life cycle and maintenance and repair requirements of the equipment is followed. [TL2-Exhibit A-1–VUH capital list with leaders] Nursing administrators play a pivotal role in establishing IT priorities. Nurses at all levels participate in design shops and regular meetings to advocate and influence nursing IT development and purchasing plans that support the role of the professional nurse and optimize patient outcomes.

Examples

IT Design Shops

Information technology annual planning process – Although there has been a long history of end users being involved in the IT decision making, there had not been a structured process for nursing input. This sometimes resulted in the lack of alignment between IT priorities and outputs and organizational goals. The current process has been perfected over the last 5 years. It has put the operational planning process team members with a strong nursing voice in the driver seat for IT prioritization. The process results in a shared vision, clear priorities and measurable outcomes. The process also includes quarterly check in as objectives and priorities change over the year.

The prioritization occurs in “Design Shops” which are held in the Center for Better Health. These design shops depend on large groups of multiple levels of employees coming together. The participants work in small groups reporting out progress to the larger group. The recommendations and decisions in the day(s) of Design Shops are iterative and continually draw on the experts in the field to inform IT of needs, desired outcomes and priorities. The final output of the Design Shops is a “Swim Lane” document that creates timelines and deliverables for each project. The document is used by users to evaluate the progress of the IT teams. [TL2-Exhibit B-1-2010 Design Shop –Patient Engagement, TL2-Exhibit B-2-Heart Failure Teaching Record]

In one of the early design shops several nursing related IT projects were identified.

- The need was identified to standardize admission and shift skin assessments to be consistent with national guidelines. As a result of this, changes were made to the electronic order entry system and the nursing documentation system. The changes were piloted for staff feedback and then rolled out across the enterprise in the spring and summer of 2009.
- Ventilator acquired pneumonia (VAP) and compliance with the VAP bundle were problematic in the nursing ICU’s. The participants in the design shop recognized the opportunity for IT to provide reminders and feedback loops for nurses to improve compliance with the bundles. As a result of the design shop both the electronic order entry system and the nursing documentation system were improved.

In addition, nurses were provided with a dashboard that is constantly open on clinical work stations for the patients on the unit. Each part of the bundle has a red, yellow and green

indicator flag for each patient. Red means the task in the bundle is not complete and overdue for a particular on a patient. Yellow means that it is nearing time for a particular task to be completed. If the steps in the bundle are complete, the task box is green. Through the use of the VAP dashboard as a reminder and flag to nurses regarding what is due, over- due and complete on their patients, the VAP standardized infection ratios (SIR) fell from 2.59 in MCJH in February of 2008 to a SIR of 0.7 in July of 2010 and in the adult hospital the Sir went from 2.23 to 1.75 in the same time frames referenced.

- Nurses identified at the design shop that the electronic medical record made it difficult to see all of the information necessary to care for the patients efficiently. Nurses stated they could not easily read the patient story and understand what had happened, was happening and was going to happen to a patient. As a result of this identification, the Overview of Patient Care (OPC) was developed which aggregates all necessary information for the nurse in one location.

Although the pilot was well received, changes were made to “de-clutter” the overview to make it easier to read. In addition, a charge nurse snapshot was developed to include all of the information charge nurses need to make appropriate assignments on patients. The overview of patient care has had broad adoption across the inpatient organization and has been adopted as a useful tool for physicians as well as nurses.

- Based on feedback at a design shop that nurses needed more alerts and reminders, a screen saver was developed for all clinical work stations which displays visual reminders and alerts for nursing staff when there are new orders for a patient, new lab results or interventions are necessary.

Accessibility to Human Resources at Off-Campus Site

Opening of the 100 Oaks outpatient campus provided many challenges for Janice Smith, RN, MS, the Chief Administrative Officer and the Nursing leader at 100 Oaks. She became aware that the human resource needs of the 1,000 employees at that campus would be difficult to manage with Human Resource (HR) functions only available approximately 6 miles away. Both managers and employees have many human resource department needs including recruitment, position changes, hiring, termination, and employee relations issues. These functions have traditionally been spread across many departments in HR. Janice set a goal to provide as much on site HR consultation as possible. Janice worked with Veronica Burns, the Director of Human Resources to develop a new title of HR generalist. This HR employee would be able to manage a wide variety of issues as opposed to the traditionally highly specialized staff in Vanderbilt’s HR

Department. Janice successfully worked with David Posch, the CEO of the VMG and the Vanderbilt Clinics to secure funding for the position. The position was funded through VMG but dually reports to Janice and HR leadership. The position was filled and HR service began in October of 2009. *[TL2-Exhibit C-1-HR Generalist Job Description]*

Resources to Change Practice

Kathy Burns, MSN, RN, a clinical nurse specialist in the CVICU became aware of research related to improved neurological survival for out of hospital arrest patients when their body temperature is cooled for 24 hours. Kathy partnered with the Medical Director of the CVICU, John McPherson and developed a program proposal for this effort. She worked through the Medical Economics and Outcomes Committee to complete trials of the necessary cooling equipment.

Kathy discovered interest for this technology across other ICU's. She began to work through the Institutional Critical Care Committee to develop the necessary justification for the devices. She worked with purchasing and with the vendor of the selected device to develop a quote for the technology. Through the capital prioritization process in the Vanderbilt Heart and Vascular Institute, funds were secured for this device.

To date, 38 of the 79 patients or 48.1% who were "out of hospital arrests" survived and are neurologically intact. This is compared to a historical 25-30% survival rate in un-cooled cardiac arrest victims admitted alive to hospital, with a lower rate of good neurologic outcome despite survival. *[TL2-Exhibit D-1-Cooling Release, TL2-Exhibit D-2-Hypothermia]*

IT Leadership for Nursing

VUMC has been listed as one of the "most wired" hospitals and health system in the country. There is a large informatics team that develops and implements healthcare technologies that enhance the delivery of patient care. Our Executive CNO, Marilyn Dubree MSN, RN, NE-BC, recognized the need for a nursing leader in informatics applications within the healthcare system. She observed that technology was beginning to define nursing practice and noted it would either enhance or detract from the professional role of the nurse depending on the implementation and use. Marilyn recognized that the science of the application of technology to nursing practice in a healthcare system required a knowledgeable and dedicated resource.

Marilyn created a position to oversee clinical applications of technology and enhance the practice of nursing. The position created the nursing informatics bridge between the

hospital and the clinics. The person selected for this position would articulate a strategy to ensure that nursing needs were met in an ever increasing highly automated environment. Deborah Ariosto, RN, MSN, PhD(c) (doctoral candidate in Nursing) joined Vanderbilt as the Director of Patient Care Informatics on November 5, 2008. Since her arrival, she has completed the assessment of nursing informatics systems and processes and begun to influence change in the system.

Deborah has been very active. Since she began in her role she has worked with staff and leaders to standardize and simplify pain documentation. She has developed a new method, system and tool for documenting patient education for heart failure patients. She directs changes to the nursing documentation system through simplification and standardization. Deborah has created the QERI-Ops group which is charged with quality, education, research and informatics initiatives with the strategic planning and operational structures of Vanderbilt nursing.

Capital Budget

As part of the budget process annually, all of the entities submit the prioritized list of the capital needs in their area. These are generally submitted in the major Capital Category (>\$100,000), routine capital (<\$100,000 but >\$50,000) and discretionary (<\$50,000). The Vanderbilt Heart and Vascular Institute spans the continuum of care and includes operations and nursing in the following areas:

- 5 Inpatient units
- 1 on campus clinic for cardiology, vascular and cardiac surgery (50,000 visits)
- 14 off campus clinics (20,000 visits)
- Non-invasive diagnostic testing s on campus and off including nuclear cardiology, Cardiac MRI, Echocardiography, stress testing, autonomic function testing, vascular testing
- Cardiac Catheterization labs
- Electrophysiology labs

VHVI does not have a capital allocation. Capital must be submitted to both the VMG and VUH because VHVI operations sit both in VUH and the VMG and both of these entities have their own capital allocations.

The diversity of services provided in the Heart Institute makes capital submission to two different entities challenging every year. Robin Steaban RN, MSN is responsible for operations and nursing in VHVI and is responsible for capital submission. She has created an Operations Council within VHVI. The Council is the operating decision making body of VHVI for all things that are within the budget and the recommending body for all things outside of the budget. All of the Medical Directors, their associated nursing manager partners and VHVI administrators are voting members of the Council. Robin works through this structure to have physician and nursing leaders prioritize the capital list for VHVI based on programmatic priorities and clinical need. Nursing leaders and physicians have equal voice in the process. *[TL2-Exhibit-E-1-Operations Council Minutes]*

Robin then takes the capital needs to both the VMG and VUH and works with the administrative teams at that level to prioritize VHVI needs against others in the organization. Robin is able to work with all administrators to agree what capital should be purchased with consideration of the entire organization in mind. She is present for the capital negotiations and is able to advocate for the needs within VHVI based on return on investment, patient safety and quality risk, potential impact to the business for unplanned failure. This participation in the organization wide process allows Robin to communicate with VHVI Medical Directors, Nursing Managers and Administrators why capital decision were made. The process builds trust in the organization and keeps staff and faculty connected to organizational priorities outside of VHVI. *[TL2-Exhibit-E-2-Five year Capital Plan]*

“Vanderbilt Shockers”

Dawn Sabine, RN, BSN is a nurse in the Vanderbilt Heart and Vascular Institute. She works as a specialty nurse with arrhythmia patients. There is a significant population of patients with CIEDs (cardiac implantable electronic devices). Dawn is the expert in caring for these patients. She recognized that although this therapy is life saving, it is also a life altering experience. Patients must make modifications to their lives once they have had a CIED placed. She recognized CIED patients needed additional support. Dawn researched what other institutions were doing and developed a proposal for a CIED support group for patients and families. She advocated with leadership in VHVI for the funding and clerical support to manage

these support groups. In 2007, the support for the group was successfully budgeted and Dawn held the first meeting of the “Vanderbilt Shockers”.

The group typically has 80-100 people in attendance. She has worked on behalf of the patients to advocate for resources for the meetings that takes place 3-4 times per year. These resources include speakers, space, recruiting volunteers as well as monetary resources.

The group has remained active and has been positively reviewed in a patient feedback tools. By increasing patient education and allowing for greater access to health care providers, patients have an opportunity to learn from experts as well as other patients about how to adjust their lives to accommodate and thrive with an ICD.

Dawn has just started an advisory board that meets on a periodic basis on behalf of the other ICD patients. The advisory board makes suggestions as to future topics, speakers and if needed, will contact new patients who are having trouble or would like to speak with another patient with an ICD. *[TL2-Exhibit F-1-Invitation]*

Can I help you find your way?

Tom Conner, RN, Manager of the Medical Center East PACU reported that staff noted many lost visitors and families outside of the PACU wandering the halls. At times, they have inadvertently entered the operating rooms. Staff consistently offers to assist people who appear lost. Numerous times when a patient is in route to the OR the gurney is stopped so the Anesthesia personnel can provide directions. Guest Services did not seem to be an option for the 3rd floor. In lieu of Guest Services, Tim contacted Julie Bulger in volunteer services. In cooperation with Beth Pittman of Guest Services, there will soon be a volunteer on the 3rd floor scouting lost people in 2 hour time blocks.

Strategic Planning

Source of Evidence 3

Describe and demonstrate the strategic planning structure(s) and process(es) used by nursing to improve the healthcare system's: 1) effectiveness and 2) efficiency.

Our strategic planning efforts are multi-tiered and multi-focused. The foundation for all planning efforts is the VUMC organizational plan. The plan is created annually at the most senior executive levels of the organization and sets the direction of VUMC. There are entity and Institute strategic planning efforts that produce plans consistent with the overall VUMC strategic planning but specific to the entity or Institute. In addition, there is a specific strategic planning process for nursing within the organization that is lead by Marilyn Dubree, MSN, RN, NE-BC, Executive Chief Nursing Officer.

Each of these plans cascade off of the VUMC. In addition, each of these plans is heavily influenced if not lead by nursing leaders. Nurses across the organization contribute and influence the strategic plans of the organization, entities and Institutes. The following will describe efforts related to VUMC, Vanderbilt entity and institute strategic planning efforts and the structures and processes that provide nurses at every level an opportunity to influence these plans to improve the effectiveness and efficiency of the healthcare system.

Vanderbilt Nursing Strategic Planning Structure and Process

In 2008 many changes were occurring in our nursing leadership. The organization had grown to the extent that a more robust nursing leadership structure was required. In that year Marilyn added several positions that reported to her as she moved into the Executive Chief Nursing Officer role. Those positions included a CNO for VUH and for the Vanderbilt Medical Group in addition to the existing CNO of Monroe Carell Junior Children's Hospital. In October of 2008, Marilyn Dubree, the Executive Chief Nursing Officer (ECNO) convened all nursing administrators for a several day retreat. The goal of that retreat was to solidify the leadership infrastructure for nursing as well as the charters for the nursing leadership structures. Another deliverable of the retreat was a draft mission and vision statements for nursing.

Marilyn gave all nursing administrative leaders (the Nursing Administrative Board i.e., NAB) an opportunity to review the organizational documents related to the mission and vision of the organization. She then asked all to participate in a dialogue about the content of these

documents and how they should inform the development of a nursing vision and mission. After much discussion, a list of agreed upon thoughts was created.

The Nursing Executive Board (NEB) members then left the NAB retreat armed with what they had heard from all nursing administrators. They began the work of crafting the mission and vision statements for nursing. Each member of NEB worked privately and then joined with the entire NEB group to share their ideas and collaborate on the final draft of a mission and vision statement. After 2 hours, the draft was presented to the larger NAB. The document was fully endorsed and has become the Vision and Mission of nursing at Vanderbilt University Medical Center.

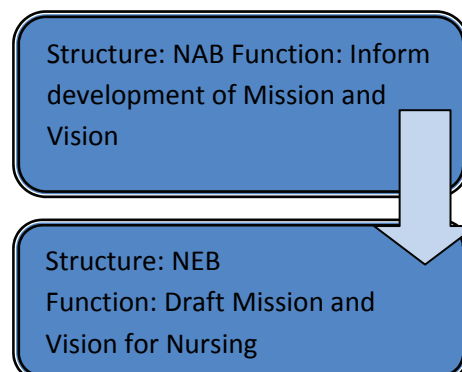
Several more workshops and retreats focusing on the development of the nursing strategic plan were held in the months that followed. Consistent with the roles of Boards in the Nursing Bylaws, Marilyn worked closely with the members of the strategically focused Nursing Executive Board (NEB) through the strategic planning process. In April of 2009, the NEB worked with Marilyn to identify three strategic priorities based on a review of internal and external priorities for nursing.

Through June and July of 2009, Marilyn reviewed the three strategic priorities with the Vice Chancellor, the Deputy Vice Chancellor and CEO of Vanderbilt Hospitals and Clinics and the CEO's of the VMG and Clinic, the Children's Hospital and Vanderbilt University Hospital. In addition, Marilyn reviewed the three strategies with managers of the Medical Center and at the Staff Nurse Councils. Feeling confident about the direction of the strategic plan, Marilyn convened an NEB retreat in the November of 2009 to begin to plan the tactics to attain the strategic priorities.

Throughout 2010, the Be the Best teams have begun to focus on the beginning implementation of the nursing strategic initiatives.

The Development and review process of the strategic plan is shown in Chart TL 3 – 1.

Chart TL 3 - 1: Process for Development of Current Nursing Strategic Plan





VUMC executives support an annual planning process that is build around the five pillars of performance used by Vanderbilt to guide organizational direction and focus. The pillars and the 2011 goals are represented in Table TL 3 – 1.

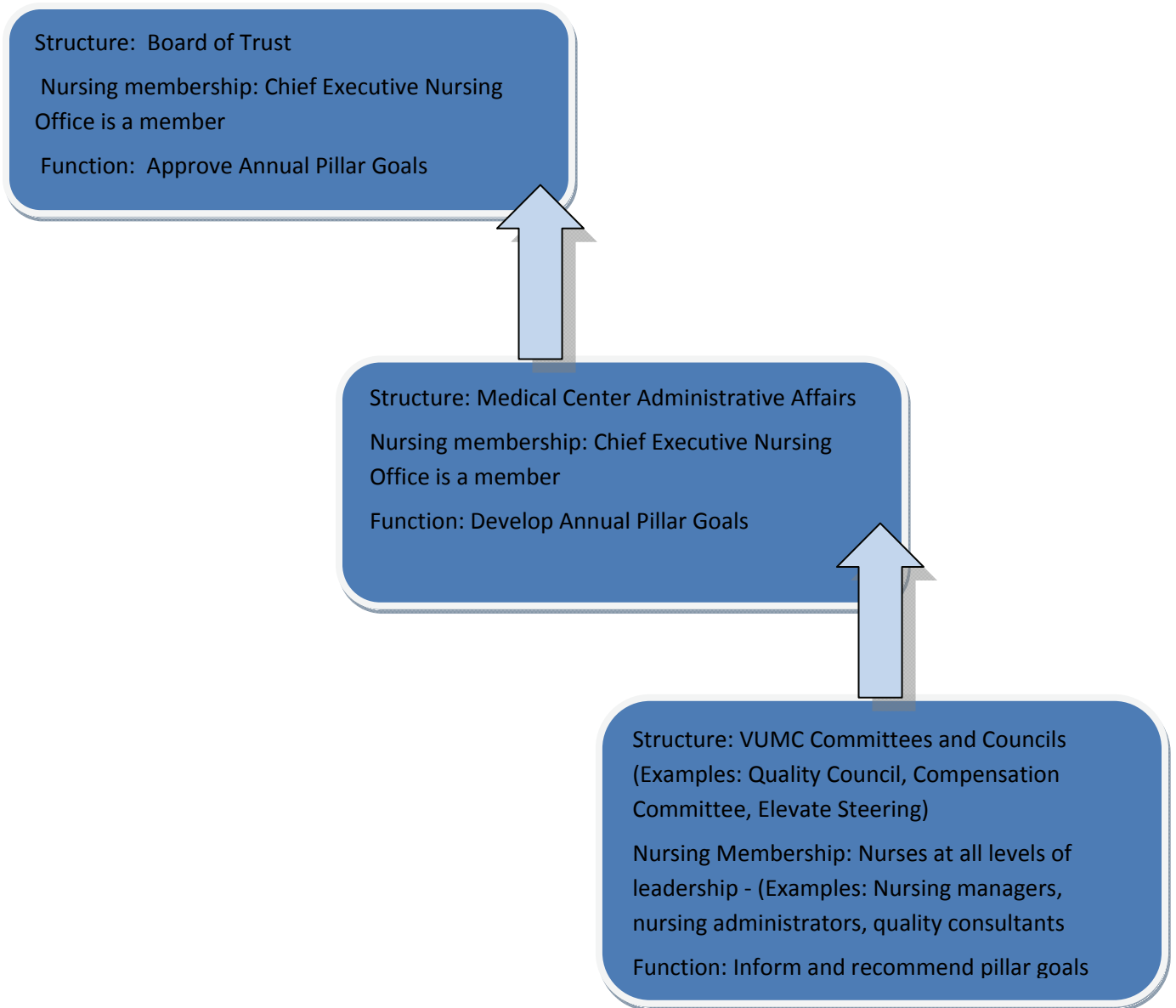
Table TL 3 - 1: Vanderbilt University Medical Center Pillar Goals

People	Service	Quality	Growth and Finance	Innovation
<p>We nurture a caring, culturally sensitive, and professional atmosphere as we continuously invest in the individual and collective aspirations of our people</p>	<p>Collegiality is a central characteristic of our culture and defines how we serve our patients, those we teach, and the local and worldwide community</p>	<p>We relentlessly pursue and measure ourselves against the highest quality performance in all areas, from patient care to scholarship</p>	<p>We invest our resources in a manner that supports our long-term obligation to society; to achieve local, national and worldwide impact in improving health</p>	<p>We seek excellence and leadership as we advance our systems of care, educational practices and our commitment to discovery</p>
<p>2011 Goals: New hire retention After 18 months to 67.5% Turnover Medical Center 12.0% Nursing 12.5%</p>	<p>2011 Goals: Improvement in access 60% new patients seen within 15 days Improve patient satisfaction with: Overall quality of care Overall teamwork between</p>	<p>2011 Goals: Mortality rate Improve to .70 of expected Indicators Improve Standardized Infection Ratio to 1.11 Reduce adverse events to 7.67/1000 patient days Achieve top performance</p>	<p>2011 Goals: Volumes meet or exceed budget for: Hospital discharges 55,085 Ambulatory visits 1,541,883 Surgical operations 47,236 Achieve Medical Center Financial Targets</p>	<p>2011 Goals: Demonstrate results from innovation projects Personalized Medicine Systems of Care Value Based Care</p>

	doctors, providers, nurses and staff Patient engagement	in clinical programs Improve reliable system design and communication Develop quality improvement learning system	VUMC results of operation VUMC cash savings Cost per Visit Cost per Discharge	
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The structure used to develop and approve the pillar goals is demonstrated in Chart TL 3 - 2.

Chart TL 3 - 2: Figure Demonstrating structure and function for Vanderbilt University medical Center Annual Pillar Goals



Each Pillar is assigned to member of the Administrative Affairs team. The members of the Administrative Affairs team include:

- Vice Chancellor of Health Affairs
- CEO of Vanderbilt University Hospital
- CEO of Monroe Carrel Children's Hospital
- CEO of the Vanderbilt Medical Group - Service Pillar
- Associate Vice Chancellor of health Affairs, Chief Strategic and Information Officer – Innovation Pillar
- Deputy Vice Chancellor of Health Affairs and CEO of Vanderbilt hospitals and Clinics – Quality Pillar
- Assoc. Vice Chancellor for Health Affairs & Chief Admin Officer
- Associate Vice Chancellor of health Affairs and Senior Vice President of Finance – Finance Pillar
- Chief Executive Nursing Officer – People Pillar

These leaders then work through teams and committees focused on each pillar to recommend goals for the coming year using historical performance data, external benchmarking data and knowledge of organizational capability and capacity.

For 2011 pillar goal development, Marilyn Dubree, MSN, RN, NE-BC Executive CNO was assigned to the people pillar. Marilyn was assisted by human resources experts in the organization to identify strengths, weaknesses, opportunities and threats related to employees and employment in healthcare in the Middle Tennessee region. Human Resources provided knowledge of the regional human resource market supply and demand, compensation trends and opportunities. The 2010 performance against VUMC goals for turnover and retention in the

first 18 months and the outcomes of the employee satisfaction survey were used to drive goal development.

Through her work as the Executive CNO, Marilyn Dubree is responsible for the largest subset of the workforce at VUMC. Throughout the year she works within the nursing structures inclusive of the Nursing Executive Board and the Nursing leadership Board to optimize performance in the people pillar. Marilyn has always focused on optimizing human performance and thus organizational effectiveness and efficiency. To that end, Marilyn developed approaches to comprehensively address human resource issues within nursing. This effort, started several years ago is called “Be the Best, Keep the Best”. This is a nursing approach led by Marilyn Dubree to select the right people, foster growth, address quality of work life issues, and create the culture that retains the right people. Under the umbrella of the Be the Best effort are several task forces. The task forces that make up that Be the Best team are represented in Table TL 3-4.

