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TL1EO

Strategic Planning

TL1EO: Nursing's mission, vision, values, and strategic plan align with the organization's priorities to improve the organization's performance.

- Provide one example, with supporting evidence, of an initiative identified in the nursing strategic plan that resulted in an improvement in the nurse practice environment. Supporting evidence must be submitted in the form of a graph with a data table that clearly displays the data.
  AND
- Provide one example, with supporting evidence, of an initiative identified in the nursing strategic plan that resulted in an improvement due to a change in clinical practice. Supporting evidence must be submitted in the form of a graph with data table that clearly displays the data.

Example a

Improvement in the nurse practice environment

Background

As part of our work for the Nursing Strategic Plan goal number 3 for Transformational Leadership and Professional Development - *To create a framework for the success of nurses as leaders at all levels by equipping nurses with the necessary knowledge, skills and abilities and exposing nurses to opportunities for continued growth and development*, in October of 2012, Monroe Carell Jr. Children's Hospital at Vanderilt (MCJCHV) introduced a new role for clinical staff nurses, Clinical Staff Leader (CSL).

Historically, Vanderbilt had followed the path of other medical centers and had charge nurses, assistant managers and managers in place. From survey data it was clear this leadership model might not be serving us well and certainly not meeting the intent of our Transformational Leadership goal. The feedback from the clinical staff nurses revealed they did not feel valued in the workplace and that the person who conducted their annual evaluation was not completely aware of their day to day work. From the manager perspective, they agreed that at times, their span of control prevented them from being truly transformational leaders. The consistent message was the need for a change in structure to support the clinical staff at the bedside and the nurse managers in a different way.

To support this significant change, the Leadership Development Committee provided an evidence-based literature search/analysis of the leadership structure of Vanderbilt University Medical Center (VUMC) in conjunction with the results from our nursing staff surveys. This analysis was focused on the impact of leader span of control. Major findings included:

- Inverse correlation between FTE: leadership ratio and revenue growth rate (Saratoga Research Institute, Price Waterhouse HR, 2003)

- Higher rates of unsafe behaviors and safety accidents with high ratios (Hechanova, Alampay and Beehr, 2001)
- Less time communicating between team members and lower levels of problem solving with broader span of control (Gittell, 2001)
- Employee engagement inversely proportional to work group size
- Agility and timeliness in responding to issues declines as ratios increase
- Significant negative relationship between work group size and leader-member exchange (Spence Laschinger et al, 2001 and Green et al)
- Patient satisfaction/staff turnover (McCutcheon, 2003)
- Regular head count to manager ratio – mean in healthcare = 16.18

In summary, span of control affects productivity, capability and financial outcomes and does not support the best nursing practice environment. Based on clinical staff and manager feedback and the literature analysis this change was based on:

Where we were	Where we wanted to go
Unrealistic scope/span of control	Provide scope of responsibility and structure to ensure success of manager
Staff reported managers do not know what we do	Long term retention of bedside clinical staff
Barriers to implementing change	Improved staff development
Limited professional development of bedside caregivers	More meaningful staff evaluation process
Perception that leaders were not concerned about staff	Bring leaders closer to the clinical work environment
	Promote change readiness

A framework was formulated that would decrease the span of control of the manager while improving communication and engagement. The plan was vetted with key stakeholders: the executive nursing administration, nurse leaders, managers, clinical staff nurses and human resource experts who then worked as a team to develop this new role.

Based on research and feedback, we identified items that we would use to populate a "scorecard" as measures for success of this change such as: turnover, quality scores, satisfaction data (staff and patient), length of stay, and financial outcomes. We are also aware of the multitude of factors that can affect these scorecard measures and the almost impossible task of showing a direct link to only one variable. However, we believe the strength of this program is grounded on feedback from the clinical nurses and our desire to provide a meaningful level of support and an improved practice environment for them. Based on this, we chose as our first focus direct measurements

of the clinical staff nurses response to the implementation of the new role. We utilized the Global Transformational Leadership Scale (GTL) survey that was sent to the clinical staff prior to implementation of the role, and 6, 9, and 12 months post implementation.

Goal

Improve the nurse practice environment for the clinical staff nurses as evidenced by improvement in the following three of the seven dimensions of the GTL.

1. Staff Development – Treats staff as individuals, supports, and encourages their development.
2. Supportive Leadership – Gives encouragement and recognition to staff.
3. Innovative Thinking– Encourages thinking about problems in new ways and questions.

Interventions

Implementation of this new role was based on the following:

- CSL to staff FTE ratio of 1:15-1:20; Meaning not every area has the same number of CSLs
- Model roll-out was tailored to area specific attributes
- Each model is dynamic
- Model applied across all inpatient units
- Model is continually evaluated and adapted to meet area specific needs

Each CSL has a cohort of staff members they provide leadership for, including mentoring and evaluation. The CSLs work two regularly scheduled 12-hour bedside shifts, which could be either at the bedside with a patient assignment or in a typical charge nurse role. Each CSL also schedules themselves for two eight hour administrative shifts. This is an exempt position which provides some freedom in scheduling to meet their responsibilities and the needs of their group of cohorts.
A new job description was written and all staff, who met the criteria, had an open invitation to apply for the CSL role, with particular emphasis on those that had been in the assistant manager and charge nurse roles. There were no givens. Interviews were conducted based on our process of “behavioral based interviewing”.

Human Resources assisted us to pull together multiple interview panels, each with a different theme of questions: aligning performance for success, planning and organizing, operations decision-making and building trust/tech knowledge. A day was set aside for panel interviews and follow-up debrief sessions. The panels included key stakeholders: unit leadership, operational managers, administrative team, clinical staff nurses and the CNO. Interview debriefing sessions reviewed the strengths and opportunities for all of the candidates so that we could subsequently tailor their orientation to their individual needs. The clinical staff nurses who participated in the interview and debriefing sessions felt empowered to be part of the new leadership model development. To garner the best chance for success, it was extremely critical that the best candidates were matched to this new role.

Once CSL selections were made, there was an intensive on-boarding, training and mentoring process. This was crucial to the success of this program. In addition, this continues today as the rest of the organization converts to the CSL model and new hires are made.

Program components:

1. Initial Unit Operations Orientation
    a. IT systems training
    b. With manager create individualized development plan (IDP) – through year 1
    c. Use of *Strengths Based Leadership* books for assessment - meet with coaching/mentoring team
2. Coaching Curriculum
    a. Weekly sessions with outside the unit coach/mentor to cover
        i. Role clarity
        ii. Change and transition – Bridges Model
        iii. Important conversations
        iv. High/middle/low performers
        v. Meaningful recognition
        vi. Transformational leadership
        vii. Strength based leadership
        viii. HR consultant
        ix. Patient satisfaction data
        x. Financial management
        xi. Shared governance
3. Months 1 – 6 training for CSLs
    a. Becoming a new leader
    b. Operational orientation classes: Vandyworks (scheduling system), Evaluation system, etc.
    c. New Leader orientation through VUMC HR
    d. Team Coaching
    e. Mid-year performance conversations – observations
    f. HR Foundations
    g. Personal classes for personal/team development
    h. Board Basics – foundation for shared governance
    i. Start project work for unit as assigned by manager
    j. Frontline Leadership Academy (if appropriate)
    k. Transformational leadership class
    l. Develop plan for further IDP

Various resources and tools are used for CSL training and development, including the *Nurse Leader Handbook* from The Studer Group, internal Elevate Website tools for leaders, *Switch* by Chip Heath & Dan Heath, Broadway Books, 2010, *Crucial Conversations* by Patterson, Grenny, McMillian & Switzler, McGraw –Hill, 2012, *Vital Smarts* website resources, *Overcoming the Five Dysfunctions of a Team Field Guide* by Patrick Lencioni, Jossey-Bass, 2005 and various professional articles.

In addition, ongoing training, coaching and education sessions are provided for the nursing managers who also coach/mentor the new CSLs. This part of the program is invaluable to the success of this important change.