Table TL 3 - 2: Be the Best Task Forces and Purpose

Be the Best, Keep the Best Task Force	Task Force Purpose
First Two Years Retention & Recruitment	To assess, develop and implement effective strategies, programs and processes for recruitment, selection, orientation and support for nurses during their first two years of employment at Vanderbilt University Medical Center.
Clinical Work Force	<p>To identify, plan, recommend, and implement strategies that:</p> <ul style="list-style-type: none"> • Ensure resources and processes are in place to appropriately deploy staff to meet organization, unit/clinic goals of quality patient care and staff satisfaction. • Promote and foster a dynamic staff and leader partnership that promotes collaboration and innovative problem solving of ongoing staff challenges due to daily demand, new programs and overall growth.

<p>Diversity</p>	<p>To cultivate an inclusive culture encompassing respect and valuing individual uniqueness at all levels of Nursing within Vanderbilt Medical Center</p>
<p>Leadership Development</p>	<p>To identify, recommend, plan, and implement strategies that will create an environment for nursing leaders that:</p> <ul style="list-style-type: none"> • Supports excellence in clinical practice and customer service • Enhances the work environment for staff and leadership • Promotes professional and personal development of staff • Fosters a workplace of participation and collaboration
<p>Nurse Wellness</p>	<ul style="list-style-type: none"> • Develop programs and services based on the identified needs of nurses • Advocate for the health & wellness of nurses • Evaluate programs and services based on indicators of success • Serve in an advisory capacity to the Nurse Wellness Program
<p>Service improvement</p>	<p>Identify and resolve issues hindering/preventing faculty and staff from doing their bedside duties that ultimately impacts meeting the needs of our patients and their families.</p>
<p>Shared Governance</p>	<ul style="list-style-type: none"> • To evaluate and monitor the establishment of purposeful shared decision-making structure within All nursing patient care areas. • To promote and foster a dynamic staff-leader partnership that promotes collaboration, shared decision-making and accountability for improving the quality of care, safety, and enhancing work-life

All of the membership of these task forces includes nursing managers and/or are lead by nursing managers. For all groups there is a high level of engagement of staff nurses and

frontline leaders. These groups report their work, collaborate and inform Marilyn in monthly “Be the Best” meetings. [TL3-Exhibit A-1-Be the Best Steering Committee Meeting Minutes] Be the Best taskforce chairs share an annual report with all nursing leaders. The reports include yearend accomplishments and proposed goals for the coming year. The nursing leaders at large have an opportunity to influence the goals for the coming year at this meeting. Through this work, Marilyn is fully knowledgeable and constantly engaged in understanding and managing human resource issues, interventions and tactics that drive performance toward human resource goal attainment. The “Be the Best” work informs her in a way that uniquely positions her to lead the organization wide human resource goal development.

Accomplishments of these task forces listed in Table TL 3 -5 demonstrate how planning has impacted efficiency and effectiveness within nursing.

Table TL 3 - 3: Accomplishments of Be the Best Keep the Best task Forces, 2009

Be the Best, Keep the Best Task Force	Task Force Accomplishments
<p>First Two Years Retention & Recruitment</p>	<ul style="list-style-type: none"> ▪ Set process in place to use peer interviewing for placement of nurse residents ▪ Revised nurse preceptor workshop based on focus groups and implemented monthly as “Preceptor 1: essential skills for the preceptor” ▪ Developed plan for ongoing preceptor training – has implemented: “Preceptor 2: communication skills for the preceptor” ▪ Offered unit based preceptor courses ▪ Orientation and on-boarding of experienced nurses – did a survey of experienced nurses who were within their first 2 years of employment at VMC; CNO breakfast w/ same population; complete a gap analysis from feedback
<p>Clinical Work Force</p>	<ul style="list-style-type: none"> • Improved nursing understanding of the need to take a break by creating break buddy system on 7 RW, creating charge nurse incentives in PCCU to encourage nurses taking a break and Kay Stobaugh presenting take a break success at April Fest • VMG Nursing Administration approved a policy for

	<p>Ambulatory Areas to Post Shifts and Fill with Available Nurses from Other Areas. Staff are able to see needs posted on the Nursing webpage and orientation plan created to guide managers to ensure demonstration of clinical competence of float nurses</p> <ul style="list-style-type: none"> • System implemented for tracking of BLS certification in Vandyworks (scheduling system) that alerts nurse and manager near due date.
<p>Diversity</p>	<ul style="list-style-type: none"> ▪ Aprilfest 2009 Three one hour Cultural Workshops ▪ Completed 7_One-Hour Cultural Workshops including <u>Lines of Communication: Interpreter Services at Vanderbilt</u> <u>Dignity and Respect: Showing our Patients Cultural Sensitivity, Generational Differences and Healthcare Disparities for the Hispanic Patient.</u> ▪ Focusing on leadership development for diversity leaders participated in “Attitudes Toward Differences” workshops, completed Diversity gap analysis of current practices and training for leadership, developed a Diversity Web Site, developed on-line Diversity Toolkit
<p>Leadership Development</p>	<ul style="list-style-type: none"> • Developed behavioral rating tool to be used for formative and annual evaluation of managers. The tool clarifies the expectation of the competent, proficient and expert manager and will help standardize performance within established nursing manager competencies
<p>Nurse Wellness</p>	<ul style="list-style-type: none"> • Implemented Traveling Nurse Wellness Fair during nurses week • Implemented “refresh rooms” in the critical care towers to assist nursing in self-care activities during work hours • Held an art retreat for high performing nurses • Completed Safety Walk to identify unsafe areas on campus where nurses need to walk when traveling to and from work locations

	<ul style="list-style-type: none"> • Increased the number of self-defense classes in 2009 • Created and implemented “Flu Jail” to encourage flu shots • 211 new nurse case referrals to the Nurse Wellness Specialist/EAP • Rounds made by NW Specialist to over 1000 nurses during Nurses Week
Service improvement	<i>See TL3 EO</i>
Shared Governance	<ul style="list-style-type: none"> • Assisted Clinics transitioning to 100 Oaks to use Shared Governance systems and processes for transition planning • Launched VCH Float Pool and planning for a virtual unit board • Verified staff involvement in Critical Care Tower transition planning. • Shared Governance overview added to new program aimed at developing leadership capability in Asst Managers and Charge Nurses (“S3”)

The goals of these committees for 2010 calendar year are listed here that demonstrate a continued focus on effectiveness and efficiency within nursing.

Table TL 3 – 4: 2010 Goals for Be the Best Keep the Best Task Forces

2010 Goals – Be the Best task Forces
<p>First Two Years Retention & Recruitment</p> <ul style="list-style-type: none"> • Use shared governance process to gather feedback and share information to achieve F2YRR goals, include VPH • Improve communication between hiring official and recruiter throughout recruitment process to on boarding • Maintain or improve selection/hiring process of new RN’s, including right person to the right area/job • Conduct assessment of managers who currently use targeted selection and peer interviewing – determine educational needs

- Improve internal transfer process – review current policy and create career development process to help guide nurses requesting transfers
- Retain 87% of new nurses during their first two years at VMC
- Implement Preceptor Nurse Alerts! and provide ongoing educational updates
- Committee will review general on-boarding rounding tool that has been created and determine need to revise current Nursing Rounding 30-90-180 tool
- Complete assessment of educational needs of leadership teams in regards to retention and socialization at the local level
- Explore the pilot of the “Buddy System” implemented on 7N and determine feasibility of rolling that system out to all units/departments

Clinical Workforce

- Complete analysis of supplemental staffing needs for in/out patient areas
 - Complete focus groups with in/out patient areas to assess need
 - Review best practice and complete literature search
 - Make recommendations for change in current process
- Partner with Nurse Wellness Committee to educate and encourage breaks for staff
 - Complete a literature search
 - Pilot analysis of two units/clinics for times of no breaks/ no lunch
 - Decrease no lunch Kronos punches by 25%
 - Create a tool kit for managers and staff for education on importance of breaks
- Implement education plan and formalize policy for floating nurses to OP areas
 - Introduce floating option, educate on policy and process at VMG Managers Council
 - Update Nursing Website for links to posted needs
- Develop and Implement Subspecialty Nursing Fellowship
 - Identify pilot area/ unit
 - Create fellowship program as a gateway to subspecialty nursing
 - Pilot fellowship will be designed and implemented in 2010
- Add additional certifications for VandyWorks tracking and alerts
 - ACLS, PALS, NRP, PEARS, and EOR
 - Implement policy recommendations on certification expiration
 - Attend Unit Boards to share information and Best Practice
- Safety and Staffing
 - Make recommendations for change in Schedule Process policy to support maximum work hours per week
 - Monitor data for rule enforcement of scheduled hours greater than hours per policy
 - Review data with Workforce Planning Committee

- Partner with other Be-the-Best Committees to improve satisfaction and strengthen the retention of the experienced nurse

Nursing Diversity

- Develop Diversity Ambassador Program Continue to collaborate with Recruitment on diversity recruitment
- MNPS Career Exploration Fair
- 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
- Continue updates to website
- Develop Cultural Awareness presentations for Medical Center Orientation and Nursing Orientation
- Support B-T-B Committees (Wellness, Leader Development and R2YR committees) in advisory capacity
- Participate in Black History Month Highlighting Nursing
- Develop celebration months for other cultures
- Collaborate with LDI, ODC and Nursing Education in an advisory capacity for development of leadership support
- Implement recommendations from Diversity Gap Analysis.
- Develop on-line diversity training
- Develop diversity training for leadership

Leader Development

- Analyze current leader span of control at Vanderbilt
- Compare staff satisfaction and turnover data and consider whether a correlation exists with manager span of control
- Compare Vanderbilt span of control with national statistics
- Define specific performance behaviors related to job description evaluation scoring
- Develop and implement communication plan
- Collaborate with HR and Recruitment related to strategies for recruiting and retaining managers

- Collaborate with organizational initiatives focused on leadership assessment and development
- Develop collaborative working relationship with others in organization who are creating leader development opportunities
- Evaluate and revise existing leader orientation pathways

Nurse Wellness

- Wellness Fair in 2010
- Continue collaboration with Clinical Workforce, Diversity and Career Development re: Maturing Workforce
- Finalization of guidelines for Refresh Room
- Additional performances of "Hey Florence"
- Art Retreat for managers to reward high performers
- Encore performance of Hey Florence
- Compete plans for Refresh Rooms
- Annual safety walk
- Wellness Fair 2010
- Continue partnerships with Professional Behavior Task Force, Occupational Health, and VPD
- Expand use of "Flu Jail" to encourage flu shots 2010
- Increase self-defense classes to 1 per month
- Improve Nurse Wellness page on website
- Collaborate on ideas to increase presence of Nurse Wellness Program/EAP and other resources to off-site staff
- Continued website development
- Increase communication about Nurse Wellness Program/EAP services to OHO and other off-site staff
- Encourage staff participation in Nurse Alerts

Shared Governance

- Fall 2009 – Total **Inpatient assessment** (qualitative and quantitative).
- Revamping of SG website and addition of "**SharedGovernASK**"
- Partner with **VMG** training and development leaders
- Bylaws Convention
- Virtual Unit Boards
- Dissemination of inpatient Unit Board assessment data
- Next Nursing Staff Summit
- Partnership with other BTB Committees

- Shared Governance Traveling Fair
- Coordination with Nursing Leader Development using SG as foundation in building leaders
- Coordination with Nursing Research Committee in evaluating effectiveness of Shared Governance
- Coordination with NEB in developing future nursing org structure
- Coordination with either Retention Committee or Mature Workforce Committee regarding experienced nurse data and action plan

[TL3-Exhibit-A-2-Be the Best 2009 Annual Report]

Entity Planning Structures and Processes and Nursing Effectiveness and Efficiency

Each entity (VUH, VCH, VPH, Clinics) has planning processes annually as well. There is a great amount of nursing influence in these planning processes. The evidence in this section demonstrates the nursing influence in all entities.

Annually, Larry Goldberg, the CEO of Vanderbilt University Hospital (VUH) leads a planning effort with the VUH team. Among others, the VUH planning team includes, Pam Jones, RN, MSN the CNO of VUH, Nancy Feistritz, RN, MSN the Associate Director of Perioperative Services, and Robin Steaban, RN, MSN Administrator for Operations and Nursing in the Vanderbilt Heart and Vascular Institute. These nursing leaders develop the VUH plan with other non-nursing leaders. A full review of the year end 2010 VUH Operating plan is provided. In addition, Robin Steaban leads the development of the VHVI operating plan. Examples of some operating plan elements that have improved efficiency and effectiveness are in the Table TL 3-7 below.

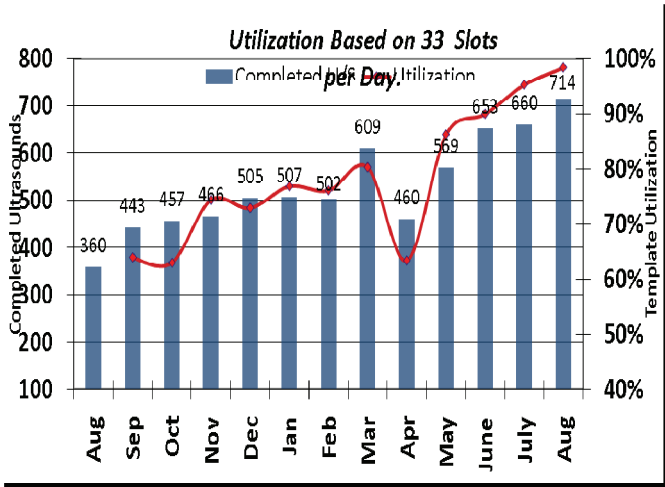
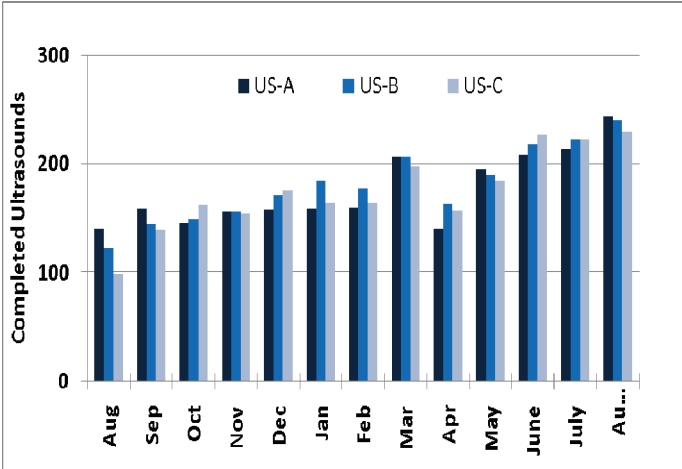
TL 3 – 7: Examples of VUH Operating Plan Examples

FY 2010 Goal	Responsible Person	Impact on Efficiency and Effectiveness
Goal was to decrease infant mortality by predicting high risk	Robin Mutz RN, MBA Administrative	Improved efficiency of utilization of ultrasound machines. Center for Women’s Health consolidated and moved 3 clinics to the One Hundred Oaks location in Feb. 08. At that time we were operating 3 ultrasound

pregnancies. This required increasing the utilization of ultrasonography for early identification of high risk infants in the face of fixed resources.

Director,
Women’s
Health

machines at less than 50% capacity. Through redesign efforts, we smoothed the template for each machine, evened the schedule for each machine and gave the sonographers daily targets for numbers of completed scans (33 is the goal). We also adopted a philosophy of “just say yes” whenever they were asked to do a scan. Through the efforts, we are now at 98% increase over the same month last year. The graph is attached.



Implement Central telemetry monitoring for 9 North, TVC observation and 15

Robin Steaban
RN, MSN,
Administrator

New telemetry equipment implemented and Central monitoring expanded to include 9 North, 7 RW, ED. This improves the monitoring accuracy within the organization by centralizing observation

beds in the ED	VHVI	of cardiac rhythms to highly trained staff. It also consolidated the human resources to one area. . The telemetry tech pool was large enough to cover all unexpected call outs with telemetry techs instead of nurses as was the norm in the decentralized model.
Integrate Vascular patient population into the VHVI inpatient bed allocation and service	Robin Steaban RN, MSN, Administrator, VHVI	Vascular patients integrated into VHIV consolidating vascular patient with nursing experts in CV care. Nurses focused only on CV patients and working with the same MD teams everyday are able to more effectively care for patients and ensure patients move through the system with accuracy and efficiency.
Develop Quality Council leading to development of a forum for review of near misses and failures in the Vanderbilt heart and Vascular Institute	Robin Steaban, RN. MSN Administrator VHVI and Brittany Cunningham, RN, MSN, Quality Consultant, VHVI	Development of ImPaCT – Improving Patient Care Together – See full story below

VUH leaders also meet monthly to review and influence Informatics priorities.

“IMPACT” in Vanderbilt Heart and Vascular Institute (VHVI) – In Support of the Quality Pillar Goal

In 2009, VHVI chartered a Quality Council. The Council membership includes all nursing managers, VHVI Medical Directors and Administrators and is focused on meeting the quality Pillar goals developed by the organization. While the Council has proven to be an effective forum for quality improvement planning, outcome review and tactical planning, the need was identified to develop a system and process to learn more quickly from near misses and harm to

patients. This is consistent with literature on Highly Reliable Organizations where one characteristic is pre-occupation with failure.

The idea was to create a forum to improve the timely and effective review of cases so early correction in systems and processes could be made to prevent harm in other patients. Robin Steaban, RN, MSN, the administrator for VHVI, supported the efforts of Brittany Cunningham, RN, MSN, VHVI Quality Consultant Jeff Boord MD, the Quality Director and Tom DiSalvo MD, the Quality Medical Director for VHVI, as the idea of a team that met regularly to focus on near misses and harm was envisioned and eventually created. Through the work of this team Managers, Medical Directors and Administrators gathered and chartered the group which eventually became known as ImPaCT or Improving Patient Care Together.

The goal of the ImPaCT effort was to craft a sustainable management process for CQI for all clinical operational units of the Vanderbilt Heart and Vascular Institute. It was the aim to create a safe environment where incidents could be shared and learned from. The work was based on the belief that continuous quality improvement (CQI) in health care systems necessitates an approach to review of:

- Care delivery processes
- Systems
- Group and individual performances
- Incidents
- Outcomes

VHVI leadership believed a robust process should be:

- Multidisciplinary
- Occur in “real-time”
- Provide detailed review and discussion of care processes, performance and outcomes
- Generate actionable rapid cycle improvement opportunities

A standing interdisciplinary biweekly managerial forum (ImPaCT- “Improving Patient Care Together”) of quality medical directors, key clinical physicians and nurses, nursing unit

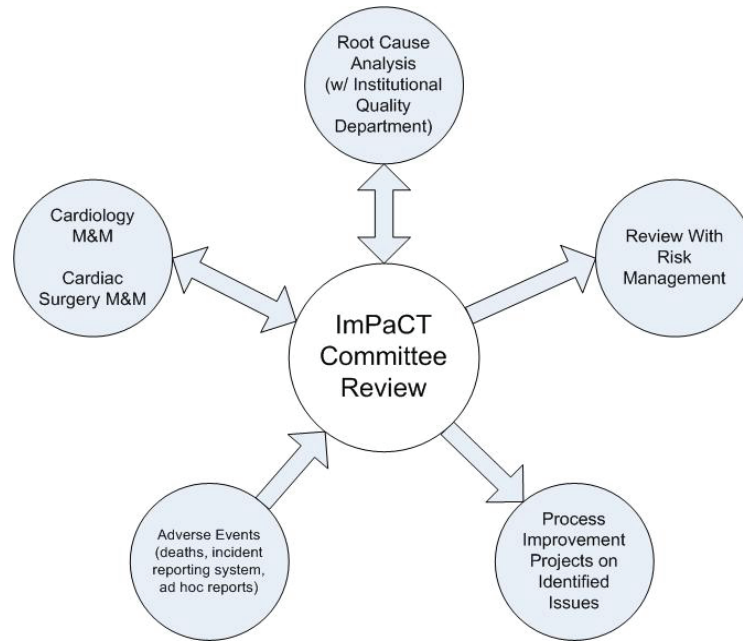
managers, hospital administrators and quality consultants was developed. The meeting follows a standing structured agenda:

- All mortalities since last meeting
- Morbidity including “major misses” and major adverse events
- Rapid response team calls
- Out of ICU “codes”
- Events reported by staff in our institutional incident reporting system
- Events or issues brought forward by any clinician or unit manager
- Interval progress on ongoing rapid cycle improvement projects

ImPaCT acts as the interchange for quality and safety information and provides the following functions.

- Adverse events and patient safety issues are discussed in a confidential forum that promotes Problem solving and accountability but avoids blame
- ImPaCT can identify events that merit root cause analysis, and also follow up on the findings
- ImPaCT coordinates communication and process improvement efforts with other departments
- ImPaCT develops and prioritizes quality improvement initiatives

The forum allows the exchange of information between many groups looking at near misses and errors. It provides a forum for closing the loop on issues raised in other forums as the members are operationally and clinically focused. A graphic of the information flow between teams is depicted below.



In the first year various types of issues have been brought to this forum. The issues identified that required action were categorized and quantified below:

Table TL 3 – 8: Issues Requiring Action

Topics	Contribution (N)	Percent
Handoff and Communication	13	28%
Medicine Administration	10	22%
Equipment	7	15%
Transport of Patients	5	11%
Education back to staff (i.e. M & M)	4	9%
Risk Management Cases	3	7%
Blood administration	2	4%
Vascular Surgery Integration	2	4%

The examples of Quality projects that resulted for the IMPACT review include:

- Development of ICU “transport time out” to improve safety of patient transport
- Development of standardized nurse report form for patients transferred in from an outside facility

- Implementation of a rapid nurse debriefing process to identify and capture key data related to patient falls
- Implementation of a handoff process for patients with an indwelling vascular sheath after catheterization
- Training on communication of adverse outcomes and errors for unit nurse managers

In conclusion, a multidisciplinary, structured, regularly scheduled meeting of physician and nursing leaders, unit managers, and administrators is a critical component of performance management and improvement. This forum not only facilitates learning and collaboration between clinical areas, but also creates a culture of safety and enhances communication. *[TL3-Exhibit-B-1-QCO ImPact Conference Poster]*

Revision of Operating Room Case Cart Operations and Supply Management

Lead by Nancye Feistritz RN, MSN, Associate Hospital Director, Perioperative Services

In November 2009, we opened a new Critical Care Tower which included 141 New acute-care inpatient rooms and 12 new state-of-the-art operating rooms, and is the most significant increase in adult inpatient hospital rooms at VUMC since its opening in 1980. In order to support the opening of the Tower, VUMC's Medical Center Support Services (MCSS) worked with a logistics consultant to redesign the current state of materials management and case cart delivery as it services the preoperative environment.

Findings from the original assessment were divided into two broad categories: Case Management operations and Supply Operations. Through extensive interviews, observation of current operations and data analysis, teams focused recommendations on these categories in three (3) areas:

1. People

Training staff and managers to develop and use standard policies, operating and reporting procedures

2. Process

Streamlining current operations to be more efficient and produce more consistent results

3. Technology

Realigning technology to better support current and future processes. In addition, multidisciplinary teams worked with MCSS to design and construct a new offsite Case Cart Operations Center. The new Case Cart Operations Center was built in Briley Park and was put into operation in November 2009. This facility replaced the majority of the current Central Supply, freeing up valuable storage space at VUH for a large percentage of the cases currently performed. With few exceptions, case carts will be processed at the CCOC. Case carts fall into one of three categories:

- Scheduled elective and add-on case carts delivered multiple times per day
- Specialized pre-built trauma supply totes and VUH pre-built instrument cart, maintained at VUH and replaced by CCOC as used
- POD specific “specialty” carts, managed at par levels and replenished daily

Carts that are not case specific but are managed through the Central Supply staff (e.g. isolation carts) continue to be managed via the VUH Central Supply.

Improvements

The following areas were identified during the assessment phase, redesigned and implemented during the course of the entire project.

Case Management/Perioperative Improvements:

- Established Preference Card Maintenance policy and SOP. In addition created charter for Preference Card Review Group which will meet regularly to establish standards and approve changes.
- Established Weekly, Monthly and Quarterly OR Management Reporting. Scheduling Accuracy as well as other performance metrics established and placed on OR Dashboard

- Established standard scheduling policies and SOP and it relates to the CCOC
- Reviewed and presented case “add-on” procedures and management of surgical block time. Presented data findings to leadership to aid in operational decisions, i.e. case block release times
- Created specialty supply and room stock carts to eliminate inventory in multiple bulk locations. (12) Specialty supply carts were created for key service lines and placed in strategic locations. Carts containing basic room stock were also created and placed in each room. These carts are replenished daily and reduce duplicate inventory as well as reduce clinical involvement in supply chain functions.

Perioperative IT Improvements:

- Implemented requirements for all non-emergent appointment requests through STARform interface
- Reviewed and made suggestions for standard reason codes

Case Cart Process Improvements:

- Established standard “home” locations for all instrument trays
- Established standard case cart build SOP
- Established supply “stay/go”, identifying which supplies remain at VUMC and which move to the CCOC freeing up much needed support space at VUMC
- Establish a policy and SOP for communication between Central Supply and OR for missing supplies and instrument trays on case carts
- Establish policy and SOP for communicating missing supplies, instruments and other items on Preference Card

Case Cart Information Technology Improvements:

- Revised use of PMM Pick Ticket to support Point-of-Use technology and preference card clean-up

- Prepared operations for Point-of-Use Technology
- Established surgical instruments “stay/go” list identifying instrument sets that should stay and be processed at VUMC and sets that should be moved and be processed at the CCOC

Instrument Processing Improvements:

- Established a policy and SOP for more strategic use of Censitrac to support off-site case cart operations
- Established a policy and SOP for determining instrument processing priority
- Realigned shift schedules to more align with the needs of the medical center
- Establish policy and SOP for identifying tray processing location
- Establish a policy and SOP for identifying critical (show stopper) instruments for each instrument tray
- Implemented quality control measures to ensure all instruments are sterilized

Instrument Processing Information Technology Improvements:

- Realigned instrument scan points
- Established management reporting for KPIs
- Rolled out interface between Censitrac and ORMIS schedule

In conclusion, the design and creation of the Case Cart Operations Center brought together interdisciplinary team of nursing leaders, front line nursing staff, administrators, physicians, and front line support staff to review, change and create new procedures and protocols that allowed case cart operations to be moved offsite.

Some production statistics:

- Case carts processed: 2,100/month
- Instruments processed: 420,000/month
- Case cart supplies picked: 70,000/month

[TL3-Exhibit-C-1-Case Cart Current Performance]

Strategic Planning

Source of Evidence 3 EO

Describe and demonstrate the outcome(s) that resulted from the planning described in TL 3.

Strategic planning and operational planning drive Vanderbilt nursing's agenda each year. Below are three examples of outcomes that have resulted from planning. They include; Nurse Residency, Door to Balloon SWAT team and MyHealth@Vanderbilt.

Strategic Planning for Needed Nursing Resources - VUMC Nurse Residency Program Background

We have had significant growth in patient volumes over the past five years. As the Nursing Executive Board and other hospital leaders engaged in a strategic planning process for the Critical Care Tower it became evident that there would need to be a more robust mechanism for attracting and retaining qualified nurses to meet the increased capacity. After one and a half years of planning, the consolidated VUMC Nurse Residency Program (NRP) was launched in July 2008 by the Department of Nursing Education and Professional Development as part of a strategic approach to recruitment and retention of staff. The program was designed to meet the strategic need of recruitment by standardizing the application, interviewing, hiring, and on boarding process. The new program was marketed through the Vanderbilt Nursing website (see Figure TL 3 EO – 1 below). The strategic need of retention was addressed by developing a program to help novice nurses successfully transition from the student nurse role to the professional nurse role, increasing satisfaction and decreasing the turnover rate of those new graduates.

The program at VUMC, is affiliated with the University HealthSystem Consortium (UHC) and the American Association of Colleges of Nursing's Post-Baccalaureate Nurse Residency Program. The residency is a year-long program, which consists of orientation specific to graduate nurses, as well as seven-weeks of core and track orientation during a rotational phase, followed by a match to a permanent unit. Once matched, the program co-leaders mentor the new nurses and lead eight monthly facilitated workshops conducted during the first year of employment. Additional details of the NRP are outlined on our Nursing website at www.vanderbiltnursing.com with a direct link:
<http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=9935>

Participants

The planning committee for creating the consolidated NRP was diverse with nurse educators, and managers who represented all inpatient nursing areas of VUMC and nurse recruiters and administrators from Nursing Recruitment and Human Resources. The members of the Residency Planning Committee included the following:

Table TL 3 EO – 1: Residency Planning Committee Members

Debbie Arnow, MSN, RN, NE-BC	Director Clinical Education and Professional Development – Children’s Hospital
James Barnett, MSN, RN	Nurse Educator – NCU
Richard Benoit, MSN, RN	Nurse Educator – SICU
Cindy Brown, RN, MSN	MCE OR Director
Ed Dennis, MSN, RN	Nurse Educator – Burn Unit
Tracey Fargo, BSN, RN	Nurse Recruiter – HR
Elizabeth Fritz, MSN, RN	Nurse Educator – Labor & Delivery
Kara Gordon, MSN, RN	Nurse Educator – MICU
Todd Griner, MSN, RN, NEA-BC	Manager – 10S
Rachael Hamilton, BA	Administrative Manager – Nursing Education and Professional Development
Beth Hodge, MSN, RN	Nurse Educator – 3 and 5/6 RW
Collette Judd	Recruiter – HR
Erin Kuhn, MSN, RN	Nurse Educator – Perioperative Services
Anya Lockert-Young	Recruiter – HR
Lori Martin, BSN, RN	Nurse Educator – VUH ED
Leanna Miller, MSN, RN	Nurse Educator – Trauma
Amy Moore, BSN, RN 3, CEN, EMT, IV	Flight Nurse - LifeFlight
Nancy Moore – RN	7RW
Christy Mullen, BSN, RN	Nurse Educator – NED VCH
Rosalyn Norris	HR Recruitment
Cathy Ollom, MSN, RN	Nurse Educator – Oncology
Terry Owens	Program Coordinator – Nursing Education and Professional Development
Shelly Padgett, BSN, RN	Nurse Educator – Cardiology
Debianne Peterman, Ph.D., MSN,	Director – Nursing

RNC-NIC, NE-BS	Education and Professional Development
Sheryl Redlin-Frazier, BSN, RN	Nurse Educator/Assistant Nurse Manager, 4 E
Laurel Roberts, BSN, RN	Administrative Director –VCH
Donna Ruth, MSN, RN	Nurse Educator – Labor & Delivery
Teresa Simpson, BSN, RN	Nurse Educator – CVICU
Sherri Stringfellow	Art Director - Nursing Education and Professional Development
Martha White, MSN, RN	Nurse Educator – 9N & 9S
Bridgette Willette	Director HR Recruitment
Chris Wilson, MSN, RN-BC	Director Clinical Education and Professional Development - Nursing Education and Development
Sandra Winfield	Recruiter – HR

Methods and Approach

The committee reviewed historical data that identified a turnover rate for first-year nurses that was typically very high and very expensive to the medical center (35-55%) and developed a program with the hypothesis that the turnover rate of this population would be reduced by employing a standardized nurse residency strategy. Working with HR and assigning one Nurse Recruiter (Tracey Fargo, BSN, RN) who would serve as the recruitment liaison for this program helped to organize the marketing and recruitment efforts.

Tracey conducted onsite visits to local schools of nursing and sent out email marketing blasts to schools around the country at the time that we posted the NRP positions. We created an introductory video and placed all information on the Nursing website. A series of town hall meetings were conducted to inform current VUMC staff of the changes we were making to the hiring process for graduate nurses. We set up one portal of entry for all of the applications to enter into the system and created and built an NRP-specific database that allows us to send out standardized communication to all candidates during each phase of the inquiry, application, interviewing, and hiring process.

An example of the marketing approach to this project through the website can be seen in Graph TL 3 EO - 1 below.

Graph TL 3 EO – 1: Nursing Website Nursing Residency Program



Outcomes

The strategic objective of attracting qualified applicants has been successfully achieved. The [TL3EO-Exhibit A-1-Nurse Residency Summary Report] shows the number of applicants for each cohort. We have been able to attract a diverse group of graduate nurses from thirty-nine (39) states plus DC with a 176 different nursing programs represented. Our average GPA is 3.43 (on a 4.0 scale) with each cohort. The percentage of graduates with BSN degrees has increased since the initiation of this program and our average now is at 80%. Our retention rate of these new graduates has improved significantly as indicated by the table below.

Table TL 3 EO – 2: Retention Rates of Nurse Residents

Cohort	3 months	6 months	9 months	12 months	>12 mos. and < 24 mos.
Summer 2008	100%	97.1%	96%	91%	85%
Winter 2009	100%	98.8%	95%	92%	92%

Evaluation:

It is clear from the data above that this program achieved both strategic objectives of recruiting a ready supply of highly qualified nursing staff and retaining those nurses at VUMC.

Door to Balloon Time SWAT Team

Purpose/Background

The goal established by the American Heart Association/American College of Cardiology for patients experiencing an acute MI was to have the culprit artery opened and blood flow restored to the heart within 90 minutes of patient presentation to the ED. There has been a long standing collaborative effort between the ED and the cardiac cath lab to achieve that goal. In 2008, the Chest Pain Center Committee identified the need to improve the door-to-balloon time for patients experiencing ST elevation myocardial infarction (STEMI), particularly in regards to the interval from activation of the cath lab until the patient arrived to the lab.

During off hours (evenings and weekends), a call team responded from outside of the hospital with a 30 minute maximum response time and this was identified as the primary limiting factor to improvement. Some staff members lived in a range that allowed them to respond to a page for an acute MI and be on site within 30 minutes but not faster. The patient could not be moved to the cath lab without staff. This fact delayed the actual intervention time because staff reported to Vanderbilt, went to the lab to prepare the area and then retrieved the patient. The median time the patient was moved from the Emergency Department to the Cath lab was 37 minutes. This left only 52 minutes for the patient to be prepped, the MD to gain arterial access, complete a diagnostic cath and re-vascularize the culprit vessel. The interval time of patient arrival to transport to the cath lab needed to be shortened.

Methods

The CVICU Manager met with charge nurses of the CVICU to develop a plan for the charge nurse to be involved in the care of acute MI patients. The plan developed was for the charge nurse to respond to a "STEMI Alert" page by going to the ED. Once there, the patient would be prepped and the ED nurse, cardiac fellow and CVICU nurse would transfer the patient to the cath lab and prepare them for the procedure by getting the patient on the cath table, connect the patient to the defibrillator pads, connect cath lab monitoring equipment and provide care until the cath lab team arrived. The roles and responsibilities of the ED staff and the cardiac fellow were also more clearly determined.

Once requirements and resources identified (CVICU Charge Nurse), protocols were developed. The team identified training needs of the CVICU charge nurse as response/cardiac catheterization environment. The CVICU Charge nurse would have to work in an environment where they were unfamiliar. There were competency requirements established and formal training and competence validation. A medication box was developed in collaboration with the pharmacy for administration of emergency meds during time the CVICU nurse would be in the lab. In addition, a fully implementable contingency plan had to be developed in case the charge nurse was unable to leave the CVICU because of acuity or other situation.

After implementation, the median transfer time decreased to 30 minutes and has been sustained.

Table TL 3 EO – 3: Participants

Jeannie Byrd, MSN, RN, NE-BC	CVICU Manager
Janice Sisco, BSN, RN	ED Manager
Laura Zelenak, RN,	Cardiac Catheterization Lab Manager
Tiffany Richmond, RN	Cardiac Catheterization Lab Assistant Manager
Carol Parsons, RN	Cardiology Case Manager
Brittany Cunningham, RN, MSN	Quality Consultant
Kathy Burns, Med, RN, CCRN	CVICU Clinical Nurse Specialist
Dan Johnson, Dph	Clinical Pharmacist
Michelle Hasselblad, BSN, RN	Director, Cardiac OR and Catheterization Lab
David Zhao, MD	Cardiac Catheterization Lab Medical Director
Thomas DiSalvo, MD	VHVI Quality Director

The workgroup implemented this change for of the D2B Swat Team in January 2008 and the evaluation follows.

Evaluation

There is an analysis of every STEMI patient coming through the ED. Interval measurements were established for each segment of time dependent care. Median time of transfer decreased from 37 minutes to 30 minutes. This has been sustained since the implementation of the process. *[TL3EO-Exhibit B-1-D2B Swat Team Policy, TL3EO-Exhibit B-2-CPC Meeting Minutes]*

My HealthCareTeam@Vanderbilt

Purpose/Background

A study was done through the electronic medical record that demonstrated a large number of patients with hypertension, diabetes, and/or heart failure whose conditions were not under control. Vanderbilt set a goal to improve the health of this population and to try to prevent costly ED visits and hospitalizations that could be avoided by improving primary care access and follow-up. *[TL3EO-Exhibit C-1-Summary Presentation]*

VUMC provided an innovation grant to create a “medical home” within our primary care practices to care for patients with hypertension, diabetes and/or heart failure in a manner that would get their chronic conditions under control and try to reduce morbidity and mortality and prevent unnecessary emergency visits and hospitalizations. The medical home would make use of RN “care coordinators” to implement evidence-based, protocol-based individualized care plans.

Methods/Approach

An interdisciplinary group took several months putting together the proposal for the project. They researched the evidence for reducing mortality and morbidity of the three chronic conditions by providing close follow-up, coaching, goal setting and behavior modification by registered nurses working with the primary providers to develop individualized evidence-based care plans for each patient. The project was then funded.

The specialists, for example the heart failure nurse practitioner, Connie Lewis, RN were engaged to write care protocols. A dashboard was built to show the progress and care needs of the patients. Care plans were developed and placed in into StarPanel, the EMR system. RN Care Coordinators were hired. Data definitions (defined what “being in control” and “at target” means) were developed. Measures were built into the EMR.

A system to stratify patients was created and the team began enrolling patients. The primary care practices’ patients were stratified by co-morbidity, and patients were enrolled in the proof of concept project, so far involving 3 primary care physicians, their care teams, and 2 RN care coordinators.

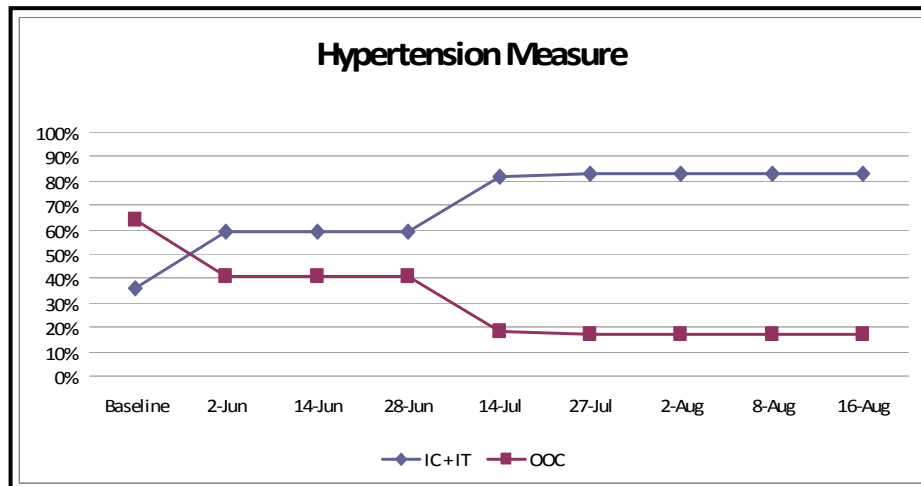
Table TL 3 EO – 4: Participants

Jim Jirjis, MD, MBA	Primary Care physician, Lead, Main Campus
Ralf Habermann, MD	Primary Care Physician
Jim Powers, MD	Primary Care Physician
Bill Gregg, MD	Primary Care Physician, Informatics
Pete Powell, MD, MBA	Primary Care Physician, Lead, Williamson Co.
Racy Peters, RN, MSN	VMG Associate Director, Operations
Betty Akers, BS Business	Administrative Director, Primary Care, Operations
Pat Covington, BSN, RN, CRRN	Clinic Manager, Operations
Anne Hurd, RN	Clinic Nurse
Julie Scott, BSN, RN	Manager, Center for Disease Prevention, Care Coordination Management
Sharon Mullins, RN	Health Information Systems Project Manager 2, Project Manager
Joan Peterson, RN, CCM, CDE	Care Coordinator
Rebecca Bumm, RN	Care Coordinator
Collin Mothupi	Quality Value Analyst

Outcomes/Impact

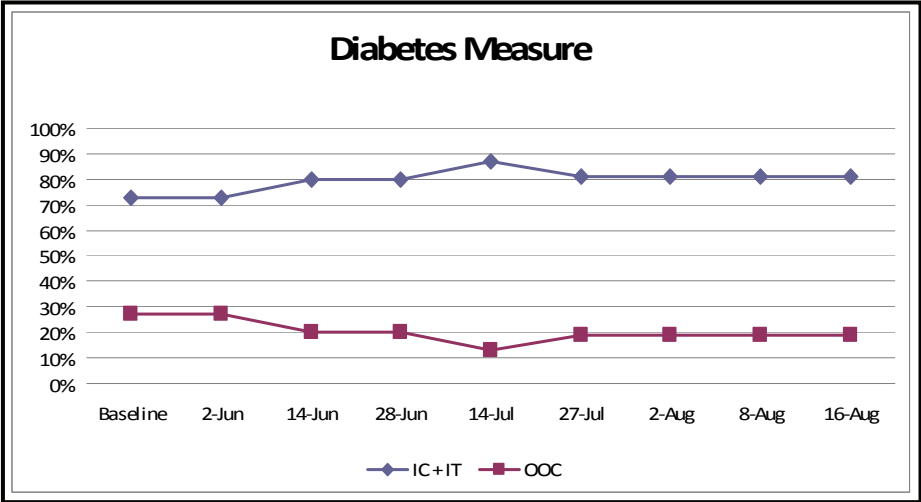
The data demonstrates the program and nursing interventions are improving patient’s control of chronic conditions. There is insufficient data at this time to determine whether incidence of ED visits or hospitalizations is affected. *[TL3EO-Exhibit D-1-MHTAV Work Plan]* Hypertension control improved after the intervention from the MyHealth@Vanderbilt team.

Graph TL 3 EO – 2: Hypertension Measure



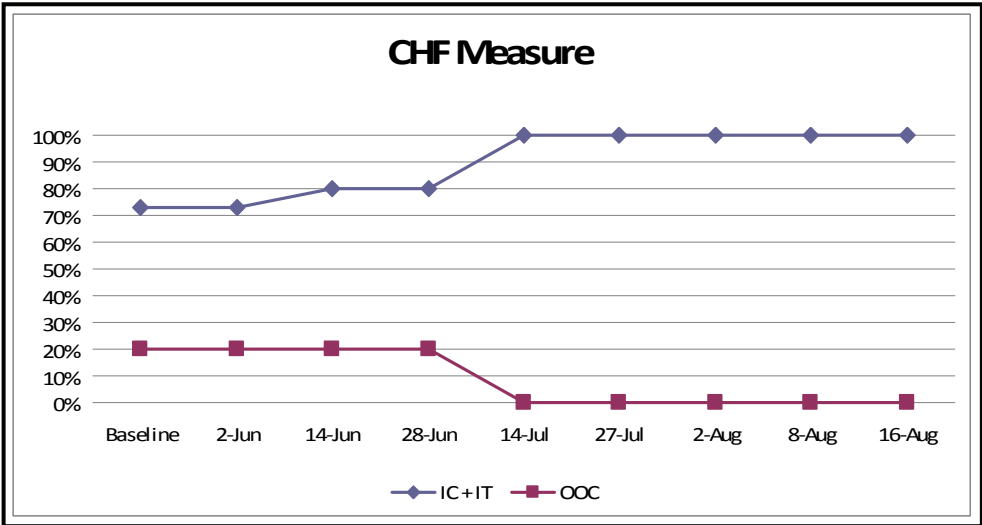
Graph TL 3 EO – 3: Diabetes Measure

Diabetes Control improved after intervention from the MyHealth@Vanderbilt Team

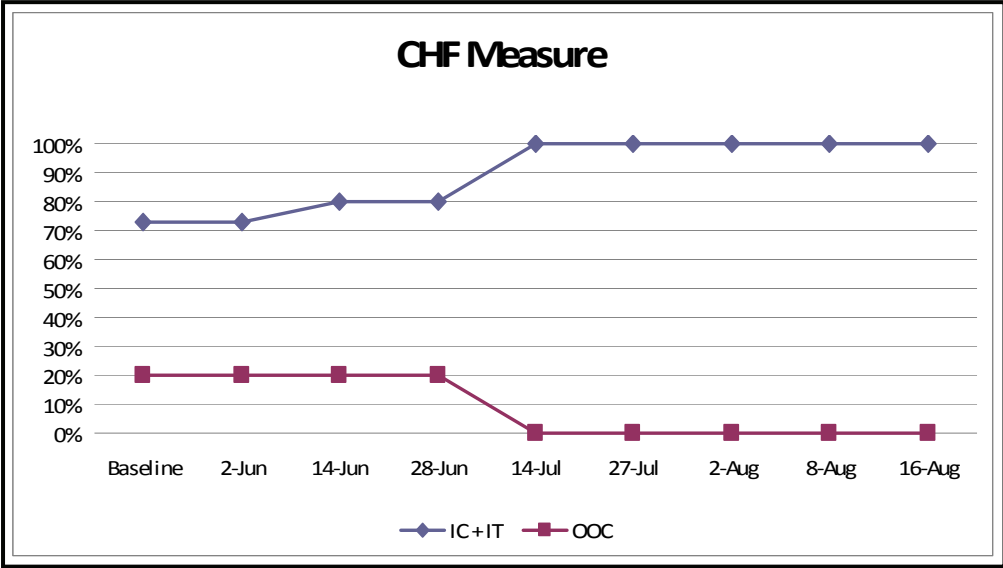


Graph TL 3 EO – 4: CHF Measure

Control of HF improved after MyHealth@Vanderbilt team interventions



Graph TL 3 EO – 5: CHF Measure



Advocacy and Influence

Source of Evidence 4

Describe and demonstrate the process(es) that enable the CNO to influence organization-wide changes.