Participants

Name	Credentials	Role in Organization	Practice Area	Role on Committee/Group/Work/etc.
Susan Hernandez	MBA, BSN, RN	CNO (previous)	Children's Hospital	Project Leader Interviewer
Erin Tickle	MMHC, BSN, RN	Director	Shared Governance	Project Leader
Connie Ford	MHA, RN, NEA-BC	Administrative Director, Inpatient Nursing (previous)	Children's Hospital	Director of impacted units Interviewer
Marlee Crankshaw	DNP, RN, CNML	Administrative Director, Neonatal Services	Children's Hospital	Director of impacted units Interviewer
Kate Copeland	MSN, RN, NEA-BC	Administrative Director, Emergency Services	Children's Hospital	Director of impacted units Interviewer
Kathy Moss	MSN, MBA, RN, PMP, NEA-BC	Administrative Director, Nursing	Children's Hospital	Interviewer
Trishonna Jackson	MSN, MBA, RN, NE-BC	Director Clinical Education & Professional Development (previous)	Children's Hospital	Interviewer
Vickie Thompson	MSN, RN	Manager, Nursing Special Projects	Children's Hospital	Interviewer
Christina White	SPHR	Sr. Human Resources Department	Human Resources	Consultant
Susan Amsler	PHR	Human Resources Consultant	Human Resources	Consultant
Cristina Loaiza	BSN, RN, NE-BC	Manager, Patient Care	Children's Hospital -	Manager of impacted units Interviewer

		Services	PSTAM	
Debbie Gardner	MSN, RN	Manager, Patient Care Services (Previous)	Children's Hospital - PMAC	Manager of impacted units Interviewer
Angel Carter	BSN, RN, NE-BC	Manager, Patient Care Services	Children's Hospital - Cardiology	Manager of impacted units Interviewer
Tanika Lankford	MSN, RN, NE-BC	Manager, Patient Care Services	Children's Hospital - PCICU	Manager of impacted units Interviewer
John David Hughes	MMHC, BSN, RN, NE-BC	Manager, Patient Care Services	Children's Hospital- PCICU	Manager of impacted units Interviewer
Cheri Wood	MSN, RN	Manager, Patient Care Services	Children's Hospital - NICU	Manager of impacted units Interviewer
Donna Nolan	BSN, RN, CNML	Manager, Patient Care Services	Children's Hospital – Perioperative Services	Manager of impacted units Interviewer
Vicki Jones	MSN, RN, NE-BC	Manager, Patient Care Services (Previous)	Children's Hospital - PACU, Holding	Manager of impacted units Interviewer
Lori Graves	BSN, RN, CNOR	Manager, Patient Care Services	Children's Hospital – Perioperative Services	Manager of impacted units Interviewer
Veronica Elders	MSN, RN	Manager, Patient Care Services	Children's Hospital – Pediatric Emergency room	Manager of impacted units Interviewer
Jerry Ballhagen	EMT- P, MBA	Manager, Neonatal and Pediatric Transport (Previous)	Children's Hospital – Transport team	Manager of impacted units Interviewer
Amanda Whitlock	BSN, RN	Clinical Nurse Manager, Neonatal and Pediatric Transport	Children's Hospital – Transport team	Manager of impacted units Interviewer
June Bowman	MSN, RN	Administrative Director of	Hospital Administration	Project Team Coach

		Clinical Operations Improvement		
Terry Minnen	M.Ed	Senior Consultant	Service Excellence Coach	Project Team Coach
Unit Staff		Clinical Nursing Staff	MCJCHV	Interviewers

Outcomes

The intervention that we measured was in October 2012 and was the actual implementation of the Clinical Staff Leader (CSL) role across all units (house-wide) at MCJCHV (Children's Hospital). The CSLs assumed responsibility for their individual cohorts at that time. Six months prior, the education and training for CSLs and managers was conducted. The CSLs did not complete any actions per their role definition before the actual implementation in October 2012. Therefore, until the role was implemented in October 2012, the model would not have had an impact on the outcome.

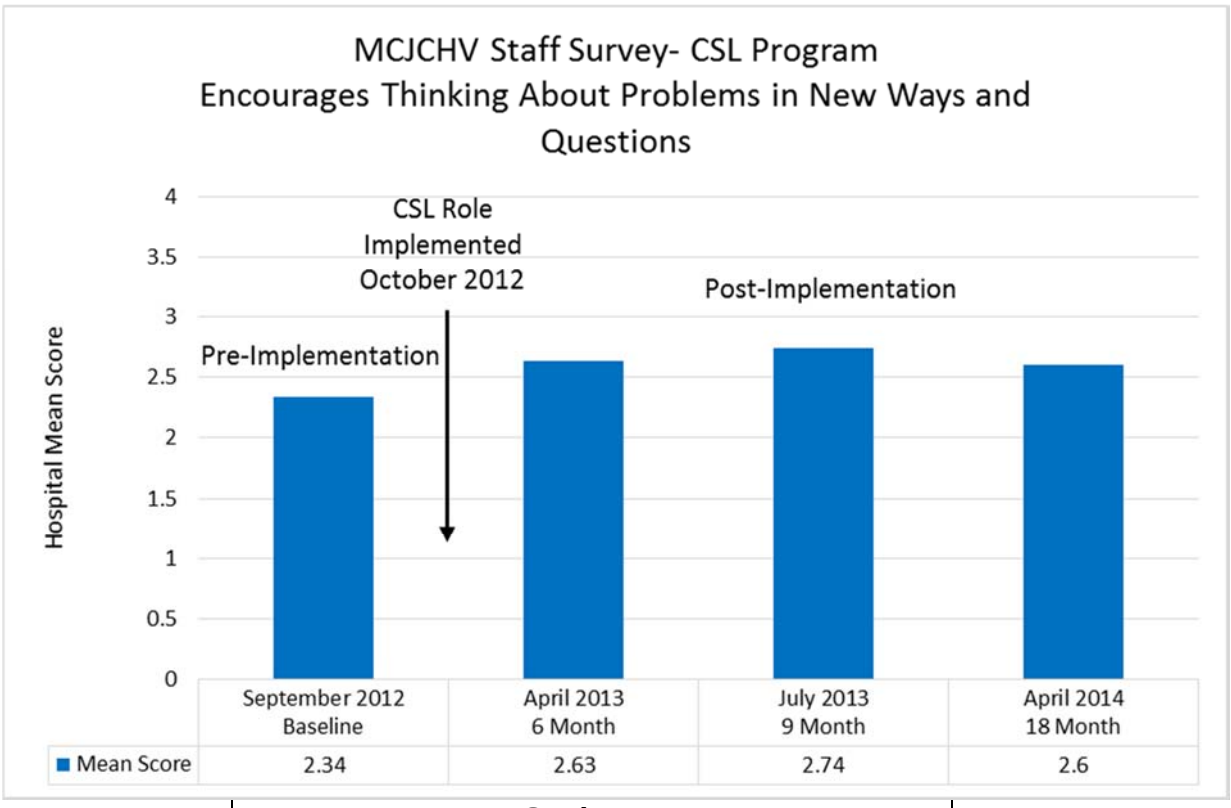
Based on research and feedback, we identified items that we would use to populate a "scorecard" as measures for success of this change such as: turnover, quality scores, satisfaction data (staff and patient), length of stay, and financial outcomes. We are also aware of the multitude of factors that can affect these scorecard measures and the almost impossible task of showing a direct link to any one variable. However, we believe the strength of this program is grounded on feedback from the clinical nurses and our desire to provide a meaningful level of support and an improved practice environment for them. Based on this, we chose as our first focus direct measurements of the clinical staff nurses response to the implementation of the new role. *We utilized the Global Transformational Leadership Scale (GTL) survey. The clinical staff were surveyed prior to implementation (September 2012) of the role; then at 6 months (April 2013); then 9 months (July 2013); and 18 months (April 2014) post implementation.*

During and immediately after the implementation of this new role, VUMC experienced a number of financial challenges that required some hard decisions that affected all staff members, such as no salary increases and loss of staff. Although these losses were not at the bedside level, everyone was affected in their own way. Even with that, the CSL model proved to be a positive change in our nursing leadership structure, as shown in the measurement of goals graph below. We have now rolled out this model to VUH and our Psychiatric Hospital and are beginning now with our adult outpatient clinics.
Here are but a few comments that support the positive impact of this role.