Marilyn Dubree transitioned from the Chief Nursing Officer to the Executive Chief Nursing Officer (ECNO) in 2007. The organization had grown tremendously by virtue of the addition of the Monroe Carell Junior Children's Hospital, extraordinary growth in the outpatient business and clinics, and the planned expansion of the University Hospital. The increase in the size and complexity of the organization was diluting the role of the CNO simply due to the diversity and demands one person had to attend to.

The executive leaders recognized the critical need to have Marilyn represent nursing at the executive level. She was, and remains, well respected by the executive team. Marilyn demonstrated that she was a valuable partner in the strategic decision making of the organization and a driving force behind quality, patient, and employee satisfaction. Marilyn also needed to be able to maintain the equal partnership of nursing with MD's at the executive level.

The executive leaders of the Medical Center actively supported and encouraged Marilyn to restructure nursing leadership so she could fulfill the role and demands of the Chief Executive Nurse. To that end, Marilyn transitioned to the Executive Chief Nurse and the added Chief Nursing Officers for Vanderbilt University Hospital, Monroe Carell Junior Children's Hospital, the Vanderbilt Medical Group and the Vanderbilt Psychiatric Hospital.

The change positioned the role of the Chief Executive Nurse to partner with the Chief Executive Officers in the clinical entities. The ECNO reports, as do the CEO's of the clinical entities to Dr. Wright Pinson, MBA, MD the Deputy Vice Chancellor for Health Affairs and the CE of the Hospitals and Clinics. She is equally positioned to influence organizational change as are the CEO's.

Intentionally written into the job description of the ECNO are requirements to participate in Executive teams and influence organizational change. The job summary (*complete job description provided in OO 2*) states; "As a member of the VMC executive team, the CNO supports and facilitates an interdisciplinary team approach to the delivery of care. This includes creating a nursing environment in which collaboration is valued and excellence in clinical care,

education, and research is promoted and achieved. The CNO ensures the continued advancement of the profession of Nursing at VMC.”

Key function number three requires the ECNO to “*participate in the planning, implementation, and evaluation of clinical programs and services, assuring appropriate resources for the delivery of care*”. Key function four requires the ECNO to “*Serve as the senior spokesperson for Nursing, advising senior leadership of VMC and individual entities, institutes and other affiliated institutions, (including the medical staff) by providing input about the implications of decisions and change on the quality of patient care, on nursing practice, and on nursing care providers.*”

To enable Marilyn to influence organization wide change, the position of ECNO is strategically placed on key committees within the structure. Table TL 4-1 describes the organization wide teams where the ECNO is either an active participant or leader of the team.

Table TL 4- 1: Organization wide committees and forums where the Chief Executive Nurse is an active participant

Committee	Purpose	
Clinical Enterprise Executive Committee	The purpose of the Clinical Enterprise Executive Committee is to bring together leadership of the Clinical Enterprise to address strategic and operational topics focused on PCC/Institute updates, patient care operational issues, and review of performance alignment of common infrastructure.	Influenced decision for VUMC to be a tobacco free campus which will be launched in November, 2010
Administrative Affairs	The purpose of Administrative Affairs is to bring together key clinical enterprise leadership and medical center leadership to address strategic and financial topics focused on the clinical enterprise.	Influences the agenda creation for Leadership Assembly and the alignment of such with the strategic initiatives With other Executives, defined participants in executive and leader incentive programs

		Proposed and gained approval for changes to NP compensation
Medical Center Medical Board	The broad, but not all-inclusive purpose of the Medical Center Medical Board is to represent and act on behalf of the Medical Staff while serving as the principal committee to which all standing and special committees report.	Influenced the decision to support a policy allowing families being present in pediatric codes
Executive Committee of the Medical Center Medical Board	The purpose of the Executive Committee is to affect a high degree of communication between the Medical Staff and Medical Center administration and to scrutinize and evaluate, on a continuing basis, patient care in terms of quality, convenience, comfort and efficiency. It shall make recommendations to the Medical Center Medical Board regarding the quality of overall medical care rendered to patients treated at the Medical Center.	Participates in decision related to MD suspension
Quality and Safety Steering Committee	Purpose is to align and monitor contributions to the Pillar Goals, manage projects and improvement assignments, and coordinate the readiness of quality assurance, and regulatory and accreditation improvement Processes.	Approves quality plan and quality goals. Participated in decisions related to the evolution of Medical Director roles in quality
Quality and Safety	Purpose is to guide and assist executive leaders, the medical	Approves quality reports and provides direction for quality

Council	center board, and the board of trust in fulfilling their responsibility to oversee safety, quality, and effectiveness of care.	initiatives
Information, Privacy and Security Executive Committee	The purpose of the Information, Privacy and Security Executive Committee is to regularly assess the operating and computing environment to identify risk factors and define safeguards against intentional or unintentional disclosure of Protected Health Information (PHI), person-identifiable, or other confidential or proprietary information created, used, or maintained by Vanderbilt.	Determines consequences for individuals who breach confidentiality Determines use of social media in clinical areas and on clinical work stations.
Executive Faculty Committee	Monthly meeting for the chairs of all the SOM and SON to purpose is to share information for the good of the enterprise. Communication and dialogue among the academic leaders.	Provides updates regarding clinical enterprise nursing issues
Clinical Enterprise Group	“The purpose of CEG is to obtain input, alignment, and ratification of strategies with Department Chairs and faculty on strategic plans, capital plans, operating budgets, public policy position and other key items. This forum also allows for information sharing on various improvement efforts in quality, services and other areas. The financials are	Provides updates on the people pillar performance and directs clinical chairs on methods to improve faculty performance related to patient satisfaction

	<p>reviewed in detail monthly identifying and discussing variances based on budget.”</p>	
<p>Human Resource Policy Committee</p>	<p>The Human Resource Policy Subcommittee is made up of designated management representatives from the major areas of the University. Each member of the committee is to provide operational expertise on how staff human resource policies would impact their areas. The role of this working committee is to review recommended changes to existing HR policies or to make recommendations on the development of new HR policies. Once a policy reaches the consensus of the members of the policy sub-committee, the policy is advanced to Policy Advisory Board, comprised of senior level executives or their designees for review and approval.</p>	<p>Voting member that reviews recruiting and hiring policy, smoking, FLSA policiess (work hours policy)</p>
<p>Clinic Redesign Executive Committee</p>	<p>The purpose of the Clinic Redesign Executive Committee is to support and assist the clinics in designing and implementing operational models that improve access, service, and evidence-based delivery of quality healthcare services for our patients. The strategy is to: Redesign and</p>	<p>Approves nursing role changes requiring evidenced based role changes (triage nurses)</p>

	implement common/measurable foundations for access operations redesign and implement common/measurable foundations for clinical operations, and support operations training and development goals of VMG.	
Organizational Compensation Committee	The purpose of the Organizational Compensation Committee is to address organizational concerns about compensation and benefits.	Directs reviews for critical nursing and other clinical roles for market equity. Makes recommendations related to salary changes

[TL4-Exhibit A-1-CEEC Meeting Minutes Feb 2010, TL4-Exhibit A-2-CEEC Meeting Minutes Aug 2010, TL4-Exhibit A-3-CEEC Nursing Presentation, TL4-Exhibit A-4-CEEC Nurse Residency Presentation] Other minutes are available upon request unless they are proprietary.

Table TL 4 – 2: Identifies the organization wide committees over which that Marilyn, as the ECNO serves as the Executive Sponsor

Committee	Purpose	
Medical Center Staff Advisory Committee	The purpose of the Medical Center Staff Advisory Committee is to act as an advisory group with both administration and staff on problems and policies that affect the medical center and the people it serves; to facilitate communication between medical center staff and administration on all levels, including but not necessarily limited to, Vanderbilt University Hospital, Vanderbilt University Medical School, Vanderbilt University School of Nursing, The Vanderbilt Clinic, and	Held retreat for group to create charter purpose for this all staff committee and how they need to be effective in providing and receiving feedback. Employee communication vehicle. Hold quarterly meeting for chair and executive te team.

	<p>medical center administration, and to maintain effective communication among staff employees of Vanderbilt University Medical Center.</p>	
<p>Leadership Assembly</p>	<p>The purpose of the Leadership Assembly is for those medical center leaders accountable for pillar goal outcomes, to gather quarterly with the Vice Chancellor and other executive leadership. These Leadership Assemblies include the quarterly Elevate Pillar Update as well as stimulating leadership topics relevant to sustaining a culture of excellence and service.</p>	
<p>Staff and Faculty Satisfaction Survey</p>	<p>The purpose of the Staff/Faculty (Community) Satisfaction Survey is to utilize the tool drive employee satisfaction and results across all pillars organization-wide. The data itself is shared with the staff and actions are communicated based on feedback.</p>	<p>Executive sponsor and thus coordinates all work with the vendor including contracting, revisions to questions, action plans and goals, time of surveying</p>
<p>Patient Family Advisory Council</p>	<p>The purpose of the Patient Family Advisory Council is to offer innovative ways for patients to receive healthcare, become healthy and stay healthy. This council plans and evaluates services, programs, policies, and teaching materials.</p>	<p>Executive Sponsor attending monthly meeting sharing and hearing feedback. Work influenced position on tobacco free campus, patient education work</p>

Advocacy and Influence

Source of Evidence 4 EO

Describe and demonstrate one (1) CNO-influenced organization-wide change.

Purpose/Background

VandyWorks

The Staffing Task Force was formed in 2001 as a request of the Chief Nursing Officer, Marilyn Dubree, MSN, RN, NE-BC, to ensure that Vanderbilt Hospital and Clinics have the appropriate staff resources properly deployed to provide consistent, safe, quality care. Through the work of this group, it was determined that an electronic tool was required to achieve this goal. A return on investment (ROI) was completed to quantify organizational benefit of an automated tool.

The Staffing Task Force surveyed VUMC nurses to understand their unique staffing requirements. Over an 18 month period, 13 vendors were evaluated to find the best product to achieve our organizational goals. Workbrain (VandyWorks) was chosen as the best match due to their track record of innovation and flexibility in retail and transportation markets. Workbrain was willing to partner to develop a unique healthcare solution that goes beyond basic staffing and scheduling and incorporates quality, safety and the ability to expand.

The initial cost of the Workbrain program outlay was \$300,000. Ongoing support of the project was an additional cost of the project. Functional and technical teams were created to continue implementation and support of the work. Marilyn Dubree, MSN, RN, NE-BC, CNO, advocated for the capital dollars and ongoing operating budget to support this project. *(More information is provided about VandyWorks in EP 8, 9, 11 & 12)*

CATS

As the Medical Center continued to grow, Marilyn Dubree, CNO, helped to lobby for a better way to monitor the nursing staff licensure, certification, education and experience. Prior to an electronic system, each unit kept paper records to track the information on their staff. The process was not consistent and it was challenging to have information readily available during surveys by the state and JCAHO. Nursing leadership partnered with Human Resources to make suggestions on the design of a program to fill this need. Marilyn presented the proposal for the required capital outlay and ongoing operating budget to the board and received approval.

The Credentials Application Tracking System (CATS) was initially created to track nursing licensure and certifications in 2005. Vanderbilt Medical Center identified that a single tracking tool would be optimal so that a repository of information would be available for collecting data on certification and licensure for nursing. A single tool would assist in monitoring license and certification compliance for all staff as well as store years of experience used for salary equity reviews among our current employees. Prior to CATS there was a gap in the system as this information was not stored in any electronic or useable format.

Vanderbilt partnered with Infoworks, the computer software company used to write an electronic evaluation program for Vanderbilt that is still in use (VPES). Infoworks was asked to write a program to track licensure and certification for our professional nursing staff. The initial cost of CATS was \$60.00. In 2006 nursing was the primary user. In 2008, pharmacy technicians were added. In 2009 licensure for Rehabilitation (PT/OT), Respiratory Therapist, Radiology Technologists, Pharmacists, Laboratory Technologists, and Dietary/ Nutrition were added. In 2010, anesthesia technicians were added. In addition, all entry level positions in patient care support, service support, and nutritional support were added. Case managers and Utilization Management were also added to round out the clinical enterprise. The total cost of CATS to date has been approximately \$230.000 for the programming plus the additional support supplied by HR to manage the program.

Methods/Approach:

VandyWorks

The Staffing Task Force (now Clinical Workforce Committee), under the direction of Marilyn Dubree, MSN, RN, NE-BC, CNO, worked with Human Resource to write a clinical policy on the "Schedule Process" for all the Medical Center staff. The policy included schedule length, maximum hours of work and gave general parameters for vacation, holiday and personal day scheduling that should be used for areas to write their own unit specific policies. (*Reference policy Patient Care Services: Scheduling Process, CL 20-06.25 – provided in EP 9*) These unit specific policies are reviewed by the Clinical Workforce Committee to ensure they were consistent with the clinical operation policy.

Initially VandyWorks was piloted in two units 9N and 9S. The manager, assistant managers, charge nurses and staff were given extensive training on how to use the program. There were many focus session groups to gain knowledge on how the system needed to work and how to make the work of the charge nurse easier to manage staffing. Using this pilot information, the rollout process was planned. The VandyWorks team would meet with each area and give a demonstration and discuss the setup process. The staff on the units were involved in the process from the beginning and offered feedback. Unit specific rules were in

place to provide consistency, fairness, and safe staffing decisions. Ongoing training was given as new capability is added to the system. The team now has a full time RN educator who is able to provide a clinical focus to the work.

After the implementation of the system in in-patient areas in both the adult and pediatric hospitals, the focus has changed to meet the needs of the outpatient and procedural areas. This work is ongoing. For some out-patient areas the VandyWorks system has not matched the unique staffing requirements and partial shift times. These areas are brought on line to use the request off function that allows tracking of leaves and to receive alerts for certification and licensure via the CATS information.

CATS

When every staff member is hired, our HR tracking system, PeopleSoft automatically loads their hiring information into CATS (unit, job code, etc). This is done by department numbers. Then licensure, certification, education and years of experience are gathered by their department and entered into CATS. This data follows the employee throughout their employment at Vanderbilt even though they may change positions. When staffs transfer to new areas, PeopleSoft automatically makes those changes.

The department administrator (PAF responsible) and the department manager have assigned access to CATS based on their job role in the People Soft system. Either of these two responsible persons can delegate up to two department assistants per area to help assist in data entry. The department manager has the overall responsibility of keeping this data up to date in the system.

Licensure and other information can be updated as needed (expiration times). Managers are also required to check the data annually at evaluation time. CATS is interfaced with VPES which is our electronic evaluation system. When a manager is doing the staff evaluation, an automatic notification comes up about reviewing CATS. The manager is then linked directly into that staff member's CATS database to be able to review their information. All staff also have a "read only" capability for their CATS information. The system is set-up in such a way that no one (manager, supervisor, etc.) can change or update their own information, their one-up must do that. That is one of the many safe guards of the system.

New capabilities added this year include a date stamp for primary source verification (State Website) and pop up messaging to remind managers or designees to enter additional information related to certification and licensure for Advanced Practice Nurses and Emergency Medical Personnel. The changes will improve complete documentation in the system.

The system uses a stop light monitoring system:

- Green- information is current
- Yellow- information will expire at the end of the current month
- Red- information has expired and needs updated

This allows the manager or designees to see at a glance when staff information needs updates.

In addition, managers of the various areas can run reports for their specific units from any information located in CATS. They can do years of experience, licensure expirations, certification expirations, and many others. This provides a unique flexibility to the managers.

CATS administrators have the flexibility of adding additional licenses and certification when needed. This flexibility in the programming has allowed Vanderbilt the ability to manage the information required as new areas/departments have been added to the system over time.

Evaluation/ Outcomes:

VandyWorks

VandyWorks is used for reporting and tracking productive and non-productive hours (in-services, sick, vacation, FMLA, etc). It is also able to track staff that clock in early for their shifts or out late when leaving. Bi-weekly rollup reports are sent to the administrative leaders showing hours and dollars associated with these costs so that the managers can manage these hours to a minimum. Managers can run drill down reports that specifically identify staff that are on the reports. Working to reduce the “in early” hours are a direct cost savings to the Medical Center by managing incidental overtime. Managing these hours along with reducing the hours needed to create and maintain a schedule for the units has been the ROI needed for this project.

Staff satisfaction with the system has been positive. They are able to access their schedule, make time off or swap shift requests from any computer. Feedback supports that it makes the schedule process fair and allows easy access. Feedback indicates there is a high learning curve but after the learning curve the system is user friendly and provides them with the information they need.

The VandyWorks technical team has been able to add new alerts to the system by pulling data from CATS in relation to nurse licensure. One example is nurse licensure compact information. The system can look at the employee’s address and send an alert message when the state of residency does not match the license entered into the system. This alert information is validated monthly to ensure that staff licensure is correct to meet compact

requirements. When staffs are identified, the unit/department manager is notified to follow up for compliance and update the system or note approved variance from the rules written for the VandyWorks system.

CATS

The CATS database has the ability to send the license and certification information to the VandyWorks program, allowing for reminders of upcoming expirations for staff and their leaders. For licensed staff using the VandyWorks system, if their license has expired in the CATS system they are unable to be scheduled until this is updated. Recent updates in VandyWorks can also project out for scheduling six weeks in advance and color code staff who have a license that will expire in the future.

The CATS team partnered with the Resuscitation Department which provides certification for VUMC staff for BLS, ACLS, PALS, etc. They now enter the new certification expiration dates into the CATS system for each all Vanderbilt staff members attending. This gives very accurate records for these certifications in the system. It has allowed the team to run reports and identify how many staff members have expiring certifications and will need training. This data allows the Resuscitation Department to more accurately plan on the number of classes needed for each of the certifications required.

The CATS system has also been able to communicate with the Vanderbilt Performance Evaluation System (VPES). Through this communication information is available during the evaluations related to the employee's status of required licensure and certification. RN licensure and BLS information is uploaded from the CATS data. The CATS system integration into VPES allows managers to easily and efficiently complete primary source verification for licensure at the time of the annual evaluation.

The years of experience data in CATS is used by HR to determine salary for current staff comparison. Using regression analysis, HR can determine cost when implementing market adjustments with this data. This has been a significant improvement and time saver over prior years saving time and dollars.

The CATS database has been invaluable during state and JCAHO visits. Reports are easily pulled that detail all licensed personnel, type of licenses and tracking of expiration dates. The system can also be used to track all required certifications for the different professions. Each unit/department has designated staff that can access and maintain each group's data for their staff and run reports.

Summary

Marilyn Dubree’s ability to actualize her vision of automated systems for scheduling and tracking of required human resource licensure and other compliance data for nursing has had far reaching and positive effects on the organization. The systems designed for nursing are now used throughout the organization. The human resource transaction systems are now organization wide and allow the organization to:

- Accurately and efficiently track licensure and competency status for individual staff
- Ensure required licensure and certification through automated reminders for staff and managers
- Improve efficiency of verification of licensure requirements
- Use years of experience data for equity reviews for the implementation of market and other organization wide adjustments as well as for individual reviews
- Improve the ability of staff to participate in creating work life balance by participating in the scheduling process
- Examine human resource utilization to improve efficiency (example: timeout report)

[TL4EO-Exhibit A-1-VandyWorks Advisory Minutes Sept 10, TL4EO-Exhibit A-2-VW Project Team Minutes Sept 2010, TL4EO-Exhibit A-3-News You Can Use Sept 2010, TL4EO-Exhibit A-4-VandyWorks Alert]

Graph TL 4 EO – 1: CATS Screenshot

Staff Credentials
 Welcome: Todd, Linda K
 Credentials for Owens, Kathy S. (0061017) Job: Dir, Nursing Professional Prac. (0746)
 Any active licensure or Temporary permit should be verified by primary source verification through the Health Service Council or through external telephone verification at 1-800-338-6343.

Type	Issued State	License Number	Expiration Date	Source Verification Date	Renew	Comments
Registered Nurse	TN	34877	01/31/2012			edit

Add New Licensure

Type	Expiration Date	Source Verification Date	Renew	Comments
Certified Nursing Executive	01/31/2014			edit

Add New Certification

Type	Focus	Initial Degree Year	Comments
Bachelor of Science Degree	Nursing	1978	edit
Master of Science Degree	Nursing	1985	edit
Masters	Business	1993	edit

Add New Degree

“In their own words”

Salary and Compensation Comparisons From Human Resources

“Prior to CATS, the HR Office of Compensation had attempted several methods for determining salary, with limited success, if an RN had x number of years of experience for current staff and new hires. Our goal was to use the full pay range for individuals in the RN title considering their years of nursing experience and their last performance evaluation score across the organization, not just within a specific unit. Any attempt at data collection was via an Excel Spreadsheet requiring a manual update each time the data was requested as well as the logistical challenges of obtaining this information from each unit across the Clinical Enterprise. When determining new hire salary rates, Recruitment did not have up-to-date information for comparing against similar individuals within the organization beyond the unit level resulting in inconsistent salary offers and creating bidding wars among hiring managers for the same applicant. And, Compensation could not easily determine a cost estimate for a nursing market adjustment.

With the creation of CATS, we now have a mechanism for capturing years of experience that have greatly improved our processes. Years of experience data in CATS updates automatically so that once the data is entered, it automatically adds the years without requiring any additional work from the manager. We have the ability to pull RN data for the entire Clinical Enterprise to compare individuals across entities and units with the same years of experience and performance evaluation scores. Data is provided to Recruitment so that salaries can be determined for new hires without disrupting salary equity with current staff, and reduces bidding wars among hiring officials from different departments. Compensation has used the data from CATS to conduct organizational wide salary equity reviews, and cost projections for market adjustments. This process is invaluable for cost projections of widespread populations such as nursing or entry level staff, each group with 2500+ employees. This method of reviewing salaries for nurses has also been applied to Pharmacy Technicians, Rehab, Respiratory, Radiology, Labs, and Dietitians. Information is power, and we have provided this invaluable data and system to our managers, recruiters and compensation teams for evaluation and use of efficient and effective methods to perform daily functions of their job.”

Leslee Hughes, MA, PHR, Manager, Compensation Human Resources

“The ability of VandyWorks and CATS to communicate is a huge win. Prior to this, the educator or assistant manager manually tracked pending expirations and emailed staff. With this current capability, the manager, administrative assistant and staff member receive an email beginning 90 days prior to expirations allowing plenty of opportunity for scheduling and completion of the needed task. In addition, the nurse is automatically removed from the schedule in VandyWorks if they fail to renew their nursing license prior to the expiration date.”

Debbie Shinkle, RN, BSN, MHA, M Ed, Manager, VCH 6A/B, Pediatric Hematology & Oncology

“Having CATS and VandyWorks interfaced is helpful with automatic notices about license expiration. This interface is also helpful with alerting staff about pending certification expirations (BLS or ACLS). It gives a 90 day and 30 day alert.”

Julie Foss, MSN, RN, NE-BC, Manager, MICU VUH

“The reports allow us to track prior to expiration dates and provide staff with ample time to renew their license and certification to meet their job requirements. Having staff removed if their license is expired helps as a last and final warning to both the manager and the staff member.”

Richard Corcoran, BSN, MSHA, RN, Manager, 9 North, Surgical Step down, VUH

“CATS has been valuable to the pharmacy to help us maintain updated information on licensure status of our staff. The notification features are a great motivator to our staff to process needed paperwork in situations where renewals may not be as timely as desired.”

Mark Sullivan, PharmD, Director, VUH Pharmacy

“The CATS database has provided us in the Respiratory Care Department with several advantages:

- 1. We are now able to easily generate a custom report with all of our staff’s licenses, expiration dates and special endorsements. This has been very helpful specifically when we had our recent TN State Department of Health inspection and they requested a list of all RTs, with license numbers, expirations dates and ABG endorsements. It only took a minute to generate this from the CATS database.*
- 2. The CATS database provides us with a quick visual of the status of all our staff with regard to special certifications, i.e. Fundamentals of Critical Care Support (FCCS), ACLS, PALS, BCLS training.*
- 3. The CATS database also assists us with tracking years of experience so we can be assured we are maintaining pay equity with all of our staff.*

Anna Ambrose, RRT, MHA, Administrative Director, Respiratory Care VUH

“CATS have been helpful to me in tracking the renewals. One less spreadsheet I have to keep. It automatically emails employees reminding them of their expiration date. One less email I have to send. I can then update the system when they have renewed their license.”

Cindy Johnson, Pharmacy

"It has been helpful to me in tracking renewals and reminding staff by the automatic emails. It is very helpful!"

Rhonda Tully, CRA, MBA, Administrative Director, Department of Radiology

Advocacy and Influence

Source of Evidence 5

Describe and demonstrate how nurse leaders guide the transition during periods of planned or unplanned change.

Vanderbilt is a system that has as one hallmark, the ability to plan and execute on change. The drive to constantly improve, innovate and lead in patient care delivery effectiveness and efficiency creates a culture where change is expected. The environment attracts those who find change intellectually and professionally rewarding. Whether change is “top down” or initiated from staff, nursing leadership is always at the heart of the change planning, implementation and evaluation processes.

The Shared Governance model at Vanderbilt provides a strong structure to engage all levels of nursing in the change opportunity. The structured described in OO 11 and SE 1, is our vehicle for shared decision making, provision of feedback, and evaluation of change effectiveness. Leaders use the rich dialogue of shared governance collaborative teams and structures at all levels to recognize the need for change, test change ideas, to refine plans for change, implement and evaluate change.

As change ideas emerge, the Nursing Executive Board places the change ideas against the strategic direction for nursing, testing the congruency with over arching objectives. The Nursing Administrative Boards which are both organization wide and entity specific are the vehicle for accountability of clearly planning change across the organization. Nursing Leadership Boards implement changes and use their area and Units Boards for rapid cycle improvement, evaluation and feedback of real and proposed change.

Nursing leaders participate in enterprise wide committees and help those teams pace the rate of change as nursing seems to be the common denominator impacted by all organizational change. The collaborative nature of nursing with all disciplines positions nursing leaders to be involved in designing change throughout the organization.

Three examples of how nursing leaders manage planned and unplanned change are described below.

Critical Care Nurse Practitioner Program

Purpose/Background

Patient volumes have been on a steady increase at VUMC. The strategic plan for the organization included the addition of a new Critical Care Tower with 3 critical care units opening in November of 2009. These units would accommodate increases in the Surgical Intensive Care Unit (SICU), Medical Intensive Care Unit (MICU) and Neuro Intensive Care Unit (NICU). As planning occurred for these expanded units, it was recognized that additional nurses in advanced practice roles would be need to provide comprehensive, team based critical care to the increased patient populations. This need was further reinforced by the unplanned reduction of resident hours due to training program restrictions.

Pam Jones MSN, RN, the Chief Nursing Officer for VUH, was the executive leader for this project. Other team members included Dr. Lee Parmley (Executive Medical Director for Critical Care), Dr. Allen Kaiser (Chief of Staff – VUH), Clare Thomson-Smith, RN, APN, JD (Director, Center for Advanced Practice Nursing and Allied Health), Devin Carr, RN, MSN (Administrative Director) and Deeanne Moore (APN – NICU).

The need for a systematic plan and approach to this was identified as a goal for the CNO during the annual goal setting process in July of 2008. A multidisciplinary group of leaders was put together to assess this need and develop a standardized model. A roadmap for decision making was developed and presented to the CEO on 8/25/2008. *[TL5-Exhibit A-1-ICU APN Coverage Plan Development]*

The project team conducted a site visit to Duke University Medical Center which had been identified as a best practice site for the use of advanced practice nurses in critical care. Clare Thomson-Smith, Director for the Center for Advanced Practice Nursing and Allied Health, also conducted telephone interviews with other experts in the utilization of advanced practice nurses to assess best practice.

A model was developed in collaboration with the ICU Medical Directors and other appropriate faculty members and presented to administration for approval. *[TL5-Exhibit A-2-ICU APN Critical Care Model]* This model included the addition of advanced practice nurses at a ratio of one (1) APN to eight (8) patients. The numbers of APNs hired allocated per unit varied depending on the resident coverage. The appropriate number of APNs were placed in the budget and hired in a staggered manner in preparation for the opening of the Critical Care

Tower. The staffing compliment was determined and put into the budget for the fiscal year, 2009-2010 which began on July 1, 2009.

In addition to the model development, the physician leaders of MICU developed an extensive training program to ensure competency for the MICU APNs. Historically, the MICU did not utilize APNs at all and Dr. Art Wheeler, Medical Director of the MICU, embraced the concept with academic enthusiasm. The curriculum is attached. *[TL5-Exhibit A-3-MICU NP Core Curriculum]*

Meal Break Time Keeping Unplanned Change

In November, 2009, Vanderbilt University Medical Center attorneys were notified of a class action lawsuit that had been filed against Vanderbilt by a former nurse. The nurse alleged that Vanderbilt had not compensated her and other of Vanderbilt employees for missed meal breaks. We learned this was a common occurrence that was happening throughout the country.

The situation was that the time and attendance system at Vanderbilt (Kronos) was programmed to deduct 30 minutes from the total time an employee was clocked into work as an automatic deduction for a meal break. If an employee missed the meal break, the employee should self-correct by cancelling the meal break deduction or reporting the missed meal break. Reporting the missed break allows the time-keeper to cancel the deduction. The lawsuit alleged that employees who did not get a meal break due to work responsibilities were not always compensated for that time. The lawsuit was based on the Federal Labor Standards Act, which requires that employees be paid for all hours worked, including meal breaks missed by employees or meal breaks that were interrupted in such a way that the employees were not able to fully enjoy their meal breaks.

The person involved in the lawsuit was the Executive Nursing Officer and became the Executive leader responsible for managing the situation. Since the allegations in the lawsuit also related to non-nurses, David Posch, the CEO of the Vanderbilt Medical Group, became Marilyn Dubree's Executive partner.

The actions taken to resolve the matter included:

- Increase all supervisor , manager and leader understanding of and ability to comply with the federal regulations and Vanderbilt University Policies on meal breaks

- Correct any error that had occurred in compensation
- Clarify the rationale for the automatic meal break deduction in the time and attendance system
- Reinforce the expectation that all staff take regular breaks
- Maintain a process of time keeping that is efficient and effective for staff and the organization

An Executive Committee was formed to manage this situation with far reaching implications to the organization. The Committee included:

- Marilyn Dubree, RN, MSN, NE-BC, Executive Chief Nursing Officer
- David Posch, MS, CEO Vanderbilt Clinic and Executive Director Vanderbilt Medical Group
- Lynn Webb, PhD, Assistant Vice Chancellor for Health Affairs
- John Manning, Assoc. VC for Health Affairs and Chief Admin Officer and Sr. Associate Dean for Operations and Admin, SOM
- Wright Pinson, Deputy Vice Chancellor for Health Affairs and CEO of the Hospitals and Clinics

An Education and Communication Committee was also formed and included:

- Susan Mezger, CCP, SPHR, Director, Human Resources
- Terri Minnen, Senior Consultant, M.Ed.
- Pam Brown, Director, Organizational Effectiveness Team
- Debora Shiflett, Director, VUMC Financial Training
- Karen Anne Rye, Assistant Director, Enterprise Wide Functions
- Debiann Peterman, Ph.D., MSN, RNC-NIC, NE-BC, Director, NE & PD
- John Callison, Senior Deputy General Counsel

- James Floyd, Associate General Counsel
- Veronica Burns, Senior Director, Human Resources
- Nannette Vaughan, Manager, Department of Employee Relations
- Payroll office and Management Information Systems

Action Steps

The first action was to review the Vanderbilt policies and understand if the policies were consistent with Federal requirements. The policies were reviewed and, while the policies were consistent, some revisions were made to clarify any ambiguities.

The second step was to investigate if Vanderbilt was following the stated policies. To that end, hundreds of supervisors, managers and timekeepers were interviewed to assess their practices related to time keeping and meal breaks. This was accomplished with the assistance of external legal manpower. The assessments found that there was variation in the administration of time keeping related to time and attendance. At this point, Vanderbilt recognized that there was potential for error in payment to employees and began to action plan.

Based on the principle for doing the right thing for employees, planning was focused on communication, education, and identifying error in payment. A team of human resource, training and financial experts was assembled to take the next steps. A process was designed to inventory the number of staff who might not have been paid accurately. The process that was developed was a survey methodology.

The survey was developed with the intent that it would be made available to all current and former staff using the Kronos system for time keeping in the last two years. The survey was developed to provide each staff member the following employee-specific information: total number of meal breaks that were deducted from their pay for the previous two years and the number of meal breaks that were credited back (logged as “no meal break”) in the Kronos system. With that information, staff members were asked to declare the number of meal breaks they missed and were not compensated for in the two year period. *[TL5-Exhibit B-1-Staff Training]*

Vanderbilt’s intention was to do the right thing for employees trusting in the honesty of employees to self-report accurately. As a result of Vanderbilt’s program of education and self-

correction (including voluntarily paying staff for all reported meal breaks missed); the lawsuit was dismissed at an early stage.

Communication and education for this entire effort was daunting. A detailed training plan is provided for review. *[TL5-Exhibit B-2-Training and Communication Plan]*

Training/Education

Managers and supervisors were first trained in required sessions. *[TL5-Exhibit B-3-Manager Training]*

The objectives of the supervisor training were to:

- Define the supervisor's responsibility and accountability for:
 - Reconciling and approving payroll data
 - Overseeing the timekeeping function
 - Monitoring of trends and practices within department
 - Communication process of policy and procedures to staff
- Identify the correct procedure for reviewing and approving time records when a staff member has not been able to take an uninterrupted meal break during work hours.
- List examples of best practice to create an environment where staffs routinely take an uninterrupted meal break.

After leaders were trained and aware of the plan, the training effort turned to staff. There were multiple sessions at various times in order to provide sessions for those working different shifts.

The training objectives were to:

- Define an "uninterrupted meal break."
- Identify the correct processes to follow to cancel an automatic meal deduction in Kronos.

- List the steps required to ensure that the Kronos time record is accurate.

Once the training was complete, staff began taking the survey. Vanderbilt provided a helpline for those needing assistance with their survey information. In addition, staff was able to go to dedicated computer rooms during the survey period in case they did not have easy access to a computer nor needed additional assistance. After the survey was closed, it was recognized that some staff who did not participate in the survey wanted to be included. The survey was reopened to staff who had not taken the survey initially.

Once staff had declared the meal breaks for which they believed they should be paid, letters were written to staff with an explanation of the compensation they would receive. They were paid the average rate of pay for the two year period for the hours they reported as not paid.

A helpline and frequently asked questions website were developed for ongoing support to staff, supervisors, managers and leaders. The Executive Leadership team continues to meet once a week with additional meetings at least twice a month to monitor progress of the effort.

Summary

This entire event caused Vanderbilt to learn about an opportunity for improvement. The event created recognition of the need for ongoing and predictable education related to time keeping. In addition, it created a model for managing meal breaks that is now being extended to other employees who do not use the Kronos system. The event tested the organization's ability. Never before had such an extensive institution-wide education effort been executed in such a short time frame. Perhaps, most importantly, the event tested Vanderbilt's commitment to employees and for defining the "right thing to do" approach to providing fair treatment to its most precious resource - Vanderbilt staff.

Measureable outcomes include:

- Policy was revised (provided for review)
- Hundreds of managers, supervisors and timekeepers interviewed
- Approximately 1,600 managers, supervisors, administrators were trained

- Approximately 10,000 employees using Kronos were trained (40 sessions which provided 24,700 available seats)
- 7217 employees responded to the survey
- 2,782 employees were compensated for missed meal breaks

VUMC H1N1 Pandemic Response

When the outbreak of H1N1 began in April 2009, through an interdisciplinary approach VUMC was ready to respond. On the weekend of the initial outbreak the Chief Medical Officer & Associate Vice Chancellor for Clinical Affairs, Chief Hospital Epidemiologist, and VUMC Emergency Preparedness Coordinator kept in close contact by phone on the developing health emergency. On Sunday, April 26th, the decision was made by this group to have an Executive Briefing early Monday morning due to the extent of the developing H1N1 outbreak. The VUMC Emergency Preparedness Coordinator, Pam Hoffner, RN, MSN was also in contact with the Regional Hospital Coordinator and requested a TN Department of Health (TDH) Hospital Advisory Committee conference call on Monday to ensure all TN hospitals were updated on the situation, communication lines were established, and to ensure a well coordinated response to the health emergency.

At the first Executive Briefing, it was decided a gap analysis of the VUMC Contagious Pathogen Plan needed to be completed to ensure readiness for a bio health emergency response. A Vanderbilt University representative would be included in all executive level meetings to ensure the University response plan was in place. There were a series of daily Executive Briefings and Operational meetings over the next several days which were chaired by Executive Nursing Leaders in collaboration with the VUMC Emergency Preparedness Coordinator, and Executive and Senior Medical Leadership. The VUMC Emergency Preparedness Coordinator and Director of Infection Control attended frequent TDH conference calls and conference calls with the Regional Hospital Coordinator.

The Monroe Carell Junior Children's Hospital at Vanderbilt received their first suspected H1N1 Influenza patient. With the arrival of the first patient, the decision was made to increase surveillance activity to include virtually all ports of entry into the Medical Center. A partial activation of the Emergency Operations Center (EOC) allowed for a succinct interdisciplinary response to the health emergency. Executive briefings were conducted on a daily basis.

The Contagious Pathogen Plan gap analysis performed by the VUMC Emergency Preparedness Coordinator in collaboration with the Executive Chief Nursing Officer revealed gaps in HR, Triage, Surge Capacity, Education, Vaccine and Antiviral Allocation/Distribution, and Ethics. To remedy these areas of vulnerability, six interdisciplinary pandemic planning teams were formed to address each gap. A chair (from senior leadership) was assigned to each team and the majority of team meetings were facilitated by the VUMC Emergency Preparedness Coordinator. The teams were given a series of tasks to rectify the gaps and these were to be completed within a designated time frame set by the Chief Medical Officer & Associate Vice Chancellor for Clinical Affairs.

The partially activated EOC remained operational along with the daily Executive Briefings for a total of nine days at which time H1N1 Influenza activity in the state of TN stabilized. During this time, it became apparent there was a need for a medical director to be assigned to the Department of Emergency and an appointment was made by the Chief Medical Officer & Associate Vice Chancellor for Clinical Affairs.

The need for a Pandemic Tabletop Exercise for Executive and Senior Medical Leadership to test the newly revised Contagious Pathogen was entertained by the VUMC Emergency Preparedness Coordinator and Executive and Senior Medical Leadership agreed this would be an excellent educational method to utilize to train senior leadership about pandemic planning. A decision was then made to hold the exercise in early September.

During the months of May, June, July, and August the Pandemic Planning Teams continued their work until their task lists were completed. Periodic updates were given to Executive Leadership by the VUMC Emergency Preparedness Coordinator and the newly appointed Medical Director for the Department of Emergency Preparedness.

The increased surveillance efforts continued at VUMC throughout the summer months and H1N1 Influenza was elevated to a pandemic by the World Health Organization (WHO) in the month of June. During the months of July and early August the VUMC Emergency Preparedness Coordinator served as a liaison and consultant to Vanderbilt University in their pandemic planning efforts with their start-up of the fall semester. She also assisted the Director of Student Health, Dr. Hanson, in obtaining a Memorandum of Understanding (MOU) with CVS pharmacy in an effort to streamline the filling of antiviral prescriptions in order to streamline patient throughput in the Student Health Clinic.

The Labor Day weekend proved to be the start of the second wave of the H1N1 Pandemic for Children's Hospital. It hit with a vengeance that allowed us to test our plan. This

was followed by an outbreak on the VU campus side. The other metro hospitals didn't experience a large second wave of H1N1 like VUMC.

A multidisciplinary H1N1 Steering Committee comprised of senior leadership was formed at the request of the VUMC Emergency Preparedness Coordinator to establish a mechanism to handle the second wave of the pandemic. This proved to be a good forum to coordinate the second wave response efforts and minimally disrupted hospital operations. A weekly conference call was also conducted with the University side and was attended by the VUMC Emergency Preparedness Coordinator.

In early September an H1N1 Pandemic Exercise was conducted and attended by 106 faculty and staff members who included a large portion Executive and Senior Medical Leadership along with VU Executive Leadership and key Medical Center departments. The main objective of the exercise was to educate senior leaders and key departments about the newly revised Contagious Pathogen Plan and the pandemic planning process. This exercise was planned and facilitated by the VUMC Emergency Preparedness Coordinator.

Following the exercise, the VUMC Emergency Preparedness Coordinator was utilized as a consultant for pandemic preparedness initiatives in several medical center departments and divisions. Faculty and staff were also assigned to a mandatory online inservice on the VUMC Contagious Pathogen Plan and Pandemic Planning. The VUMC Emergency Preparedness Coordinator was an active participant in the development of this inservice in collaboration with the pandemic planning education team, infection control, and the Chief Hospital Epidemiologist.

During the fall and winter months, the adult side of VUMC experienced a few surges in H1N1 influenza cases that primarily affected the MICU. The H1N1 Steering Committee and VU conference calls continued to meet on a weekly basis and H1N1 issues were addressed on a weekly basis in this forum some of which included: weekly surveillance reports on flu activity and N-95 mask usage, antiviral distribution, H1N1 vaccination distribution, education of patients and visitors, and ECMO issues. At the beginning of December H1N1 surveillance reports indicated a marked decrease in disease activity in TN and at VUMC. At this time a decision was made by the H1N1 Steering Committee members to decrease meeting frequency to bi-weekly. In early January, the flu surveillance systems continued to indicate very little H1N1 activity and the decision was made to discontinue the H1N1 Steering Committee with the understanding to resume the meetings if activity started to increase.

At this time the VUMC Emergency Preparedness Coordinator continues to monitor H1N1 activity in collaboration with Infection Control and the Chief Hospital Epidemiologist and the pandemic planning process continues at the medical center.

In summary, the success of VUMC's and Vanderbilt University's response plans was due, in large part, to an exceptional degree of interdisciplinary collaboration within Vanderbilt as well as extensive external communication and collaboration at the local, state and national levels.

Advocacy and Influence

Source of Evidence 7

Describe and demonstrate how nurse leaders value, encourage, recognize/reward, and implement innovation.

Examples and methods of valuing, encouraging, recognizing and rewarding innovation are found across the organization. The following are some of those examples.

Table TL 7 – 1: Examples

<p>Recognition and reward through the Center for Frontline Leadership.</p>	<p>Through the Center for Front Line Leadership program, Vanderbilt Nursing invests in training aspiring leaders into the field. Since 2006, Vanderbilt has partnered with the Advisory Board to make the Center for Frontline Nursing Leadership program available to Vanderbilt nurses. At the end of the program, all participants are honored by presentation of their projects to the Nursing Administrative Board members. <i>[TL7-Exhibit A-1-CFNL Graduation Jan 2010]</i></p> <p>The Future of Nursing Leadership Award was initiated in 2007 to recognize the incredible impact of frontline nurses who have completed the Advisory Board Academies' Center for Frontline Nursing Leadership. Tanika Wilson, RN, BSN, Assistant Manager PCCU was recognized for her work on "Drip Double Check reduced medication Errors" in 2009. Debra Grimes, RN, Charge Nurse in Women's Health was recognized for her work in "Creating an Acuity Based Staffing Model" in 2008. Both of these award winners are highlighted on the Vanderbilt Nursing Web site. The web site provides videos of each of these award winners.</p> <p>http://www.mc.vanderbilt.edu/root/vumc.php?site=vanderbiltnursing&doc=18887</p>
<p>Annual Nursing Awards</p>	<p>Every year nurses from across the VUMC system nominate the best and the brightest for recognition at Vanderbilt. The nurses to be awarded are selected by a committee. The nominees and the award winners are recognized annually at a presentation ceremony during Nurses week.</p>

Information about these nurses remains posted on the Vanderbilt Nursing Website. The 2010 award winners are listed below.

Spirit of Nursing Award:

Elliott Douglass, RN, BSN, WOCN

Monroe Carell Jr. Children's Hospital at Vanderbilt

What is the essence or heart of nursing at Vanderbilt? Several moving and inspirational pieces were submitted, but the nursing council selected a poem, submitted by Elliott Douglass, R.N., the wound ostomy and continence nurse at Monroe Carell Jr. Children's Hospital at Vanderbilt. Douglass, who spent most of her 13 years in nursing working with adult patients at Vanderbilt University Hospital, says coming to work at Children's Hospital three years ago brought her love of nursing full-circle. It is a life-long passion that began at the age of 3, when she developed epiglottitis and nearly suffocated. She says James O'Neill, M.D., then chairman of Surgery in Pediatrics, saved her life, and her experience in the critical care unit at Children's left a deep impression on her. Poetry has been another passion for Douglass. "In high school, the boys would ask me to write poems they could use to give to their girlfriends," Elliott says with a laugh. Her love of poetry and nursing blend nicely in the winning essay for the Children's Hospital "Spirit of Nursing" contest.

The Rebecca Clark Culpepper Award:

Jan Malone, RN, BSN

Interim Nurse Educator/Charge Nurse, Monroe Carell Jr. Children's Hospital at Vanderbilt

The Rebecca Clark Culpepper award is given jointly by Vanderbilt School of Nursing and Vanderbilt Medical Center Nursing to honor Becky's many contributions to both areas. The recipient can be a nurse at VUMC or faculty at VUSN. The recipient of this award exhibits mentorship of fellow nursing staff, faculty or students and actively promotes of the nursing profession. There is a commitment to professional development at all levels.

In December 2009, Jan accepted the Interim Nurse Educator position for the Pediatric Surgery and Adolescent Unit. Jan had agreed to support the unit in

this role as temporary position while the regular Educator is out on maternity leave. During her short time in this role, she has been active in attending clinical practice and policy meetings. She actively seeks out evidence based research, collaborates with the management team, and seeks staff input to support her recommendations. In addition to this new role, Jan is an active member in the Society of Pediatric Nursing and has recruited many new members into the organization. Recently, Jan was confirmed as the new Vice President for the Middle Tennessee Chapter of Pediatric Nursing. She attended the National Society Pediatric Nursing Conference in Orlando, Florida this May.