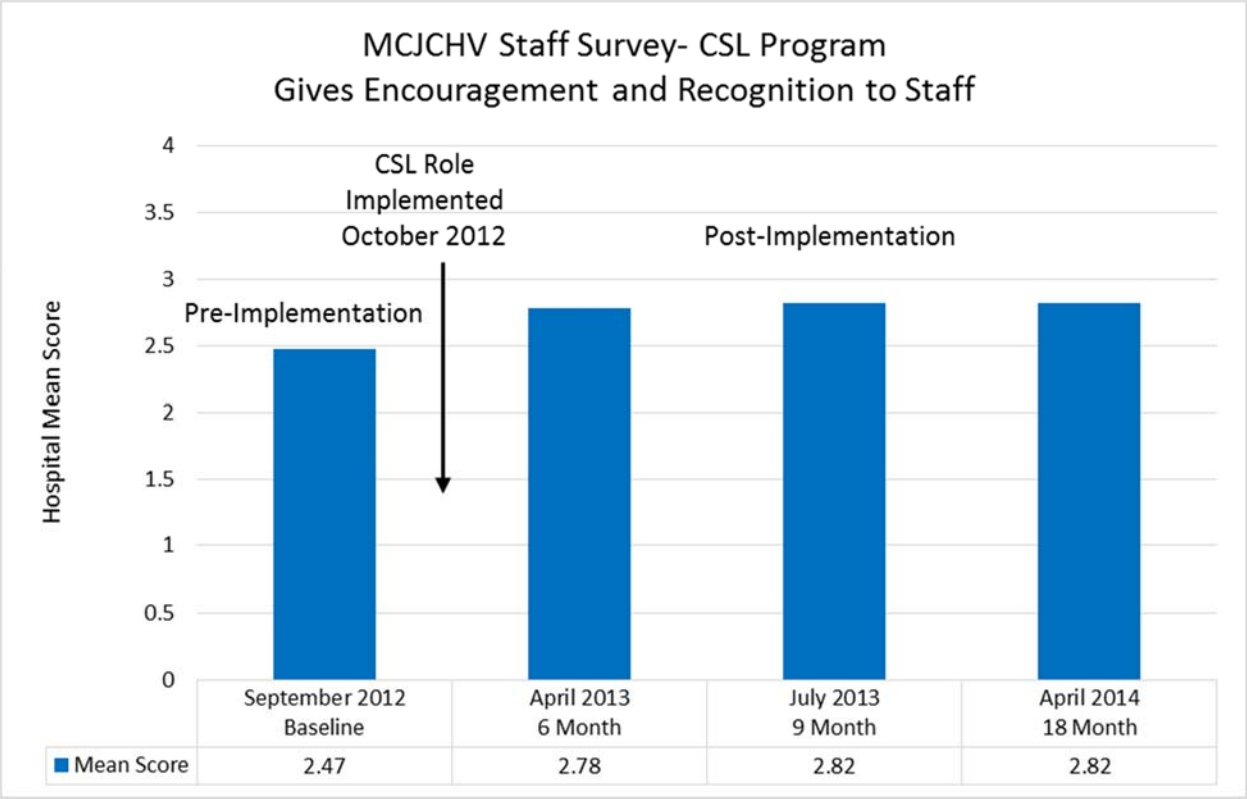
CSLs said	Staff said
I am feeling more confident in my ability to give direct and meaningful feedback to staff	I love having someone do my evaluation that knows what I do

I am able to see how our unit fits into the bigger picture of the Medical Center	It is nice to have a leader on nights
I can motivate my team differently now and recognize them individually	I like having a nursing leader working beside me to take care of patients
	I love the level of accessibility to my leadership team

Managers said
I love the model and the staff are finally reaping the benefits from having someone who works with them to be the one who evaluates them. They also see the work they are doing to improve the quality in the unit.
They are much more aware of patient acuities than the manager. They are able to coach in the moment with newer relief staff leaders (RSL) related to these acuities and how staffing could be flexed up or down. They also meet with the QIA nurse and help her develop and implement approaches to improvement in certain areas.
The CSL team does a great job being visible and available to staff, as well as assisting them with whatever questions or concerns they have. They also bring an invaluable clinical perspective to the office, as well as a leadership perspective to the daily unit workflow. In these ways, the CSL role has succeeded immensely in a way that the Assistant Manager model did not.
I do want to say that the introduction of the CSL role has had a direct and noticeable impact on staff morale and, I believe, retention. In this sense, I am very satisfied with the CSL role.



Scale 1-4			
1	Strongly Disagree	3	Agree
2	Disagree	4	Strongly Agree



Scale 1-4			
1	Strongly Disagree	3	Agree
2	Disagree	4	Strongly Agree

Example b

Improvement due to a change in clinical practice

Background

As is the case with many large teaching medical centers, Vanderbilt University Medical Center (VUMC) struggles with patient capacity. Vanderbilt University Hospital (VUH) is currently at 91% occupancy year to date (YTD) against a budget of 89.3%. As our average census is running high, patient discharges are down 8.7% because the average length of stay is 5.1 YTD against a budget of 4.6. With the adult hospital running at, or near, full capacity, ED visits are down 5.6%, as 51% of the time they are on diversion. As these statistics illustrate the current capacity issues, administration has been looking at metrics, trying to understand how we can efficiently facilitate discharges and reduce length of stay to improve patient throughput and increase ED admissions.

During a VUH house-wide staff nurse council meeting, Chief Nursing Officer, Robin Steaban, MSN, RN, NEA-BC brought this question to the clinical nursing staff. Through this conversation, Robin was working to understand delays in patient discharges. One

of the clinical nurses offered this information, “when I get a discharge order for a patient at 10am, I am typically passing medications, and working with my other patients as well. Typically, the patient with the discharge orders is the least sick patient, so naturally, that patient falls to the bottom of my priority list.” The clinical nurse suggested units have an additional RN to facilitate discharges, and hypothesized that having this additional RN could increase discharges prior to 11am. Steaban took the feedback from the clinical nurse council meeting, and began to plan the patient flow nurse pilot.

6 North, Neuroscience Stepdown was chosen to pilot the patient flow nurse. This unit specializes in caring for the neuroscience patient population, including patients with closed and open head injuries, epilepsy, Parkinson's disease, multiple sclerosis, meningitis, and stroke. In fiscal year 2015, 6 North was having difficulties discharging patients prior to 11am, with only 8.8% of patients being discharged in this time frame. In addition, only 53.2% of patients were discharging within two hours of orders being written for their discharge. The remaining patients were waiting longer than two hours for discharge. In addition, 6 North was having difficulty reducing their length of stay (LOS), which for FY15 was 4.7 days. Because of their average census of 26.5/28 and their difficulties with discharges and length of stay, 6 North was an excellent unit to pilot this project.

Nursing Strategic Plan

This work falls right in with the Nursing Strategic Plan (Organizational Overview 3). The mission of the Vanderbilt University Medical Center department of nursing is to partner with patients, families, the community, and other disciplines to advance health and wellness throughout the lifespan and across the continuum of care through excellence in nursing care, education, and research. For 2013-2016, VUMC department of nursing identified four key strategies to carry out this mission.

I. Vanderbilt Personalized Patient Health Care
II. New Knowledge, Innovation, Improvements & Effectiveness
III. Transformational Leadership & Professional Development
IV. Workforce Strategy

These key strategies include specific goals and tactics to achieve these goals. The patient flow nurse project ties directly to two areas of the nursing strategic plan:

I. Vanderbilt Personalized Patient Health Care
    a. Goal 2: Consistent and reliable systems and tools to manage transitions of care
        i. Develop and implement people, process, and technology to support the communication of the plan of care across the continuum. Example: Transition work teams
II. Workforce Strategy
    a. Goal 2: Monitor and evaluate workforce trends in order to make decisions that optimize the efficiency and function of the nursing workforce.
        i. Determine optimal alternative staffing models and strategies.
            1. Workforce design and planning: throughput.