In her Interim Nurse Educator role, Jan assigns preceptors to orient new staff, pediatric nurse residents, and nursing practicum students and also coaches and mentors the preceptors and helps them individualize plans to meet the needs of the new staff members and students.

Jan encompasses the true spirit of nursing through her passionate commitment to elevate the nursing profession and her commitment to her colleagues. This is demonstrated through her quest to engage others to join nursing organizations and seek continuing education opportunities that advance nursing practice and organizational standards.

Vanderbilt School of Nursing Faculty Award:

Clare Thomson-Smith, JD, MSN, RN, FAANP

Assistant Professor of Nursing

Director, Center for Advanced Practice Nursing and Allied Health

This award is given to the Vanderbilt School of Nursing faculty (nurse or non-nurse) who has made the greatest contribution to the field of nursing.

Clare Thomson-Smith serves as a role model, advocate and a mentor at the School of Nursing, the Medical Center and the Tennessee Nurses Association. She contributes to the academic mission of the school by facilitating courses for the much-in-demand Health Systems Management program of study – teaching students from around the country who are or will become nurse administrators and leaders for health systems throughout the country. As director of CAPNAH which is dedicated to supporting existing

and emerging practices, she and her team have made significant strides in mentoring advanced practice nurses and allied health professionals into the profession and the VUMC culture with a robust array of activities and professional development opportunities.

She has used her J.D. degree to become an advocate for policy development related to advanced practice nursing. She serves as chair of government affairs and health policy committee for the Tennessee Nurses Association and can navigate the often challenging and ever-changing landscape of health care legislation in the state. She voluntarily contributes her time to these efforts to support the role of advanced practice nursing because she believes in the important role that advanced practice nursing plays in health care delivery – throughout Vanderbilt, the state and the country. Thomson-Smith is widely viewed as an expert in her field and was recently selected as a 2010 Fellow of the American Academy of Nurse Practitioners, recognized for her outstanding contributions to health care through clinical practice, research, education or policy.

Advanced Practice Nurse of the Year Award:

Kimberly Huffman, RN, MSN, PNP

Pediatric Otolaryngology

Kimberly is the Vanderbilt Children's Hospital resource for the Pediatric Otolaryngology service. She provides continuity of patient care by participating in daily team rounds and attending rounds, evaluating consultations in the ER and with inpatients, and facilitating preoperative and postoperative care of patients. Although Kimberly joined the Peds ENT team in 2008, her knowledge and clinical skills are well beyond expected for her years of training. Kimberly confidently assists in patient management and instructs residents how to care for common pediatric otolaryngology problems. She is a huge resource for ensuring proper multidisciplinary care of pediatric patients. She maintains open lines of communication with the Pediatricians, Peds GI, Peds Pulmonary, PICU, NICU and ER. In addition to these duties, Kimberly serves at the tracheotomy resource for Children's. She provides education to nurses, patients and families and ensures that the necessary equipment and supplies are available prior to discharge. In fact, she is often contacted to serve as a tracheotomy resource for patients not

treated by the Otolaryngology service. In addition, she has developed the website for the Peds ENT department and her efforts there are decidedly centered on patient understanding and care.

Kimberly has created and implemented several new evidence-based practice (EBP) order sets for the Peds ENT service (including postop cleft lip, postop cleft palate). She was also instrumental in developing a Children's hospital-wide, standardized post-tracheotomy order set. Kimberly also serves on the Nursing Research Committee.

Kimberly is an integral part of the Pediatric Otolaryngology team. She is a patient advocate, and provides seamless continuity of care from the clinic and OR to the hospital. She educates residents and nurses on a daily basis and is a Children's-hospital wide resource for tracheotomy patients. Through her collaborative efforts with other services, Peds ENT patients receive the best care possible.

Staff/Unit/Department Educator of the Year Award:

Kara Gordon, RN, MSN, Nurse Educator

Vanderbilt University Hospital Medical Intensive Care Unit

The recipient of this award demonstrates participation in and models lifelong learning and positively reflects the image of nursing. Education is Kara's passion. She is a positive, knowledgeable, cheerful and caring person. Kara's main focus is providing the staff with the tools needed to deliver excellent patient care. She fulfills this challenging task while remaining positive and helpful.

All aspects of Kara's work are based on evidence. She models and promotes evidence-based nursing practice, while coaching the staff in obtaining and using evidence. She also collaborates with the EBL librarians in obtaining needed information and utilizes critical care research from the National Teaching Institute. Through the utilization and sharing of evidence, Kara is able to influence nursing practice on the unit and organizationally.

Kara plays a leadership role in both unit and organizational initiatives, including, but not limited to, blood stream infections, Pressure Ulcer

Prevention, nurse resident education, HINI, bariatric equipment and the work around the Critical Care Tower. Helping to maintain a calm environment when anxiety was very high supported the staff to focus on safe patient care. Kara has been a leader in the work around the Critical Care Tower. She was instrumental in developing the education provided to all critical care nurses prior to the move and opening.

Kara is an advocate and support for the staff in regard to professional and personal educational goals. She mentors staff in studying for and taking the Critical Care RN certification exams and helps them obtain study materials. Kara encourages staff to become certified in CVVHD for our renal population. She works with graduate students and also took a refresher pathophysiology course recently at Vanderbilt. Kara encourages staff to continue their education whether it is graduate work or other.

Kara is a valued role model and colleague to the staff of the MICU and many others throughout the Medical Center and also a great friend.

Julie Foss, RN, MSN, NE-BC

Nurse Manager, Medical Intensive Care Unit

Julie has been the manager in the MICU for 21 years and some of the staff has been with her the entire time! Her hard work, dedication and nurturing spirit have helped to create the awesome work environment in the MICU today. MICU staff believes she is one of the finest leaders. Julie is a role model for shared governance. She sets a tone of enthusiasm and inclusion. Each staff member knows their comments and ideas are valued. Through unit board, staff meetings, frequent emails, Friday communication, rounding and general visibility, staff are able to provide feedback and stay informed about the Medical Center and MICU.

Julie recognizes other departments' contributions to patient care and urges the staff to show appreciation to those who support patient care. Recently she shared how a member of our Environmental Services team went above and beyond the call of duty to help with a challenging patient. As a result, we were able to celebrate and honor the ES staff member. She co-chairs the Retention and First Two Years Retention Committee for Be the Best. She is

also active in HED Advisory, UTI Advisory, Falls Prevention, Handiworks, VAP Dashboard, and Rapid Response. Julie helped lead efforts in transitioning to the new Critical Care Tower.

Julie treats all people with respect and compassion. She lives the Credo and is positive and inspires the staff to do the same.

Licensed Practical Nurse of the Year Award:

Arthur Thompson, LPN

Neurology Clinic

Our staff fondly refers to Arthur as "Mr. Vanderbilt." Over Arthur's thirty-five years at the Vanderbilt University Medical Center, he has been in the forefront of many great activities that have helped to make this institution the place it is today, through Nursing. Some things Arthur has been a part of are: the first Unit/Clinic Board in our clinic (and is presently the Unit Board Chairperson); a leader in feeding the staff and the patients' family members on Thanksgiving Day in the Neurology units; advocating for the LPN name badge change; a member of the original Nursing Staff Council, and instrumental in the need to expand and develop a clinic nurse council to better represent the outpatient nurses.

Although for many years, Arthur has been a mainstay in the Stroke division of the Neurology Clinic, he is also a part of the Movement and Headache team in the Neurology Clinic. Arthur continues to be an alternate for VMG's Nursing Staff Council as well as alternate for the Nursing Staff Bylaws Convention Delegate.

This year Arthur Thompson has been appointed to the Tennessee State Board of Nursing, and he is one of only three licensed practical nurses on this important board. This appointment honors the role of the LPN and instills pride for all Vanderbilt Nurses. Arthur is the type of nurse that makes Vanderbilt Nurses stand out and his work contributes to making us a Magnet designated organization. Arthur is a good friend to both patients and staff.

Research and Evidence Based Practice Award:

Donna Christensen, RN, BS

Evidence Based Medicine Specialist,

Case Management Department

In Donna's role as an EBM Specialist, she meets the criteria for this award many times over on a daily basis. Since 2008 Donna has served as a leader on the Nursing Research Committee to build resources that support staff to access nursing literature, conduct critical analysis and make practice recommendations.

Donna supports many nurses in their quest through individual consultation and the development of web-based EBP tools. One example is the "Got a Question" tab on the Nursing Research web site. Nurses or any member of the team can post a clinical question and receive a summary of the evidence available to answer the question. The traffic in this activity is very high and Donna has a personal commitment to provide high quality answers. A large number of nurses have benefited from Donna's extra efforts and thus supporting quality patient care. Donna does work with the research staff in the Eskin Biomedical Library on the complex questions, but screens each one herself. Donna is a role model on providing feedback and presenting her opinion.

Donna compiled all of the Research website links and for the search tips section. This has given any nurse at Vanderbilt access to many resources which provide evidence to support or improve patient care. Donna's greatest contributions may not lay within the realm of research itself, but her evaluation of the implementation process. This evaluation process is critical for us to continue to improve nursing practice at Vanderbilt as well as move the science of nursing forward. Donna has been a leader in the efforts to move Vanderbilt nursing to a higher level of evidence-based practice. Her contributions to the Nursing Research Committee are invaluable and showcase only a portion of Donna's dedicated work

Team Award:

Monroe Carell Jr. Children's Hospital at Vanderbilt

Perioperative Services Guatemala Mission Team September 2009

Each year throughout the Medical Center, different individuals and teams travel the U.S. and the world on medical missions. Several teams have gone to Guatemala and we salute all of those teams and individuals. The

particular team being recognized by this award is the Guatemala Team of September 2009.

The success of this team's hard work is measured in the quality of the lives changed; specifically the children of Guatemala. From the 96 patients screened to the 51 who received surgical care, this team had a direct impact on the quality of life for many. Surgical outcomes were measured by clinical data, but cannot compare to the emotional well-being. The clinical outcomes are followed by both The Shalom Foundation and individual physicians at Vanderbilt. They were also able to follow-up on past surgical patients and bring that news back to other staff from previous mission trips.

The team demonstrated a strong sense of inquiry in preparation for the trip by packing all necessary equipment and supplies and taking into account cultural aspects as well. Coloring books and candy were mixed in with surgical drapes and scalpels. Spanish translation of teaching materials was instrumental to the team's success. None of this could have been accomplished without research and team coordination.

The interpersonal communication skills team members honed have improved "hand overs" here at Vanderbilt. In addition, team members reported they got back to the basics of nursing, through having to "make do" and be creative. Working with the staff from the local hospital was rewarding for the team and enhanced learning on both sides. Their welcoming attitudes taught the Vanderbilt team a lesson in inclusiveness. The team faced challenges and overcame many obstacles. However, it was worth it to see the smiles and to receive the handshakes and the hugs. Changing lives in a different country means changed lives back here at Vanderbilt.


Rosamond Gabrielson Staff Nurse of the Year Award for Monroe Carell Jr. Children's Hospital at Vanderbilt, Vanderbilt Medical Group, Vanderbilt Psychiatric Hospital, and Vanderbilt University Hospital
Lisa Foust, RN, Vanderbilt Medical Group, Vanderbilt Health One Hundred Oaks

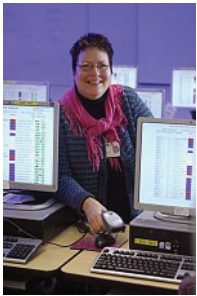
Lisa Foust has defined the model for "team approach." Her colleagues respect and admire her. They turn to her for patient care advice routinely. Lisa treats every patient as her own, and leaves nothing for the next person to finish. Lisa's friendly and confident demeanor immediately establishes a good rapport with patients. But what she offers our patients is far more than a great first impression. To them, she is a reliable and loyal advocate who inspires trust and confidence. She is central to their success in blood pressure management, weight loss, dietary and exercise compliance, and lipid management, as she is integral to the follow-up on these patients both in clinic and in the interim between clinic visits.


Lisa has been integral to the success of the Vanderbilt Heart Preventive Cardiology program. In only two short years Lisa has become so knowledgeable about management of cardiovascular risk factors that she is able to anticipate the next step (e.g. changes in medications) and prepare for it, and she frequently makes pertinent suggestions for patient care and is able to integrate complicated factors like cost, likelihood of patient compliance, side effects, and/or drug-drug interactions into her decision making suggestions. Lisa has promoted preventive cardiovascular health, women's health, and Vanderbilt, and she continues to self-educate. She attends evening Vanderbilt Lipid Club journal club meetings regularly and she served as a host at several OHO opening events to promote the new clinic. She has also been critical in helping design and implement a free (daily!) heart health screening program for women at OHO (this program could serve 500-1000 women per year).

Lisa makes many contacts with other RNs and practitioners to constantly stay involved in what is going on in preventative medicine. Lisa is also the frontline contact for the preventative program's involvement with the lipid management practice. She works with that team's NP, MDs and research team to ensure that patients who qualify for new and ongoing research studies are entered and have assistance.

Lisa Foust is the absolute epitome of nursing. She is an incredible and loyal colleague. She is a patient advocate, and her leadership style is organized and thorough. Her impeccable work ethic, leadership, thoughtful approach to patient care, and contribution to Vanderbilt deserve not only recognition,

	<p>but great reward.</p>
<p>5 Pillar Leader Award</p>	<p>Two nurse leaders this year were honored by the entire organization as 5 Pillar Leaders. All leaders serving VUMC are eligible with the exception of executive leadership guided by the following criteria:</p> <ul style="list-style-type: none"> • Nominees in a leadership position for at least one year. • Nominees must be in good standing and nominations must be supported by “one up” leader. • Nominations may be made by any faculty or staff member. Self-nominations are not accepted. • Nominees must demonstrate consistent practices that impact success across the five pillars and demonstrate consistent Credo behavior <p>The following excerpt was taken from the Reporter and written by Paul Govern</p> <p><i>9/25/2009</i> - Several staff and faculty who do consistently outstanding work were honored last week at Vanderbilt University Medical Center's Leadership Assembly at Langford Auditorium.</p> <p>Donna Williams, MSN, R.N. NEA-BC, an administrative director with Operative Services, was presented with the Five Pillar Leader Award for superior</p>  <p>All-around leader Donna Williams, R.N., received a Five Pillar Leader Award. (photo by Susan Urmy)</p> <p>Performance across VUMC's management “pillars” — employee satisfaction and retention, service, quality, finance and innovation — and for upholding the VUMC Credo.</p> <p>The award was presented by John Brock III, M.D., surgeon-in-chief at the Monroe Carell Jr. Children's Hospital at Vanderbilt.</p>

	<p>“Donna Williams is simply the best of the best. She makes everyone around her better. There's no greater honor for someone like me than to work with someone like Donna,” Brock said.</p> <p>December, 2009 Karen Hughart, M.S.N., R.N., director of Systems Support Services, was presented with the Five Pillar Leader Award, which recognizes superior performance across the Medical Center's management “pillars” — service, quality, finance, people and innovation.</p>  <p>Karen Hughart, M.S.N., R.N. As director of Systems Support Services, Hughart has aided clinical information technology implementation at VUMC. Over many years, she and her staff have had a hand in Vanderbilt's growth as a clinical information technology powerhouse.</p> <p>“Karen's dedication to her staff is remarkable,” the award nomination stated. “She never fails to demonstrate respect and consideration for others. She is known to many seasoned Vanderbilt nurses as 'the best manager I ever had.' ... Karen embraces the sense of ownership that is key to the Vanderbilt Credo.”</p>
<p>Reward and recognize System</p>	<p>Vanderbilt offers a method for leaders to reward and recognize staff through the Reward and recognize System. The system is an electronic one-stop shop for rewards and recognition! This year the system was open to colleagues who can now more easily recognize each other with Life Occasions E-cards or Performance E-cards to simply say “congratulations on the new baby” or “thank you for your efforts”.</p> <p>RECOGNIZE awards will be issued by award givers through MyVUMCRognition in the form of points. Points can be saved or spent in</p>

	<p>our Universal Rewards Mall which offers over 5,000 merchandise items and numerous gift cards.</p>
<p>Credo Award</p>	<p>The Credo Award recognizes staff and faculty who exemplify the Medical Center's standards for service and all-around professionalism, while the Five Pillar Leader Award goes to those who exemplify Medical Center leadership standards. Awards are bestowed each quarter.</p> <p>The Credo Award went to Edie Vaughn, R.N., staff nurse (on 9 South)</p>  <p>Edie Vaughn, R.N.</p> <p><i>“Edie spoils everyone she comes into contact with. She's such a joy to work with and to watch her welcome every patient with her smile.’ ... ‘Edie brings warmth, laughter and insight to our workplace. Edie has been walking the Vanderbilt Credo every moment of every day long before the Credo was even published.”</i></p>
<p>Orientation Buddy System</p>	<p>Alaina Knight, staff nurse on 7 North was awarded the opportunity to present a poster on the buddy system she helped develop on her unit at the American Heart Association Quality forum. Expenses for the trip were paid. <i>[TL7-Exhibit B-1-Buddy System Poster-ONSITE]</i> Alaina noted that when nurses came out of orientation, they still needed support. They did not always have the chance to experience or become competent in rare but necessary care 7 north nurse are called to deliver. Alaina devised the “Buddy System” for nurses out of orientation. After the RN is out of the typically 6 weeks of orientation the new nurse is paired with an experienced nurse. The experienced nurse and the new nurse have assignments close together geographically. The experienced nurse gets report from the new nurse and checks on the new nurse every two hours. The experienced nurse is responsible for monitoring, supporting, coaching the new nurse and stands ready to assist in any moment. This was received with great reviews by staff. The idea has been formalized in other units.</p>
<p>Nursing stress management in</p>	<p>The PEDS ED has seen a tremendous amount of growth in the past 5 years now seeing approximately 60,000 children annually. With growth comes an</p>

<p>the Pediatric ED</p>	<p>increase in the number of traumatic injuries, newly diagnosed cancers or other diseases, and deaths. The management team has been committed to come in for every death for the past 2 years. Upon arrival, the management team will assist the family, staff, and lead debriefings for the team. This support has led to an increased awareness in staff for the need to “take care of themselves” emotionally and physically given the stress factors of the job. There have been many informal and formal debriefing for the team.</p> <p>Gregg Horn, a staff nurse (who is now a Charge Nurse) was very passionate about proactively managing the level of staff stress. He developed a stress survey to get a baseline for the level of stress that the staff was experiencing. His work and the support of the management team led to more formal debriefing and an increase in visibility of EAP in the PED on an ongoing basis. EAP now makes monthly rounds in the department for day and night shifts to assist with the stress levels of the staff. This is in addition to the debriefings that occur after an event.</p> <p>The post survey results were very positive. The work has been transforming how nurse manage stress. <i>[TL7-Exhibit C-1-VCH ED Stress Project]</i></p>
<p>Daily shift to shift staffing report earns Leann Grimes Recognition</p>	<p>It can be difficult to plan the right staffing for a unit. It is especially difficult when varying patient acuity requires many different nurses to patient ratios all in the same shift. This is true in the OB/GYN inpatient unit which provides care for post partum, ante-partum and GYN ONC patients. The AWOHNN guidelines are used for staffing and to determine the nurse to patient ratios. Even more difficult than creating the budget is managing the unit day to day to ensure the appropriate care is provided within the budgetary plans. Leann Grimes, charge nurse developed a daily management tool used by the charge nurses to make the assignments based on acuity of the patients. The tools tell the charge nurse how many nurses are needed and how to balance assignments. The tool has been in use since 2008 and is extremely effective. The Advisory Board recognized Leann for her work through a Future of Nursing Award. Leann was recognized in the Frontline Leader graduation and on the Vanderbilt Nursing Web site. <i>[TL7-Exhibit D-1-Staffing Sheet]</i></p>
<p>Vanderbilt Professional</p>	<p>This program is fully reviewed in EP20. VPNPP is the professional advancement program for clinical nurses at Vanderbilt. It is the way nurses</p>

Practice Program	are recognized for their excellence in nursing through promotion that allows them to stay at the bedside. Both pay and title change as nurse's advance in this program.
Evaluation recognition	All performance evaluations at Vanderbilt are performance based. Annually, employees have an opportunity to be recognized for contributions above the norm in the evaluation process. The evaluation rating scale is a 1-5 scale. A score of three is considered competent and meeting the expectation of the job. A score of 4 is considered proficient and a score of 5 is considered excellent and expert performance. Criteria established for level 4 and 5 include more leadership such as coaching and mentoring. It also includes broadening influence in the organization through sharing of expertise. The salary adjustments are consistent with the level of performance varying for each staff member based on their evaluation score. See OO 17 for more detail.
E ³ = Exploring Executive Excellence: Building the Legacy and recognizing future leaders	<p>Among managers, there are some who will be the future of nursing. They are among the best. In an attempt to recognize their talent and invest in succession planning, a program has been developed to do just that. The program for nurses stems from a focus on recruitment, retention, and ongoing development of nursing leaders as part of our Be the Best (BTB). In November, 2008, the Director of Nursing Education and Professional Development brought together a small subset of our BTB committees to discuss what type of mentoring or coaching program VUMC should develop for current or potential nursing leaders. Nurse managers had been encouraged to pursue additional education and achieve certification but had not been provided with formal mentoring. In addition, the majority of nurses were pursuing advanced education in a clinical track with few pursuing a leadership track.</p> <p>Planning began in November 2009. The following committees and departments had representation on this committee:</p> <ul style="list-style-type: none"> - Recruitment and Second Year Retention - Leader Development - Diversity - Nursing Education and Professional Development <p>In addition, a few managers participated on this planning committee to provide their ideas and feedback about what a mentoring program include.</p>

The committee determined the focus of a leader mentoring program should be the development of nurse managers in preparation for administrative roles. The objectives were to:

1. Ignite a passion for nursing leadership.
2. Attract talent to the Nursing leadership role.
3. Create an environment where emerging Nursing leaders recognize that leading nurses is satisfying work and where nurses feel invited to explore career opportunities.
4. Help nurses learn and apply the art and science of nursing leadership.
5. Transform a nurse's passion for clinical excellence with individual patients to a passion for creating environments for all nurses to practice clinical excellence.

The work was informed by similar work at St. Barnabas Health System and their willingness to share their program details.

The program launched September 7, 2010 and will annually offer 6 managers time, exposure and experience with members of the Nursing Executive Board..

The pilot program will run for one year (September 2010 – September 2011). During the year long program participants will be required to meet with each mentor for at least one hour. The participants are provided with a portfolio of the Executives strengths as well as their own strengths determined through the use of "Strengths Finders". During that session the participant should ask questions and will spend some time after each meeting reflecting on several questions. (Provided TL7 – Peterman). The participants are able to negotiate a more formal and long term mentoring relationship with an Executive if they wish.

A formal evaluation has been designed for the pilot program.

[TL7-Exhibit E-1-E3 Overview, TL7-Exhibit E-2-E3 Mentoring Schedule, TL7-Exhibit E-3-E3 Questions Example]

Interdisciplinary rounding and plan of care development in the CVICU recognized through national presentations

The following is an account of innovation that was recognized through presentations at national meetings.