Goal
Increase the percentage of patient discharges on 6 North Neuroscience Unit prior to 11am.

Interventions
After the pilot unit was identified, nurse manager Ali Grubbs, MSN, RN worked with her team to design the Patient Flow Nurse (PFN) role to facilitate patient throughput by supporting the roles below:

- Patient:
    - Increased time with primary nurse
    - Enhanced patient/family education
    - Provides single point of contact regarding discharge needs
- Primary Nurse:
    - Increased time with patients in their acute level of treatment
    - Improved response time to critical patient needs
    - Provides seamless handover for newly admitted patients
- Provider:
    - Provides single point of contact regarding discharge needs
    - Integrates knowledge of patient flow at the unit level and its impact on capacity

In addition, the PFN collaborates with all members of the healthcare team to facilitate:

- Discharges:
    - Prioritize the unit flow at the beginning of their shift
    - Act as a liaison between the multi-disciplinary teams to safely discharge patients home
    - Efficiently discharge patients with the ultimate outcome to improve the patient's perception of discharge as evidenced by increasing Press Ganey scores
- Admissions:
    - PFN takes responsibility of patient admissions by pulling patients to the unit (when available)
    - Complete all pertinent admission responsibilities, including admission history, first full assessment, and communication of patient needs post transfer
- Transfers:
    - PFN will proactively call transferring unit to facilitate timely patient transfer

After outlining the duties of the PFN, 6 North identified a clinical nurse to pilot this role and began piloting the week of September 14, 2015. After three weeks of piloting, tremendous improvements were made in discharges prior to 11am, which increased from FY15 average of 8.8% to 27.3% of patients discharging prior to 11am. In addition, they found remarkable improvements to other metrics including:

- Length of Stay: reduced from FY15 average of 4.78 days to an average of 3.89 days

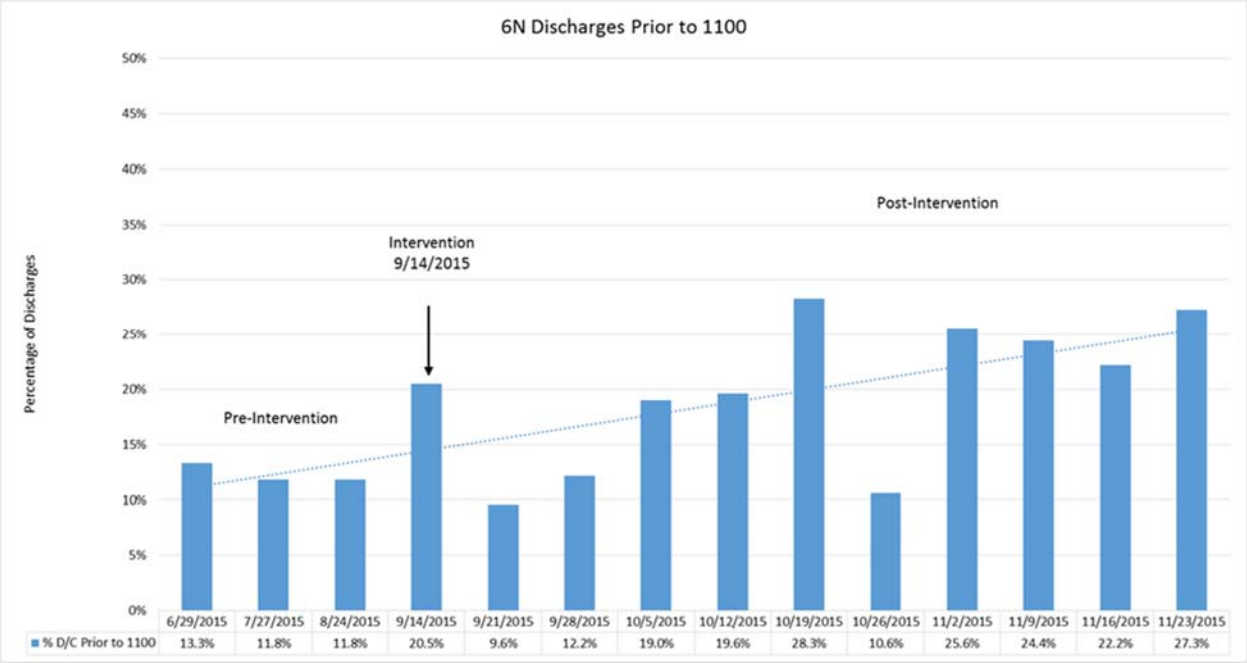
- Patient discharges within 2 hours of discharge order: increased from FY15 average of 53.2% to 61.8 %.

The success of the PFN project resulted in a return on investment (ROI) analysis. After looking at the improvements in discharges and length of stay, and the ROI, administration supported enterprise-wide implementation of this role throughout VUH. Enterprise wide implementation will use a three phase approach that allows for performance evaluation prior to implementation of phases two and three. The goal is to have the PFN project rolled out to all units in the adult hospital by March of 2016.

Participants

Name	Credentials	Role in organization	Practice Area	Role on committee
Robin Steaban	MSN, RN, NEA-BC	Chief Nursing Officer	VUH	Administrative Sponsor
Ali Grubbs	MSN, RN	Nurse Manager	6 North	Project Leader
Kristin Reid	BSN, RN	Clinical Nurse	6 North	Patient Flow Nurse
Daphne Dowlen	BSN, RN	Clinical Nurse	6 North	Patient Flow Nurse
Candace Tillquist	MA, MMHC	Administrative Director	Neurosciences PCC	Advisor
Mary Duvanich	RN, MSN, MMHC	Associate Nursing Officer	Ortho PCC, interim Neuro PCC	Advisor

Outcome


6N Discharges Prior to 1100
Percentage of Discharges
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Intervention
9/14/2015
Pre-Intervention
Post-Intervention
6/29/2015 7/27/2015 8/24/2015 9/14/2015 9/21/2015 9/28/2015 10/5/2015 10/12/2015 10/19/2015 10/26/2015 11/2/2015 11/9/2015 11/16/2015 11/23/2015
% D/C Prior to 1100
13.3% 11.8% 11.8% 20.5% 9.6% 12.2% 19.0% 19.6% 28.3% 10.6% 25.6% 24.4% 22.2% 27.3%

TL2

Strategic Planning

TL2: Nurse Leaders and clinical nurses advocate for resources to support nursing unit and organizational goals

- Provide one example, with supporting evidence, of a nurse leaders' advocacy that resulted in the allocation of resources to support an organizational goal. AND
- Provide one example, with supporting evidence, of a clinical nurse's (or clinical nurses') advocacy that resulted in the allocation of resources to support a nursing unit goal.

Example a

Nurse Leader Advocacy

Introduction

Vanderbilt Psychiatric Hospital (VPH) is an 88 bed free-standing hospital that provides behavioral health care for adults, adolescents and children. They have the only inpatient beds for children with behavioral health disorders in the region. Over the last few years, the number of adults, adolescents and children admitted with a primary or secondary diagnosis from the autism spectrum scale has increased. Obviously, the largest number is being seen in adolescent and child. One of VPH's organizational goals at this time was to "improve the existing violence risk assessment procedures and educate faculty and staff on their proper implementation". Statistically, both actual and potential risk for harm (violence risk) was determined to be from the patients admitted with a diagnosis from the autism spectrum scale, at approximately 60%. Laura Webb, BSN, RN-BC, Nurse Manager (leader) in the Child and Adolescent unit (there are no nursing administrative leaders between the nurse managers and the Chief Nursing Officer (CNO) in VPH; thus the managers cover all of the units and other programs), advocated for a partnership with Vanderbilt University Kennedy Center TRIAD Center.
TL2a-1 VPH Org Goals

The Treatment and Research Institute for Autism Spectrum Disorders (TRIAD) Center and the Vanderbilt Kennedy Autism Clinic are world renown for their research and treatment of adults and children with autism spectrum disorders. They were the perfect partners for behavioral management training for the VPH clinical staff.
http://vkc.mc.vanderbilt.edu/VKC/triad/
https://www.autismspeaks.org/resource/vanderbilt-kennedy-autism-clinic

Starting in June 2012, Laura Webb, BSN, RN-BC, Nurse Manager in Child and Adolescent, advocated for an autism behavior management training program and resources to improve the management of care for all VPH patients related to autism spectrum disorders. The most immediate need was for those patients receiving care through the autistic child and adolescent program. This was vetted through the

Professional Practice Board and the VPH Staff Nurse Council. TL2a-2 Professional Practice Board Meeting Minutes; TL2a-3 VPH Staff Nurse Council Meeting Minutes

The goal of this initiative was to improve the effectiveness, efficiency, reliability, and safe delivery of patient centered care to VPH patients admitted with diagnosis on the autism spectrum. This would be accomplished through education and providing the needed resources and behavior management training for the VPH clinical nursing staff. Laura partnered with the CNO, clinical staff nurses, mental health specialists, social workers and physicians to work with Kim Frank from the Vanderbilt Kennedy TRIAD Center to develop the training and determine the best presentation/learning environment for the VPH clinical staff.

Getting started

Ms. Kim Frank, educational consultant from the Vanderbilt Kennedy TRIAD Center, which provides autism-specialized resources and services to families and professionals (Vanderbilt Kennedy Center, 2014), presented an autism training and resource poster at the Vanderbilt Psychiatric Hospital (VPH) Grand Rounds. Following the VPH Grand Rounds the clinical nursing staff worked with Ms. Frank to determine further education and resources to strengthen their program. TL2a-4 Grand Rounds Flyer & Sign In Sheet

As part of the ongoing training and education in March 2014, John Staubitz and Pablo Juarez provided autism behavior management planning training to the VPH clinical nursing staff. This training introduced concrete techniques needed to manage the autism spectrum disorder (ASD) population. This is one of the most critical aspects of providing care for patients with autism. Topics for the training included:

- Why visual supports are helpful for patients with ASD
- Types of supports that are considered evidence-based interventions
- Introducing and using visual supports
- Producing visual supports

The Kennedy Center also conducted several VPH clinical nursing and staff in-services to provide further training regarding Applied Behavior Analysis (ABA) (behavior management education) for managing the care for the autistic child or adolescent. Knowledge of these techniques and resources are provided to the patient's family to ensure the behavior management continues after the patient is discharged from the hospital.

An ongoing clinical nursing staff training program is facilitated by clinical nurses Heather Rattigan, BSN, RN and Christa Paramore, BSN, RN-BC along with mental health specialist (MHS) Sarah Biggs. This interprofessional training approach resulted from the relationship with the Kennedy Center. A redcap survey was used to poll all VPH nurses about needs going forward after the initial training. Nurses were able to advocate for their educational needs via participation in the survey.

Outcome

The VPH clinical staff nurses and mental health specialists act as “care champions” to pass on the skills and resources learned from the ABA, behavioral management training, to the nursing staff. Tailored education was provided for staff based on learning needs. Offering a personalized care plan based on diagnosis is specifically mentioned on our website as well. Individualized behavior management plans are now initiated for each patient receiving care on the VPH’s autistic child and adolescent child unit. The VPH clinical nursing staff is also deployed to the Monroe Carell Jr. Children’s Hospital at Vanderbilt to provide ABA training for the boarding of ASD patients. TL2a-5 Personalized Care Plan

Funding for ABA Training and Needed Resources

Funding for the ABA training and needed resources were provided by the VPH’s Chief Nursing Officer, Avni Cirpili, DNP, RN. Funding has been allocated for training materials and funds are also allocated for the clinical nurses’ work time when they provide on-going behavioral management education to the VPH clinical nursing staff, along with training that is conducted at the children’s hospital for the clinical nurses. Funding for this initiative shows that hospital administration values the need for ABA training to ensure high quality patient-centered care for the ASD patient population.

Example b

Clinical Nurse’s Advocacy

Improving Pain Control for Limited English Proficient Patients in Post-partum

American society has changed from a European-American-African basis to a more diverse, multicultural immigrant society. According to the 2012 United States Census, the proportion of foreign born population has increased over the last three decades, from 14.1 million in 1980 to 40.8 million in 2012. The proportion of the foreign born population who spoke a language other than English at home also increased to 85% in 2012.

Our abilities as care givers are greatly reduced when we cannot communicate well with our patients. How we respond to the changes in our society and understand the differences in language, culture and religion is the key to providing excellent care. Nurses face daily challenges when caring for patients, especially in providing adequate pain management. Since pain is considered a subjective experience, we rely on self-reporting pain intensity as a critical part of pain assessment. Analgesics, a mainstay of management for acute pain, are typically titrated based upon reported pain intensity. Thus, pain communication is a significant concern when providing analgesic medications to patients who have difficulty in communicating pain intensity.

At Vanderbilt University Medical Center, 4,731 women gave birth in 2014. Of those women, 26.6% had low English proficiency (LEP), representing nearly 30 different

languages. Vanderbilt provides on-site interpreters in major languages, such as Spanish, Arabic, and Kurdish, and we utilize language line phones installed in all postpartum rooms. Even with these resources, it can be challenging for clinical nurses due to occasional lack of timely access and fears about the quality and confidentiality of the interpretation provided. Also, it can be a challenge to locate a suitable interpreter for some of the less common languages found among the patients. Utilizing family members as interpreters is often the fastest and most convenient method of communicating with the patient. This method, however, is controversial with questionable accuracy and confidentiality, as well as potential legal issues. Therefore, the need for a fast, convenient and accurate method of communicating pain with postpartum patients was needed to improve pain management for LEP patients. TL2b-1 Email Sorting of Languages

Providing excellent pain control for all patients hospitalized at Vanderbilt is one of our long-standing goals. In FY quarter four (April-June) of 2012, Vanderbilt's patient satisfaction scores for "Nurses' efforts to manage physical pain" were declining. In June of 2012, the percent of excellent responses was at the lowest point in over a year, and it was identified that pain was an organizational priority for FY13. At VUMC, organizational goal alignment is critical, as it is understood that true change and improvements have to start at the point of care, at the unit level. Because of this culture of goal alignment, organizational priorities are cascaded down through focused committees to the unit level. The Pain Management Subcommittee took on this organizational goal and led efforts for improvements. On the heels of a Joint Commission visit, in the fall of 2012, the Pain Management Subcommittee indicated that pain reassessment compliance was a major area of focus.

While there was an organizational priority set on pain reassessment; during this time, the Obstetric Postpartum Antepartum unit (4 East) struggled to complete pain reassessment following intervention. The way to determine if a pain management plan is successful is to reassess after intervention. The unit average compliance with pain reassessment following intervention was 75%. Because of this, unit leadership from 4 East identified pain reassessment following intervention as a unit goal for improvement. On a daily basis, nursing leadership monitored the documentation of pain reassessment within two hours of intervention. In addition, an overall weekly audit was completed to monitor compliance and address issues. The goal was to increase documentation compliance to greater than 90%.

With pain re-assessment set as a unit priority, the ability to perform accurate pain assessments and achieve adequate pain control was much more difficult with LEP patients. Nurses on 4 East struggled to achieve this goal, as nearly 26% of their patients had LEP. Nursing assessment of pain type, location, and intensity rely heavily on verbal communication, it was clear that the clinical nursing staff needed additional resources to meet the pain management needs of the LEP patients and address their unit goal of

improving compliance with pain reassessment. Julia Yao, BSN, RN, a clinical nurse on the postpartum unit, took the lead in improving pain management for the LEP patient population.