Table TL 7 – 2: Participants

Kathy Burns, MSN, RN	CVICU Clinical Nurse Specialist
Jeannie Byrd, MSN, RN, NE-BC	CVICU Manager
Kirk Krokosky, RN, CCRN	CVICU Resource Nurse
Tonya Beattie, BSN, RN2, CCRN	CVICU Staff Nurse
Jillian Russell, BSN, RN	CVICU Staff Nurse
Brian Widmar, MSN, RN, APN, CCRN	Cardiac Surgery Nurse Practitioner
April Kapu, MSN, RN, APN	Cardiac Surgery Nurse Practitioner
Dr. John McPherson	CVICU Medical Director
Dr. Chad Wagner	CVICU Medical Director
Dr. Lee Parmley	Director, Division of Critical Care/Department of Anesthesiology
Anna Ambrose, RRT, MHA	Administrative Director: Respiratory Therapy
Dan Johnson, Dph	CVICU Clinical Pharmacist
Robin Steaban, MSN, RN	Administration of Operations and Nursing/Vanderbilt Heart and Vascular Institute
CVICU Unit Board	
CVICU Staff	

CAUSE/REASON FOR CHANGE:

An individualized plan of care was present in the patient record, but it was compartmentalized into specialty notes, diagnosis-specific clinical pathways, and current order sets.

This process frequently resulted in:

- Missed or delayed communications and verbal relay errors
- Care intervention and progression delays
- Suboptimal utilization of the specialty expertise offered by team members

- Lack of understanding of the reasons for ordered interventions – resulting in reduced ability to apply prioritization and critical thinking skills while implementing and evaluating care outcomes
- Conflicting orders
- Lack of patient and family understanding of the plan of care
- Patient and family concerns that, with so many people involved, care coordination was not occurring

HOW WAS IT DONE

This process has been ongoing over the last two years with constant review and enhancements.

Phase I:

A “blank” interdisciplinary plan of care form was created with columns for initiation dates, patient goals, evaluation codes (examples: met, continued, revised, discontinued) and signatures. His approach and form originated in a hospital-wide, interdisciplinary committee whose objective was to improve the creation (and evidence) of an individualized, multidisciplinary plan of care. The CVICU agreed to be one of the pilot units. The form’s purpose was to supplement, not duplicate, the goals presence on the diagnosis-specific clinical pathways and to identify and track one to three of the patient’s priority, individualized goals. In the CVICU, the form was primarily used to document individualized blood pressure, cardiac output, incentive spirometry, activity, or nutrition goals set for the patient.

All members of the interdisciplinary team were asked to contribute to the form. It quickly became a nursing-only form as other disciplines began rebelling against having to “double document” their goals. Despite its failure as a document that was completed by the interdisciplinary team, the CVICU nursing leadership team recognized that use of this tool succeeded in demonstrating that individualized goals were being established by the team and that goal prioritization was occurring.

The primary failures were:

- Completing the form was not part of workflow. It was a separate work task. The form was completed after the rounding and care planning process occurred because completion was a performance expectation – not because the tool was a valued, working document. The “real” care information was still in scribbles on the white board, in the parameters written sideways in the margins of the nurse’s worksheet during rounds, or in information jotted on a strip of “stuck down” silk tape during OR – ICU handover reports.
- The tool did not include a comprehensive plan of care.
- The form directed that information be documented in “measurable goal” verbiage. Nurses who are caring for patients with complex, multi-system, changing needs do not actually think in complete goal statements. So, “the plans” are usually target parameters and interventions. For example: Providing adequate nutrition is a goal for all patients. Increasing tube feeding to a target of 75mL/hour without evidence of gastric distension, diarrhea, or aspiration makes the generic nutrition goal measurable and individualized. The working “goal” for the busy nurse is actually the intervention to “increase tube feeding rate to 75 mL/hour as tolerated”. The rest is known. Repetitive documentation of this information for all patients is considered to be academic and without true value. It detracts and reduces compliance.

PHASE II:

The underlying objective of the quality initiative was to improve interdisciplinary care planning, to ensure that plans of care were comprehensive and clearly communicated, and to ensure that progress toward meeting goals was timely and ongoing.

Therefore, Phase II of this project expanded to include:

- 1) Restructuring of the Rounding/Plan of Care development process in the CVICU. This included redesign and standardization of the rounding format to achieve effectiveness and efficiency. All members of the team should have opportunity to contribute, but this needed to be accomplished without concurrently extending rounding time. Designing this process was challenging because the CVICU is a mixed CCU/Cardiac and Vascular Surgery unit with two rounding teams: One lead by rotating Intensivists with consistent NP/PA providers and one lead by rotating Cardiologists with rotating Residents. *[TL7-Exhibit F-1-CVICU Rounds Pocket Card]*
- 2) Redesign of the Plan of Care form to include: *[TL7-Exhibit F-2-Plan of Care (Instructions)]*

- a) Designated, labeled spaces for multi-system/multi-focus goals and interventions
 - b) Checkboxes for select quality focuses to reduce oversights (Examples: DVT prophylaxis ordered, bowel regime ordered, and daily review of need for lines/tubes done)
 - c) Dedicated space to indicate the patient's status on the clinical pathway so that there would not be a need for multiple record entries to complete goal achievement documentation. The clinical pathway still provides the foundation for the plan of care. The form is used for individualization of the plan when a diagnosis specific pathway is present; it provides the complete plan of care when a pathway is not available.
 - d) Removal of the requirement to document the plan in formal, measureable goal form.
- 3) A process design that ensured that the bedside nurses would be active participants in multidisciplinary care planning and not just data reporters and recorders. Bedside nurses assess and evaluate progress or regression from pathway and goal achievement on an ongoing basis. It is nonsensical, nonproductive, and professionally-demoralizing to exclude nurses from this process during physician-led rounds. *[TL7-Exhibit-F-3-CVICU RN Handover Report]*
- 4) Redesign and standardization of the unit's RN-RN handover form to provide more structure and consistency for information transfer. This became integrated into the overall project because a better system for information transition was needed to help the newer nurses feel better prepared (and thus more confident) for their role in rounds and to help to focus the "ramblers". AM rounds start immediately after change of shift. Any nurse can feel unready to provide comprehensive information about a new patient and his/her needs when they have just assumed care and have not yet completed a full assessment.
- 5) An initial RN-RN handover tool was drafted by the CVICU CNS by combining features from forms originally created by staff nurses for personal use and from forms created by RN preceptors to help their new orientees get organized, ask the right questions, and provide the right information during handover reports. The handover form was/is two pages. Page one is an ongoing record of the patient's invasive lines and significant procedures. It is designed to provide quick access to key information (without repeatedly searching the record) and to assist with comprehensive reporting on complex patients. Page two is designed for transition of current assessment and order information. A new page two is used for each handover. Form use was endorsed by the CVICU Unit Board and peer

education and coaching was provided. After several months of use, a page two revision was spearheaded by a staff nurse. Input from all CVICU nurses was solicited by the staff leader. More preprinted, circle, or fill in the blank options were added. Checklists for select, staff-identified, high risk handover details were incorporated. The revised form was approved for implementation by Unit Board.

Key elements of the expanded process included better preparation by nurses to participate in rounds (new RN-RN handover forms), incorporation of plan of care documentation into the workflow process, a more comprehensive, multidisciplinary plan of care (new plan of care form and new, standardized, expanded rounding team and format), and a summation. At the end of rounds, the nurse reads back the plan of care. This ensures that nothing has been missed or misinterpreted. Because we are a University hospital, rounds are teaching opportunities. This results in suggestions and discussions that may be generalized. The read-back helps to ensure that the nurse, the person who is responsible for implementing and coordinating the plan, is clear.

OUTCOME:

This very important, but complex improvement initiative was started two years ago. Parts are hardwired and require little ongoing support, but it is still (and may always be) in evolution and improvement mode. The rounding and plan of care development processes are firmly implanted with the cardiac and vascular surgery patients, but the rounding format is not as consistent with the cardiology patients. The Residents on the Cardiology service rotate monthly and process success relies heavily on the Cardiologist leader, how long the Residents have been on service, and the confidence/assertiveness of the staff nurse participant. Pre-service meetings have begun with the Cardiology Residents. Expectations for the rounding process and plan of care development are now part of their unit orientation. Laminated pocket cards describing the process and delineating role responsibilities for rounding and plan of care development are available.

Part of the initiative is to consistently involve the patient and family in rounds and plan of care development. Patient and family inclusion is increasing, but is still variable and quite dependent on the Attending Physician or Intensivist who is leading the rounds.

Nurses are now consistent participants in AM rounds. If they do not join the rounding team, the team seeks them out. A comprehensive plan of care is consistently documented during morning rounds. During the abbreviated evening rounds, the plan of care is evaluated

and, if needed, modified. Although goal achievement and plan modification are now consistently discussed, documentation of the evening revisions on the plan of care form remains an improvement opportunity.

The new plan of care is initiated immediately after rounds. Previously, key aspects of the plan were unknown until orders were entered and reviewed. Discussion of the plan of care (including consult input) includes resolution of conflicting orders. The process is also assisting with intervention sequencing and prioritization.

An unexpected outcome of this process has been the identification of some behavioral, delay patterns with specific nurses. Example: When the plan includes removal of lines or catheters and the plan is read back to the team, repetitive intervention delays become evident. These delays are being recognized and reported.

EVALUATION

- Direct observation of the rounding process
- Audit of the Plan of Care Forms
- Feedback (solicited and unsolicited) from the Nurses, Physicians, Residents, Nurse Practitioners, and other team members

INFORMATION SHARING

- Processes and forms were shared with other Vanderbilt ICUs at the Institutional Critical Care Committee
- Poster presentation at the 2010 ACCA Cardiovascular Administrators' Leadership Conference in Atlanta, Georgia
- Presentation at the UHC Cardiovascular Council meeting in the Fall of 2009 at Duke University

[TL7-Exhibit-F-4-Poster-ONSITE]

Visibility, Accessibility, and Communication

Source of Evidence 10

Describe and demonstrate how nurse leaders use input from direct care nurses to improve the work environment and patient care.

There are multiple ways nursing leaders have access to staff nurses and respond to information from them to improve the environment nurses work in and the resulting patient care. Through staff meetings, unit boards, leader rounding, staff nurse councils leaders learn what barriers exist to patient care and ideas staff have to improve equipment, systems and processes. The following demonstrates the request and the leader and organizational response.

Table TL 10 – 1: Request/Response

Input from Nurse(s)	Leader Response
Vital Signs changes	Jon Coomer, the manager of the psychiatrics VITA/Adult 3 unit gathered information from staff related to work flow issue. Some of the feedback given was that all patients were required to have vital signs at 6 a.m. regardless of their clinical condition. This was a concern to patients and staff and added little clinical advantage. The MD's did not round until 9 a.m. so the vital signs were not relevant from 6 a.m. for clinical decision making and often had to be repeated. A group of staff redesigned shift responsibilities to allow the day shift to absorb this work. <i>[TL10-Exhibit-A-1-VITA Daily Schedule]</i> Both staff and patients verbalized appreciation for the change and it has had no noted affect on management of patient's clinical issues.
Myelosuppression preceptor improvement	A nurse on the myelosuppression noted the need for improvement in the orientation program. The Manager supported her efforts to improve the orientation through guidance, coaching and mentoring. The manager used the opportunity to help the nurse develop new skills and to meet the needs of the unit. The nurse convened a preceptor group to review the orientation of new hires. The group surveyed staff about their perceptions of orientation and then informally surveyed the preceptors. From these experiences, there were several suggestions for

	<p>improvement in orientation. Those included: Development of an orientation checklist, teaching sheets of common medications and procedures, list of frequently used phone numbers; 10 rules for all 11 North staff. <i>[TL10-Exhibit-B-1-Meeting Minutes]</i></p>
<p>Targeting clinical growth in the Neonatal intensive care unit</p>	<p>The NICU staffs were concerned that they were not getting assigned to the right patients for them to get exposure and gain experience in clinical areas where they needed development. A spreadsheet existed that identified which nurses were competent in which skills and this was to be used as a guide for the charge nurses in making assignments. In a complex 76 bed unit, charge nurses found the use of the tool difficult and nurses were still not assigned to patients that would allow them to learn new skills. In a charge nurse meeting they identified that a white board could be placed in the charge nurse office with the necessary skills listed at the top. Staff would be encouraged to write their names in the column where they needed experience. <i>[TL10-Exhibit C-1-Charge Board Photos, TL10-Exhibit C-2-Mentorship Charge Meeting]</i> Charge nurses could “at a glance” know who needed what experience and make assignments accordingly. Staff nurses have expressed greater satisfaction in getting assignments that help build their skill since this change took place.</p>
<p>Bone Marrow transplants and discharge needs</p>	<p>A staff nurse on the Myelosuppression unit was concerned that patients were not being prepared adequately and consistently for discharge. The staff nurse discussed her concerns with the casemanager and the management team. The manager supported the staff member through coaching and mentoring to meet the developmental needs of the staff as she developed a discharge checklist. After a trial use of the checklist on her own patients, she found she was able to identify discharge issues earlier allowing early intervention. The manager used this small test of change by one nurse to improve the discharge process for all patients. In-services are in progress (October, 2010) for all staff to begin to use the form. <i>[TL10-Exhibit-D-1-Discharge Checklist]</i></p>
<p>Staffing Changes 11 North</p>	<p>The staffing rations on 11 North which is a hematology unit were decreased several years ago because so much chemotherapy was delivered as an outpatient. However, staff began to verbalize that the acuity was changing on the unit and in particular, the night workload was difficult to manage. The manager and finance officer were able to demonstrate the need and the 12hours of RN coverage was added per</p>

	day to the staffing template. <i>[TL10-Exhibit E-1-Staff Meeting Minutes]</i>
100 Oaks Women's Health Shift Changes	Patient Care Technicians in the 100 Oaks Women's Clinic requested 10 hour work days instead of 8 hours work days. This would allow them to work 4 days a week instead of 5. After reviewing the request, the manager determined that the needs of the clinic would be well served by providing a schedule with 9 hour shifts and a ½ day on Friday. The Friday is split with some staff working in the a.m. and some in the p.m. After a pilot, the decision was made that the shift change was advantageous to the work place and to staff. The change has now been fully implemented. <i>[TL10-Exhibit F-1-PCT 9 Hr Staffing Template]</i>
Clinic Scheduling	Stephanie Nelson, RN, Clinical Nurse Coordinator recognized patient flow was hampered by the way patients were scheduled on Dr. Kaufman's template for urodynamic testing. Often these patients were new to the practice and needed to be seen by Dr. Kaufman prior to their test being performed. Stephanie requested that Dr. Kaufman's template be changed to reflect his actual practice pattern instead of 45 minutes after actual testing occurred. There was also a need recognized for a special procedure slot for new medication Dr. Kaufman was administering. The procedure needed to be done in the treatment room with a sonesta chair. This required that the team collaborate to accomplish this complicated scheduling. Stephanie spoke with Gail Bauer and Leslie Denton the manager of the area and they worked to have the Macroplastique appointment placed on the schedule at 1300 to allow for procedure to be done while the last UDS was being accomplished in adjacent room without interference. The scheduling change also allowed the staff to ensure all of the proper equipment for special procedure was in place in the early am for procedure to be done @ 1300.
Development of Standard roll-out process in the ED	During Karin League's, BSN, RN masters program in Health systems management through the Vanderbilt University School of Nursing, she had the opportunity to complete 210 practicum hours with Brent Lemonds, RN. Brent is the Administrative Director for Emergency Services and provided Karin with the opportunity to observe the challenges of leadership in a large, fast paced, high risk area that experiences change at a phenomenal pace.

	<p>Karin had a passion and interest in quality. She chose a practicum project that would fit with the department's need for change management tools around quality, evidence-based practice, and process improvement. Brent and Karin worked together to develop the Standard Rollout Process tool. The tool is based on multiple theories including Lewin's theory of Change, Stetler Model Theory, and Roger's Diffusion of Innovation. Other evidence included in the development included human factors studies and the use of tested tools such as PDSA, Gap analysis, and SWOT analysis.</p> <p>The resulting product was designed to assist teams to clearly define their goal for change, cultivate the stakeholders involved, develop an action plan with a timeline and clear accountability, communicate the plan effectively, and utilize PDSA cycles for improvement and sustainability.</p> <p>Under Brent's leadership, the Emergency Department and VCH PACU/Holding have utilized this tool for the past year. There are several examples of its use at http://www.mc.vanderbilt.edu/root/vumc.php?site=adulthood&doc=25041</p> <p><i>[TL10-Exhibit G-1-Standard Rollout Presentation, TL10-Exhibit G-2-Standard Rollout Process]</i></p>
Hand washing Foam in the PACU	<p>In the PACU, it is difficult to have foam to wash hands with close to the patient because there are no walls between patients, to mount hand washing foam. If someone comes to the bedside to see the patient, there is a distance that they must walk to get to the foam. At the request of the nurses, Betty Sue Minton, RN, MSN placed foam on the wall behind the patient slot, but to get to it, you had to come into the slot and reach behind the patient to foam your hands. Therefore, the foam on the wall behind the patient was difficult for physicians to use.</p> <p>Betty Sue knew that each PACU slot had a bedside table that is usually at the foot of the stretcher and that would be a good place for the foam to be located. A nurse could foam their hands before they went into the slot to see the patient and then again as you were leaving the slot. Plant Ops built a round flat surface that attaches to the side of the bedside</p>

	<p>table. The hand washing foam is mounted on the round surface. It takes up no room on the top of the bedside table, so it is still very usable for patients and the staff. <i>[TL10-Exhibit H-1-PACU Hand Foam]</i></p>
<p>ECMO Improvement</p>	<p>ECMO Specialist (made up of RN's and RRT's) work very well collaboratively and during a PM&I (Quality Review meeting) the team members pick patients to present. We review every patient that goes on ECMO. The center does a large volume of ECMO patients and thus, reviews up to 6 patients in one session. The team members are given guidelines to present. This gives the team members the opportunity to express their concerns and also hear what the physicians were thinking during this process. It has led to multiple open discussions and changes including the one below.</p> <p>Daphne Hardison, RN became the manager in January 2009 and had noted some process issues and inconsistency in the way prime blood was "treated"/buffered. The ECMO circuit was usually primed with 2 units PRBC's. The blood product was buffered so when patients go on ECMO and are exposed to the blood it not only is anticoagulated but has electrolytes and gasses in a range to prevent the heart from going into a stun picture. The team had different ideas on how to make this the correct gas and what is acceptable. Because the protocols requested a physician order, Daphne required all team members to go to the physician and get an order instead of just adding different medications. ECMO is not utilized by all physicians every day; therefore there was even more inconsistency with the physician orders than when the specialist did their own thing. Many team members felt it very difficult to get the orders during the intense time of ECMO Cannulation and requested a solution of some sort to include a protocol. Daphne took this back to the group and facilitated a discussion where a decisions was made to create a protocol that came from our director's (surgical and medical) that allowed the team members to treat the circuit gas appropriately and independently. This has not only led to the ECMO Specialist independence but the physicians are not expected to come up with answers during a code situation. <i>[TL10-Exhibit I-1-ECMO WIZ Order Guidelines, TL10-Exhibit I-2-Minutes Medical Director, TL10-Exhibit I-3-</i></p>

	<i>Team Meeting Minutes Aug 2010]</i>
9 North and pill splitters	When Richard Corcoran, RN, MSN manger of 9 North first came to 9 North two years ago the first step he did was round on all employees to get to know them and identify any areas they felt needing improving rapidly. Two items came up repeatedly – pill splitters, and pill crushers. Nurses stated that they never were available and hunting them was a big time waster. Within 2 weeks Richard had a pill splitter and a pill crusher attached to each Work Station on Wheels. The pill splitters have remained and are replaced as needed. On 9 North pill crushers moved to the top of each unit supply care for infection control reasons this past January. These replaced the smaller individual crushers in use prior to that time. <i>[TL10-Exhibit J-1-Unit Board Minutes]</i>

“In her Own Words” – Story by Anisha Fuller, Manager 4 East, OB/GYN

“In April of this year, one of the night shift nurses, Amy Suddeath, sent me an email stating that she had taken the initiative to investigate some cost saving measures that could be taken in our department. I have attached her initial email, for your review.”

EMAIL FROM AMY SUDDEATH – APRIL 27, 2010

“Anisha,

For the past 3 years, I have complained about what a dumping ground our nurse servers are. I know that they are intended to be helpful to staff but they are so randomly stocked that I think we spend more time going from server to server hoping to find something than we would spend just going to the main cell. I get so frustrated with them that it has become by personal mission to clean them out approximately every 6 weeks or so. After cleaning them out several times, I decided it would be really interesting to see just how much the items being stuffed in the servers (and rarely used because no one knew they were there) were actually costing our unit in restocking charges. I cleaned out the servers and returned everything to the main cell. Six weeks later I cleaned them out again. I wrote down everything I returned to the cell and contacted Karen Sterbutzel, Supply Chain Director. She provided me with a price list for every item stocked on our cell. I used the list I had prepared from my "six week cleanup" and computed the cost of all the items I had returned to stock just that one time. The total cost of those items was \$110.00. If every six weeks that same amount was returned to the cell, the

annual cost would be \$952.00. I don't think a lot of our staff realize that every time they stick something in the nurse servers, that missing item has to be restocked on the cell to maintain par. Our patients are not paying for us to maintain par, the unit pays. Therefore, if everyone would return items to the cell when they aren't used, the unit could save approximately \$1000.00 per year.

Here is a list with prices for some of the most frequently "dumped" items:

<i>Specipan</i>	<i>\$0.38/ea</i>
<i>Pitchers</i>	<i>\$0.29/ea</i>
<i>Socks</i>	<i>\$0.66/ea</i>
<i>Bath wipes</i>	<i>\$1.42/ea</i>
<i>Catheter kits</i>	<i>\$ 1.88/ea</i>
<i>BP cuffs</i>	<i>\$2.94/ea</i>
<i>Bedpan</i>	<i>\$0.63/ea</i>
<i>Soap</i>	<i>\$0.22/ea</i>
<i>Shampoo</i>	<i>\$0.22/ea</i>
<i>Toothpaste</i>	<i>\$0.22/ea</i>
<i>Bath basin</i>	<i>\$0.39</i>

I realize that we do sometimes use these things if we are lucky enough to find them when we need them, but how often do we just go to the cell instead of wasting time looking in the servers?

Just this past weekend, I was looking for Tucks pads in the servers and found probably 10 bags of items that looked like they were gathered in preparation to set up empty rooms. That is a great way to be prepared especially when things are as busy as they have been lately. However, in almost every bag I noticed that there was shampoo, toothpaste, a toothbrush, tissue, deodorant, blue or brown socks, and a package of bath wipes. Most of our patients don't need any of those things because they usually bring all of those things with them. If you add up the cost of all of those items it is \$4.08 per patient. If you estimate that we admit 8 patients per day, that same setup would cost our unit \$32.64/day or \$11,913.60/yr! That's almost \$12,000.00 a year the unit could save just by giving those items out on a request only basis. I have worked at other facilities where a "room setup package" was charged to the patient on admission and extra items were also charged when requested. I don't see Vanderbilt ever doing that but we could definitely be more conservative with those items instead of including them with every room setup.