In the fall of 2012, Julia Yao, BSN, RN, a clinical staff nurse on the postpartum unit, took the lead in improving pain management for LEP patients on her unit. She developed a simple visual chart to assess pain intensity in LEP patients in an effort to improve pain control for this segment of the unit's patient population. This chart was intended to improve pain communication between LEP postpartum patients and staff nurses, resulting in better pain management as measured by analgesic doses administered to LEP women following vaginal delivery. TL2b-2 Visual Pain Chart

Implementation of the Visual Chart

The Vanderbilt University Medical Center Obstetric Postpartum Antepartum unit is a 36 bed in-patient unit with more than sixty clinical staff nurses and patient care technicians. Approximately 1,258 women admitted to the postpartum unit had LEP in 2012, the year this project began.

A simple visual chart was created to improve pain assessment communication between LEP patients and the clinical nurses. The visual chart contains picture icons that the patient points to, assisting the nurse with establishing pain location and intensity. The icons are associated with a numeric rating scale (0-10) so that the appropriate analgesic and dosage can be administered. Ten additional icons were placed on the back of the visual chart to help the nurse with the patient's daily personal hygiene and hunger issues. The chart was created using "Johnson Board Maker" software.

Staff members were educated on the daily health care challenges the unit encountered with the multi-cultural patient population. Literature on cultural sensitivity was reviewed with staff and posted on the staff lounge bulletin board. Staff members were trained how to introduce the visual chart to the patients through initial use of an interpreter. Reminders and challenges with implementation were discussed at regularly scheduled staff meetings. Approximately half of the staff used the interpreter to introduce the visual chart, and half introduced the chart themselves. No difference in patient use of the visual chart was noted between those who did and did not use the interpreters for initial instruction.

Outcome

The primary outcome of this project was the number of analgesic doses of NSAID (ibuprofen) and opioid (oxycodone) administered during their 2-day hospital stay. Analgesic prescription for postpartum patients following vaginal delivery is standard on the unit, so dose of medication was not examined. This outcome was measured before and after implementing the visual chart. The records of fifty-two LEP patients (26 pre and 26 post-implementation) were reviewed for analgesics administered.

The average number of doses of Ibuprofen was 4.46 (median = 5) before implementation compared to 6.88 (median = 7) with the visual chart (p = .001; Table 1). Doses of oxycodone ranged from 0 to 10 before and 1 to 13 after implementation. The average dose of oxycodone was 2.92 (median = 2) without using the visual chart compared to 6.96 (median = 6.50) with the visual chart (p < .001). In addition, the total number of dosages of analgesics also significantly increased after using the visual chart (p < .001). Thus, using a visual chart to enhance pain communication with LEP patients improved the amount of analgesics administered during the postpartum hospitalization.

TL2b- Table 1 - Dose of analgesics administered pre- post-implementation.

	N	Mean without chart	Mean with chart	Independent t-test
Ibuprofen	26	4.46	6.88	P = .001
Oxycodone	26	2.92	6.96	P < .001
Total Analgesic Use	26	7.38	13.84	P < .001

Funding for Visual Charts

With the significant improvement in pain management for LEP post-partum patients following the use of the visual chart, Julia advocated for and obtained support and funding to purchase software to improve the graphics for the visual chart and support printing and laminating. Once the chart was upgraded, laminated copies were distributed on the unit. TL2b-3 Letter of Support for Funding

The funding came from the Vanderbilt Institute for Clinical and Translational Research (VICTR). VICTR is Vanderbilt's virtual home for clinical and translational research. Supported by the Vanderbilt Office of Research and the NIH sponsored Clinical and Translational Science Award (CTSA), the mission of the institute is to transform the way ideas and research discoveries make their way from origin to patient care (translation). This is accomplished using a multi-faceted approach through collaboration with a wide variety of research partners, by training, nurturing, and rewarding participating researchers, by funding research, by developing new and innovative ways to involve the community in research, by developing new informatics and bio-statistical systems, and by making available the latest technologies and sound research results affecting patient care. TL2b-4 VICTR Approval of Funding

Julia has also presented this work in research poster sessions internally and externally. TL2b-5 Pain Management Poster

(TL2b-1 Manager Email 10.31.12; TL2b-2 PPT re Pain as a Priority Goal; TL2b-3 Meeting Minutes 8.1.12; TL2b-4 Meeting Minutes 9.11.12; TL2b-5 Meeting Minutes 12.5.12)

TL3EO

Advocacy and Influence

TL3EO: The CNO influences organization-wide change beyond the scope of nursing.

- Provide one example, with supporting evidence, of a CNO-influenced positive change that had organization-wide impact beyond the scope of nursing services. Supporting evidence must be submitted in the form of a graph with a data table that clearly displays the data.

Background

Marilyn Dubree, MSN, RN, NE-BC, Executive Chief Nursing Officer is a member of the highest decision-making body at the organizational level for Vanderbilt, the Health System Staff Meeting (HSSM). This puts her on the same level with the highest ranking decision-makers in the Vanderbilt University Medical Center (VUMC) organization. Marilyn's ability to influence change and decision-making at this highest level was instrumental in her executive role to support and facilitate the development of Patient and Family Advisory Councils within each entity of VUMC.

Marilyn Dubree MSN, RN, NE-BC, Chief Executive Nursing Officer, along with Dr. Paul Sternberg, Chief Patient Experience Officer and Chief Medical Officer serve as the executive sponsors for The Patient and Family Engagement Steering Committee. This is a clinical enterprise-wide committee that provides oversight for patient and family engagement initiatives across the clinical enterprise, including the development of a common framework for patient and family engagement. The committee consists of a practicing physician, a member of the front-line clinical nursing staff, an advanced practice nurse, the chief marketing officer, the director of experience and access, the administrative director for patient and family centered care for the children's hospital, the chairs of the advisory councils for the adult, children's, and behavioral health patient and family advisory councils, and the senior director of patient and family engagement. Representatives from the Vanderbilt Behavioral Health (VBH) Patient and Family Advisory Council are active members on the Patient and Family Engagement Steering Committee.

Initially, Patient/Family Councils were launched in Vanderbilt University Hospital (VUH) and Monroe Carell Jr. Children's Hospital (MCJCHV). After much success with these two entities, an outpatient council (clinics) was started. Early concern on how to successfully have the same type of Patient/Family Council for Vanderbilt Psychiatric Hospital (VPH)/Behavioral Health delayed the start of that council. In efforts to improve patient/family satisfaction and provide the same avenue for patient/family input as the other entities at VUMC, a Patient/Family Council was needed for VPH/Behavioral Health.

Goal

Increase the percentage of excellence rating for Adult Patient Satisfaction Dimension for overall rating of hospital in Vanderbilt Psychiatric Hospital.

Interventions

In April 2012 Marilyn went to the executive leaders (CEO, CMO, Director of Business Development) at Vanderbilt Psychiatric Hospital about the opportunity to create a patient and family advisory council for VBH which could contribute to increased patient satisfaction and improved patient outcomes. VBH leaders were invited to attend a session of the adult patient and family advisory council for Vanderbilt University Hospital.

Afterwards, leadership met with Terrell Smith MSN, RN, Director of Patient and Family Engagement, to discuss implementation of a similar advisory council for Vanderbilt Psychiatric Hospital and overall for Vanderbilt Behavioral Health. The primary goal of this new board was to ensure that patients and families would be able to provide feedback on how operational actions impacted patients and families during hospitalization. The VBH Patient and Family Advisory Council was formed, and was composed of fourteen patient and family members who represented all of the inpatient psychiatric programs. The council was also comprised of three VBH leaders: the Director of Business Development, the Chief Administrator and the Chief Nursing Officer.

One of the first tasks of the VBH Patient and Family Advisory Council was to develop a charter which would outline the purpose and objectives of the council. Some of these objectives include:

1. Collaborate with the VBH leadership to improve quality of care provided to patients and their families.
2. Offer suggestions to VBH leadership in planning and evaluating services, programs, policies, teaching materials, and education to healthcare providers
3. Collaborate with VBH leadership to improve patient and family satisfaction.
4. Contribute to the education of present and future healthcare providers at VBH.

One of the first actions of the council was a focus on information and education. To address some of the educational needs identified about what to expect from admission through hospitalization. They raised several concerns: long wait times, lack of information on the treatment plan, and a lack of information about the hospital for families who are scared of admission.

The families also shared with leaders some concerns about the admission process once they arrived at VPH: additional wait time in admissions, feeling unwelcomed when they arrived to the unit, and a lack of information about what to expect from the hospitalization. In addition to the admission process, council members also raised concerns about the lack of educational materials available to families, concerns about

the lack of ability for patients to go outside and get fresh air and the overall discharge process.

The VBH Patient and Family Advisory Council partnered with the staff and developed a family handbook designed to aide families in navigating the hospitalization process. This new approach was put into place in July 2013.

Members of the Patient/Family Council also began to share information about the council with all VPH staff. They were also able to share a message of hope with all new VPH staff. To this end, they collaborated with nursing education at VPH and a council member presented the family perspective to all new VBPH staff during VPH new hire orientation.

Additionally, information obtained from the council members was shared with clinical nursing staff in the Nursing Staff Council. Actions that were being planned were communicated with the Patient and Family Advisory Council to get feedback about the proposed change. One example of this was when VBH was changing its search policy. The policy was presented to the council and their feedback was obtained. The feedback confirmed that the existing practice was highly intrusive and that the proposed change, which was more individualized based on the assessment, would be more patient centered and thus better received.

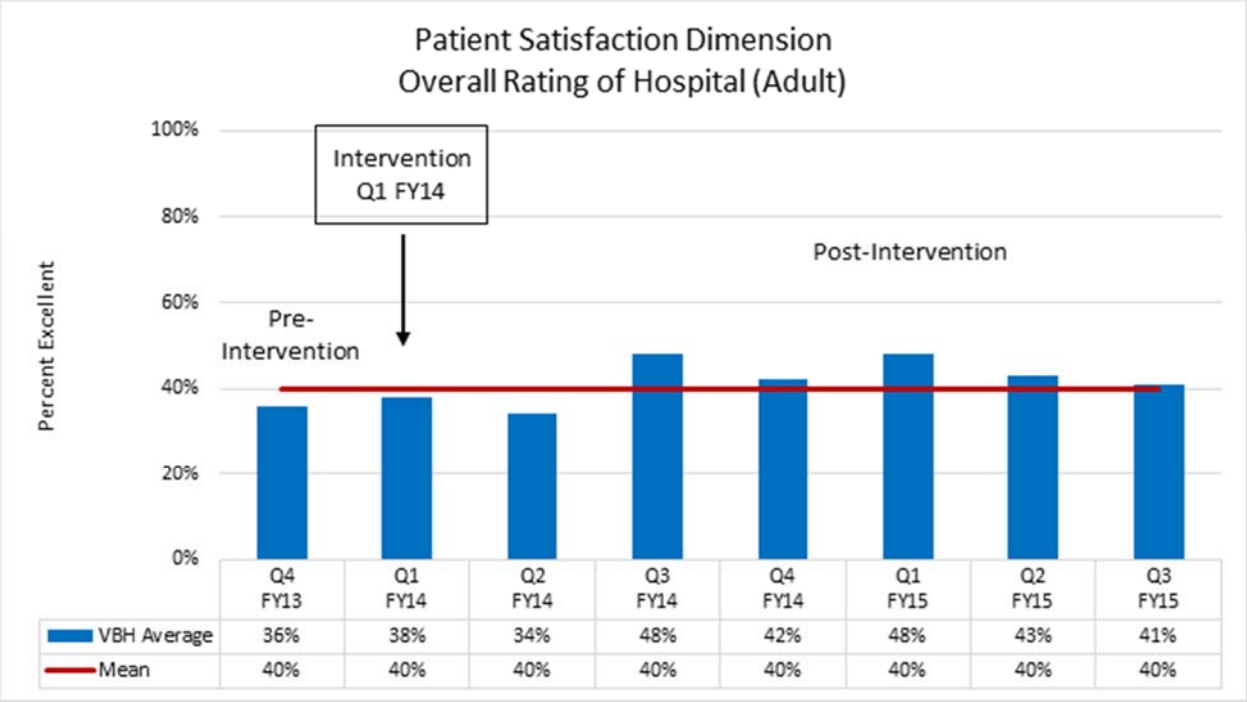
Based on the work with the VBH Patient and Family Advisory Council we have seen an improvement in our satisfaction scores.

Participants

Name	Credentials	Role in Organization	Practice Area	Role
Marilyn Dubree	MSN, RN, NE-BC	Executive Chief Nursing Officer	Clinical Enterprise	Executive Sponsor
Paul Sternberg	MD	Chief Medical Officer Chief Patient Experience Officer	Adult Clinical Enterprise	Executive Sponsor
Terrell Smith	MSN, RN	Director, Patient/Family Engagement	Clinical Enterprise	Advisor
Harsh Trivedi	MD	Executive Director Chief Medical Officer Vice Chair for Clinical Affairs	Vanderbilt Behavioral Health	Member
Stephan Heckers	MD	Department Chairperson Professor	Psychiatric Administration	Member
Rhonda	BA	Director, Outreach	Vanderbilt	Member

Ashley-Dixon		& Business Development	Behavioral Health	
Avni Cirpili	DNP, RN, NEA-BC	Chief Nursing Officer	Vanderbilt Behavioral Health	Members
Jennifer Barut	MSN, RN-BC	Director, Nursing Education and Professional Development	Vanderbilt Behavioral Health	Member
Johnny Woodard	BSN, RN-BC	Manager/Educator	Vanderbilt Behavioral Health	Member
14 patient and family members	Names protected			Member

Outcome



TL4

Advocacy and Influence

TL4: The CNO is a strategic partner in the organization's decision-making.

- Provide one example, with supporting evidence, of the CNO's involvement in the organization's decision-making (not involving technology).
  AND
- Provide one example, with supporting evidence, of the CNO's involvement in the organization's technology decision-making.

Introduction

As evidenced on the VUMC executive organizational chart (See OO4), Marilyn Dubree, MSN, RN, NE-BC is an equal member of the VUMC executive leadership team as the other executive leaders, including the CEOs of the entities, the Medical Chiefs of Staff, Chief Quality Officer, Chief Compliance Officer, etc. Marilyn reports directly to Dr. Wright Pinson, the Chief Healthcare Officer, CEO of Vanderbilt Health System and Senior Associate Dean for Clinical Affairs. This positions Marilyn to be a strategic partner in VUMCs organizational decision-making processes and to share parity with medical and administrative leadership in setting the course for the clinical enterprise.

Marilyn is also a member of the highest decision-making body at the organizational level for VUMC, the Health System Staff Meeting (HSSM). She is frequently tapped to serve as Executive Sponsor for organization-wide initiatives and changes. Marilyn's ability to influence change and decision-making at the highest level was instrumental in her executive role change and facilitated the following two examples: restructuring of the Patient Care Centers (PCC), particularly the Psychiatric Hospital and Behavioral Health, and the selection of our new organization-wide electronic health record system.

Example a

Behavioral Health Patient Care Center extends beyond the walls of the inpatient Psychiatric Hospital based on Executive CNO influence

Background

In 1997, patient care centers were formed at Vanderbilt University Medical Center to consolidate leadership of inpatient and outpatient areas that serve the same patient populations. The goal of developing these PCCs was to support greater coordination between corresponding inpatient and outpatient care teams. This was prescient of today's focus away from volume-driven, episodic and fragmented care toward value-driven, population-based and well-coordinated care. PCCs were a means to embed patient-centered care in the structure and day-to-day operation of Vanderbilt's clinical enterprise.