One last thing, during one of my server cleanouts I found 25 BP cuffs. Some were still wrapped and were returnable to the cell. Most were unwrapped and there was no way to tell if they were used, from an isolation patient's room, or were defective and just stuffed in the server for convenience. I ended up throwing away all of the unwrapped ones for patient safety. BP cuffs are \$1.94/ea and were the most frequently dumped item. If staff could discard them when they are worn out and only remove them from the cell when they are replacing old ones, lots of money could be saved.

My point in this project is to make all staff aware that it is really important to return things to the cell if they aren't going to use them. The unit is charged for every item that sits in the servers unused. I know we all get busy and sometimes don't have time to do the most cost effective thing. Would a box, placed at each nurses station to put unused items in, be helpful? Maybe our volunteers could help us with restocking those items? Any other suggestions?

I think that we all do our best in using our resources wisely, but sometimes need a little motivation to improve. I hope everyone finds this information informative and helpful. I have a price list of every item on our cell, so if anyone is curious about how much something cost I would be happy to let you know."

Thanks!

Amy Suddeath, RN

"In summary, she had noticed that many of the non-chargeable supplies were being haphazardly stored in the cabinets (nurse servers) throughout the unit. This practice was causing costly clutter, and resulted in inaccurate par levels in the unit storage room. Amy made the suggestion that we create specific storage locations among the existing servers, and formally organize what is placed in them. I thought it was a great idea, and supported her taking it to our Unit Board meeting. She was put on the agenda, and presented her findings to the department. Everyone was in agreement that we could better organize how we store supplies, and they voted to adopt Amy's suggestion.

Together, the staff decided which cabinets would be best suited for centralizing linens and supplies. Five cabinets were designated for this purpose. Labels were made, and the cabinets were organized to one standard. Since then, the staff have maintained how the servers are utilized. Amy still does her six-week "round-up," but she finds less and less clutter each time.

I have helped support her project by encouraging her to present to Unit Board, and endorsing her project in that forum. Empowering her to take action on something she identified as a problem has added to an atmosphere of staff empowerment and recognition for innovative ideas. I facilitated the coordination of support needed to initiate the organization of her project, and have continued to do so. Amy has drafted several emails to the staff, and asked that I send them out on her behalf. This shows that I support her efforts, and request that others do, as well.

It has not been a long-standing project, but it will be interesting to see if our non-chargeable costs to the unit decrease over time. I applaud Amy's drive and persistence, and am proud to be her manager. She's a great member of the team. Incidentally, Amy received her RN3 while working on this project."

"In Her Own Words"

**Submitted by Christine Kennedy, MSN, RN, Administrative Director, Adult Medicine –
September 7, 2010**

"At Vanderbilt University Medical Center, an interdisciplinary team, the Pain Management Task Force, has been working on improving pain management assessment and reassessment with a particular focus on streamlining documentation in our charting system Horizon Expert Documentation (HED). One specific objective was to provide direction to the staff to choose and use one pain scale appropriate to the patient. After our Pain Management Guidelines were updated in November, 2009, the Pain Management task force had been working with staff to get their input as to how we could improve our documentation format related to assessment and reassessment of pain.

During focus groups with staff, it was identified that not all staff understood which pain scales should be used for patients who were "able to self report" versus those patients who were "unable to self-report". For example, some staff members were using the Wong-Baker Faces scale for patients who were "unable to self report". By definition, the Wong-Baker Faces scale is to be used for a patient who is able to self report. This scale is typically used by a child or someone who prefers to point to a face rather than using the numeric rating scale (NRS). One change made in a release that took place on July 19, 2010 was to differentiate the scales for patients "able to self report" from those patients who are "unable to self report". Patients who are "unable to self report" are typically non-verbal patients who cannot communicate their

needs. In order to identify if patients are in pain, staff observe physiological or behavioral cues to determine if the patient is in pain. The following scales: FLAAC, NIPS, NPASS, and PAIN AD, are summative scales used at Vanderbilt for patients who are “unable to self report”. There are some patients for whom we cannot use any of these summative scales and for these patients the nurses describe physiological or behavioral cues to try to determine if patients are in pain.

After the July 19 release of changes in HED, our system support staff and educators rounded on staff to help explain the rationale for these changes. In general this change was well accepted and during rounding with staff this was generally seen as improvement.

There was one concern identified. It was identified by users/staff that due to the change in format, there was no longer an option listed under the pain assessment drop down boxes for patients who cannot self-report pain. This was identified by staff, communicated through the HED Advisory committee and forwarded to the Pain Management Task force. A solution was identified by the Pain Management Task Force and vetted with staff. The solution was to add two descriptors, one each under behavioral cues and physiological cues. The purpose of adding these options was to allow the nurse an indicator for behavioral and physiologic cues that suggests the patient is not in pain. This can be used for the shift assessment as well as for reassessment after interventions.

Deborah Ariosto, MSN, RN, Director of Patient Care Informatics was instrumental in helping to facilitate conversations and devise the redesign released on July 19, as well as the additional simple solution. With the help of Nancy Rudge with HED, the additional changes requested by the staff were released to the organization on August 31, 2010. We appreciated the feedback from our clinical staff and appreciated the quick response from informatics and system support staff for implementing this small but important change. At this time, the feedback from this change is that it has addressed the concern identified by the staff.”

[TL10-Exhibit K-1-Pain TF Meeting Minutes, TL10-Exhibit K-2-Pain Management HED Screen Update, TL10-Exhibit K-3-Pain Documentation Revision]

Visibility, Accessibility, and Communication

Source of Evidence 10 EO

Describe and demonstrate changes in the work environment based on input from the direct-care nurses.

Transition from Systems Support Specialist to Clinical Application Specialist

Purpose/ Background

The use of informatics systems has become extremely important for nurses to accomplish patient care. Vanderbilt develops many of the informatics tools nurses use and the pace of change is great. For many years, the System Support Department of Informatics which supports end users in the clinical areas has reported to the Executive Chief Nursing Officer. The role of the “Systems Support Specialists” (SSS) on that team has largely focused on implementation of new systems. After implementing two large-scale, complex clinical nursing applications back to back, our institution realized there was a problem. User feedback from nurses indicated the Systems Support Department is great at implementation of systems, but not as accessible as they would like for ongoing support. A goal was established by the team to allow Systems Support to respond in real-time to increasing regulatory requirements without additional FTE’s and to increase user independence and proficiency in all clinical computer systems. The hypothesis was that user-based versus centralized support will increase overall institutional satisfaction with systems support services. This plan that responded to needs of nurses began the transition of Systems Support Specialist to Clinical Application Specialist.

The project was based on the following information.

- User feedback was that Systems Support provided great support for implementation of systems but there was dissatisfaction with accessibility for ongoing support.
- Ever increasing regulatory requirements and scrutiny by regulatory bodies required users to be able to meet documentation requirements and use systems to leverage their understanding of the patient status and patient needs. Users must be knowledgeable of the most effective use of tools and processes, and there needed to be iterative enhancement to those tools and processes for documentation

Transformational Leadership
Visibility, Accessibility and Communication (10 EO)

- The increasing size and complexity of the organization created a need for new support strategies.
- SSS staff needed an opportunity to expand their skills and leadership abilities.
- Customers should become less reliant on SSS and be able to use all informatics systems more effectively and independently.
- SSS must demonstrate the success of informatics system from a user’s perspective as well as a systems perspective.

Table TL 10 EO – 1: Participants

Karen Hughart, RN, MSN	Director of Systems Support Services
Gwen Holder, RN, MSN	Assistant Director of Systems Support Services
Sara Seaman, RN, BSN	Clinical Applications Specialist for Adult Neurology/Epilepsy & Neuro ICU
Lillian McGehee, RN, MSN	CAPS for Adult Surgical ICU, Surgical Step-down, & General Surgery unit
Ron Reed, RN, ADN	CAPS representative for VCH covering general surgery floors for young/adolescent as well as medical infant to adolescent
Tom Mack, RN, BSN	CAPS Representative for adult medicine floors and Medical ICU
Lisa Grunwald RN, ADN	CAPS Neonatal Intensive Care Unit
Valerie Kibler, RN, NP	CAPS representative for adult colorectal, urology, orthopedic, and general surgery units
Sara Winters RN, BSN	Clinical Application Support Team Lead

Approach/Methods

The first step in developing a plan for area based Systems Support Specialists was unit selection. CAPS would be assigned to a unit or group of units that complement one another. Variables influencing the development of CAPS assignments to units or “pods” included the following:

- “sister” units (same management) would be grouped together
- patient flow from ICU to step down/general care floor should be considered in the groupings

- acuity, number of staff, number of patients, geography should be considered

Once assignments were made, the teams began to move toward implementation. Clinical Application Specialists (formerly Systems Support Specialists) met with unit leadership to establish relationships, expectations, desired outcomes, and boundaries. They introduced the idea of Clinical Application Specialists to staff nurses and used that time for information sharing and to begin to build relationships with nursing staff.

The next phase was an observation phase. During this time, CAPS observed workflow in their assigned areas and were oriented to the unit practices. They gathered information via a survey focusing on current use and knowledge of clinical applications. This information was used to prioritize education efforts.

The survey yielded information on:

- Nursing documentation systems including medication bar-coding
- Application downtime procedures
- Electronic Medical Record
- Provider order entry system

[TL10 EO- Exhibit A-1-Computer Applications Support Survey]

The next phase of implementation was the identification of priorities and ongoing support. The CAPS assessed educational and work process simplification needs of the staff to:

- Identify opportunities to leverage existing tools to help meet clinical and operational objectives.
- Identify potential systems enhancements that would make the tools more effective/efficient
- Prioritize needs and develop a plan to address priority needs
- Implement the plan
- Evaluate and revise objectives and strategies on an ongoing basis
- Provide support on the units

- Answer questions about computer applications during daytime hours
- Explain computer related processes
- Troubleshoot computer problems as they happen
- Follow up on issues that arise
- Decrease the time between questions and answers
- Engage in problem solving alongside staff and follow through to resolution

It was recognized that there was a need for on- going learning for the CAPS. Learning needs were met through collaboration across CAPS in CAPS meetings that were held every two weeks. This provided an opportunity to share information and trends they had observed on CAPS units. The meetings provided a forum for preliminary review of tools developed in response to education requests, suggestions, and issues experienced by nursing staff with clinical applications. CAPS met with unit leadership and unit boards to discuss ongoing work and priorities or obtain feedback. *[TL10EO-Exhibit A-2-CAPS Overview]*

Outcomes

A goal of the project was to have CAPS staff on the unit 80-90% of the time of their worked hours in order to be available to staff when the questions arise.

From November 15 – December 15, 2009 CAPS spent 481 man hours on the units. There were a total of 6 CAPS representatives covering 18 units/pods. These 6 CAPS employees worked a mixture of 30 – 40 hours per week.

The initial goal was that CAPS would spend 80-90% of work time on the units.

Initial Outcome – CAPS time spent on units:

- Average for all areas = 68%
- VCH = 66%
- VUH = 63%
- Round wing = 75%

Based on the initial results the goal was modified to 60-70% of work time spent on units. This was found to meets the needs of the users on the units as well as SSS central office work

The areas where the CAPS provided assistance included:

- Hardware Issues
- Implementation Support
- Staff Orientation
- Management Team Efficiency
- Troubleshooting
- Problem Resolution
- Project Preparation
- Quality Improvement

Examples of improvements made based on presence of the CAPS are described here.

Hardware

- On the 8th floor of Children's Hospital a need was recognized Workstations on Wheels (WOWs) were in demand for multiple groups. Reorganizing existing WOWs to place scanners on machines used by nurses who give meds improved overall satisfaction, maintained hardware for all groups and did not affect unit budget.
- On the round wing units more wireless scanners were needed to replace tethered scanners when large numbers of isolation patients were on the unit. Following intensive care unit moves to the critical care tower (with all new equipment) our CAPS person was able to negotiate two “new” wireless scanners from the “old” ICU space at no cost.

Implementations

- Children's hospital reported “quick and painless rollout of Falls Risk and Braden Q Indicators”
- Tamper resistant printers and pharmacy upgrades were supported
- Large scale efforts to streamline the three ICU moves to critical care tower, including testing of all hardware functionality, printing capability, and behind the scenes changes for location compatibility primarily conducted by the 3 ICU CAPS representatives

- Plan of care rollout for the 8th floor of Children's hospital in two weeks time educating over 100 staff in coordination with the educator

Staff Education and Orientation

- 20 or more new staff in Children's hospital received on-on-one review of technology tools available to them, followed by requests from seasoned staff to also participate in learning experience
- Mini lunch education sessions on 9 south for discussion of downtime process improvement
- Training on unit specific applications such as pre-orders and plan of care at time of need.
- Encouraging StarPanel use in NICU by customizing views for staff and illustrating features available to them
- Assisted physicians on MICU to gather information and links to allow viewing of IMPAX images from home

Management Team Efficiency

- Detailed assistance to leadership team for retrieving and searching for quality safety measures on patient records, including those that are discharged, and chart audit reviews
- Charge nurses on MICU were taught how to most proficiently access "fix it now" reports
- 9 north charge nurses had white board indicators customized to assist in managing quality care goals

Trouble Shooting/Problem Solving

- Directly taking calls during daytime hours to reduce wait time on calls to the help desk – following up with help desk to manage data collection and trends of issues
- From routine CAPS rounding learned that SICU had certain lab screens they are accustomed to seeing that were not displaying correctly after the move to the Critical Care Tower. Through detailed follow up discovered that certain screens in HEO were “hard coded” to the 3N/C location only. Resulted in thorough evaluation and reconfiguration of three similar instances.

Project Preparation and Quality Improvement

- Anticipating needs of NICU leadership and staff for implementation of Admin-Rx during 2010
- Improvement of Admin-Rx scan rates following embedded CAPs representative on Round Wing (Table 1 below)

Empowering nurses with suggestions for HED improvements to take ideas to HED advisory committee. Several have been approved!

Table TL 10 EO – 2: Admin RX Scan Rate Trend

Admin RX Scan Rate Trend	
Month	S34 total
February	73%
March	84%
April	96%
May	97%
June	99%

Next Steps

- Expanding CAPS role to more areas in the medical center

- Continuing to manage expectations with controlled growth of the program
- Ongoing efforts to maintain quality initiatives housewide with direct impact support
- Submitted abstract to ANIA 10/08 - Sara Winters RN BSN and Valerie Kibler RN NP

[TL10EO-Exhibit A-3-CAPS Outcomes]

CVICU Ultrasound Guided Peripheral IV Insertion

Purpose and background

The CVICU staff, leadership and medical directors were interested in reducing the rate and the risk of central line infections. This work was initiated by Kirk Krokosky, RN who was a night shift staff member in the CVICU at the time. They observed that some patients received central lines because peripheral access was not possible. They hypothesized that if they could eliminate or delay the need for central line catheters they would reduce the central line infection rate. On a parallel course, they wanted to improve the quality of peripheral intravenous access and patient comfort while obtaining said access.

The two primary reasons to pursue this project were:

- to reduce the number of central line associated blood stream infections (CLABSI) by decreasing the need for or delay the placement of central lines most commonly PICC lines.
- To improve success of peripheral IV insertion in patients that were considered “difficult sticks” related to obesity, edema, known poor quality veins.

Methods/Approach

- An intensive analysis was done on BSI cases that occurred during a five month period (July-November 2008, n=7 cases).
- It was found that medical cardiology patients who acquired BSI were all related to the presence of a peripherally inserted central catheter (PICC).
- Based on this analysis, in early 2009, all staff were re-educated on care and maintenance of central venous catheters, including PICC lines.

- As a parallel course, a process to find an alternative to inserting PICC lines in patients previously identified as non-peripheral intravenous (IV) access candidates was pursued. These candidates were determined by the presence of:
 - Edema
 - Obesity
 - Unsuitable or poor quality veins
 - History of multiple attempts

- A review of literature revealed that ultrasound guided venous access technique has been used with success by physicians in the emergency department setting.

- A competency based protocol for nursing insertion of ultrasound guided peripheral IV access was developed.

- The data demonstrated a significant reduction in PICC usage (Figure 2) and a subsequent decrease in BSI rates.

[TL10EO-Exhibit B-1-Ultrasound Guided IV Insertion Policy, TL10EO-Exhibit B-2-Ultrasound Guided IV Manual, TL10EO-Exhibit B-3-QCOR Ultrasound Poster-ONSITE]

Table TL 10 EO – 3: Participants

Kirk Krokosky BS, RN,CCRN	Developed project, conducted in-services
Jeannie Bryd, MSN,RN	Project oversight
Kathleen Burns Med, RN	Assisted with development & provided guidance on in-services and data collection.
Lee Parmley, MD	project oversight, collaboration at the provider level with the Vascular Access Group
John McPherson, MD	project oversight, collaboration at the provider level with the Vascular Access Group
Chad Wagner, MD	project oversight, collaboration at the provider level with the Vascular Access Group

The CVICU Collaborative Committee	provided data review, support and endorsement of the project
Staff nurses of the CVICU	

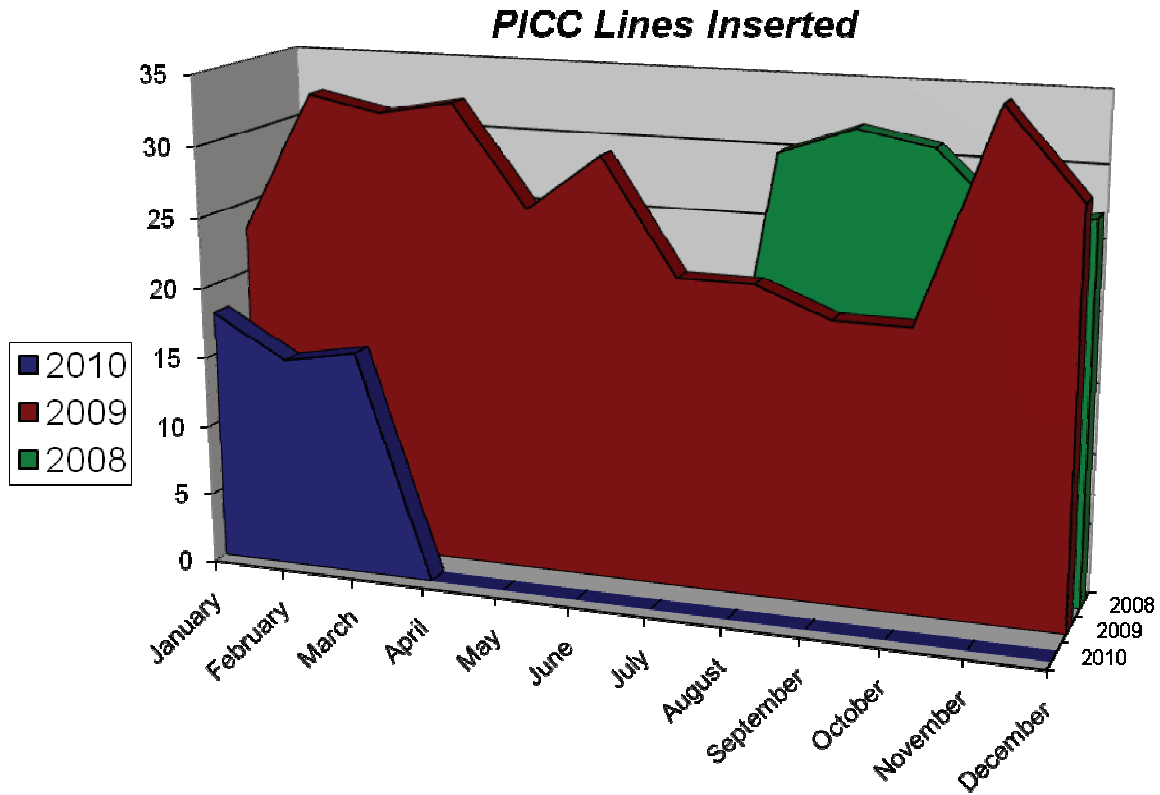
Outcomes

The table below compares success rates of lines placed traditionally (no ultrasound) vs. those placed with ultrasound guidance. Most noteworthy is the success rate on first attempt of 64% [with ultrasound] up from 27% (without ultrasound). As for PICC insertions the top graph in figure 2 shows a dramatic decrease in PICC insertions in the first four months of the live project (Jan- April 2010). Graph 3 shows an encouraging trend downward in the number of blood stream infections.

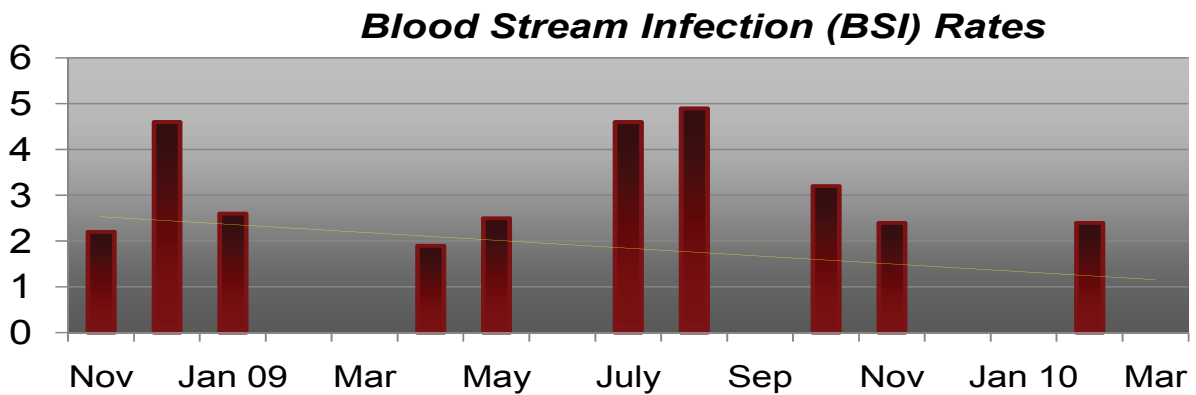
Table TL 10 EO – 4: Success Rate with ultrasound vs. no ultrasound

Traditional Peripheral IV Technique					
Attempts	1	2	3	4	5
# of Patients	6	6	6	0	4
Success rate	27%	27%	27%	0%	18%
Ultrasound Guided Insertion Technique					
Attempts	1	2	3	>3	
# of Patients	21	9	3	0	
Success rate	64%	27%	10%		

Graph TL 10 EO – 1: Decrease in PICC Lines Inserted



Graph TL 10 EO – 2: Blood Stream Infection Rates



Summary

The CVICU has seen a significant reduction in PICC line usage and subsequent reduction in CLABSI rates as a result of the implementation of ultrasound guided peripheral IV insertion. The project has been a success and the area is moving forward to train more staff in the technique. To date there have been no major complications related to the technique. The CVICU staffs have been asked to place lines in other units and currently the Burn Unit is developing its own program based on our materials and data. The use of ultrasound guided technology by specially trained nurses has increased the success rate of obtaining peripheral IV access. As a result, the reduced need for or at least delayed placement of central access was achieved. This reduction has brought about a downward trend in BSI rates.