Late in 2013, executive leadership determined that the Patient Care Center model needed restructuring again, reconfirming its emphasis on patient-centered care; to

“reboot” the shift that had occurred from a functional organizational structure back to a patient centric one. The goals of the reconstituted PCC model were to create an organizational structure that:

- spans environments, time and multiple disciplines
- supports integrated, multi-disciplinary coordinated approaches to care to create value
- promotes efficiency and high reliability
- utilizes seamless processes that promote value creation across the continuum
- provides standard work processes when individual patient populations do not dictate variation
- ensures an actively engaged staff

Each PCC is structured around shared leadership, comprised of a medical leader, a nursing leader, an administrative leader, and where needed, an advanced practice nurse leader.

The Executive Chief Nursing Officer (CNO), Marilyn Dubree, MSN, RN, NE-BC, was integral to the planning and decision-making process, serving as one of the executive sponsors, as these goals for the new Patient Care Center structure were synergistic to the core values of the Nursing Strategic Plan; individual engagement in health and wellness, inter-professional collaboration and communication, shared decision-making, highly engaged workforce, and nurses as leaders at all levels in the health care system.

Nursing leadership for psychiatry had long been focused on inpatient nursing within the psychiatric hospital and clinical services. Outpatient behavioral health services reported to a separate patient care center. This complex nursing specialty has required focused attention and dedication, as its patients span across the entire enterprise. At Vanderbilt University Medical Center (VUMC), approximately 60% of all admissions have a behavioral or mental health diagnosis that could possibly interfere with them following their treatment and discharge plan. Separation of inpatient and outpatient psychiatric nursing leadership led to disjointed practice and did not support our goal of population-based and coordinated care. In order to optimize care to patients with a mental health diagnoses, Marilyn advocated for reorganizing the psychiatric enterprise leadership structure.

Distinction to behavioral health practice is the importance of the care continuum to successful clinical outcomes. The role of nursing leadership across that continuum is critical to not only the care of patients in the psychiatric hospital and ambulatory sites but to the entire health system. In order to best meet the needs of this patient population, the psychiatric PCC was redefined as Vanderbilt Behavioral Health. This structural definition is inclusive of the VUMC psychiatric hospital, outpatient services, and ambulatory practices. The executive CNO asserted the role of the CNO for all psychiatric and behavioral health nursing oversight. This structural change has allowed the expertise of this nurse executive to be accessed by all clinical leaders across the Vanderbilt Health System.

For issues of psychiatric patient care within our adult and children's hospitals, the new CNO structure has modeled the collaborative use of experts in problem-solving and best practice. In addition, the secure oversight of advanced practice nursing in the ambulatory and community practices is a quickly expanding area of workforce development. The opportunity to model this breadth of nursing leadership encompasses our commitment to excellence in all components of nursing practice and enhances our strategic commitment to succession planning.

By strengthening this PCC to cross the enterprise;

- nurse staffing has been optimized
- the clinical staff leader and administrative coordinator roles have been implemented
- a full-time education leader was added to support the needs of Vanderbilt Behavioral Health
- the psychiatric mental health nurse residency program was implemented in order to recruit and retain the best mental health nurses
- APNs were added to make the total of 25 to serve patient needs across the organization

Marilyn's innovative leadership, advocacy for best patient outcomes, and ability to impact organizational decision-making led to this restructuring that created the Behavioral Health Patient Care Center. Here at Vanderbilt, Marilyn not only has the role of Executive Chief Nursing Officer, but she truly represents and leads across the organization with intention. TL4a-1 3.19.14 PCC 2.0 Leader Mtg Min; TL4a-2 Plan for Inpt and Outpt Roles (see highlighted areas, both tabs); TL4a-3 VBH PCC RN Memo_ Cirpili; TL4a-4 March 15 PCC update NAB PPT; TL4a-5 Service Line Discussion Leader Mtg

Example b

Nursing's voice heard in selection of new electronic health record vendor, particularly important to The Clinic Nursing Staff

Background

In early 2015, Vanderbilt University Medical Center (VUMC) was notified that the current vendor supporting our Electronic Health Record (EHR) will no longer support the software used as of March 2018. This announcement impacted a number of software applications used across our clinical enterprise. With this news, the VUMC Leadership Team initiated a new program, named "Clinical Systems 2.0", or "CS 2.0".

In addition to responding to the change set forth by the vendor, this was also an opportunity for VUMC to "clean up" some of the issues related to the EHR. Long-standing was the need to improve integration in our EHR to track the patient's information across the continuum. Inpatient and outpatient clinical staff would be able to easily view the same information and track the patient's "story" in a linear fashion. Appointed by the CEO, the CS 2.0 steering committee chairs were identified: Titus Daniels, MD, MPH Medical Information Services Medical Director, Neal Patel MD, MPH,

Chief Medical Informatics Officer, and Marilyn Dubree, MSN, RN, NE-BC, Executive Chief Nursing Officer. The role of the steering committee was to preserve the strategic direction of the project, review and approve critical business decisions, and escalate enterprise decisions to executive team and/or executive sponsors. With Marilyn Dubree working as a steering committee chair on this important initiative, nurses knew that their feedback and perspectives would be sought out, and valued in this critical decision making process. TL4b-1 CS 2.0 Announcement

After the development of the steering committee, a program leadership team was named and charged to manage the day to day operations and project goals. In order to achieve these goals, inter-professional core working groups were established to provide the necessary insight for each of their functional areas. The core working teams consisted of clinical, technical, revenue cycle, and informatics. The clinical teams included physicians, clinical nurses, ancillary/support staff, and advanced practice nurses. The initial nursing clinical team was made up of eight nursing leaders. When Marilyn noticed this, she immediately advocated for a larger and more diverse nursing team to ensure representation of nurses from different areas at all levels, including nurse residents, experienced nurses, nurse educators, and nurse leaders. In the end, there were over fifty nurses serving on these teams.

Marilyn took a particular interest in ensuring the outpatient entity was included in this process. As referenced earlier, the outpatient areas at Vanderbilt have brought forth concerns that the inpatient and outpatient EHR have been disjointed, making it difficult for staff to follow a patient through the continuum of care. Marilyn ensured that outpatient representatives were at the table to provide this important perspective. TL4b-2 Clinic Staff Nurse Mtg. Min- Feedback CS 2.0 5.6.2015

After these clinical teams were formed, an outline and expected timeline was established. Based on early work with the teams, the selection was brought down to two vendors. The following steps were taken for the actual vendor selection.

Step 1: Validate future state opportunities and high-level requirements through Architecture Analysis and Functional Interviews:

Marilyn recognized that functional interviews were one of the first key steps in getting nurses involved in this process. The purpose of functional interviews was to better understand current state systems used in clinical care workflow, and to discuss what is working well. The CS 2.0 team then utilized the feedback to begin identifying key functional requirements necessary in the future clinical system. These sessions were conducted with our four entity Staff Nurse Councils, and in specific nursing care areas to assess specific needs, such as labor and delivery, interventional radiology and other procedural areas. In these sessions, not only were clinical staff nurses able to present what types of things they appreciated about current systems and what needs to be changed, they also provided patient care scenarios they wanted to see from vendors in demo sessions. The outpatient nurse representatives vocalized that a more integrated medical record would facilitate workflow and promote better continuity of care

from the outpatient to the inpatient setting. All scenarios were to show how the system would follow the patient through the continuum.

Step 2: Align and validate key requirements with desired future state clinical system

The information from the functional interviews was brought back to the steering committee and core working teams. Marilyn worked to ensure the input from clinical staff nurses was taken into consideration in setting up the vendor demo sessions. The clinical staff nurses advocated that the following components of clinical documentation were necessary to include in vendor demonstrations: standard care documentation, plan of care, patient education, patient engagement, decision support, medication administration, transitions of care, ability to follow the continuum of care and nursing work list. All of these items were included in the scripted demo sessions.

Step 3: Facilitate two vendor demos, architecture sessions and evaluation processes

Scripted demo sessions from the two vendors were conducted. Marilyn emailed all clinical nursing staff, inviting them to the demos. The intent of these demos was to provide an overview of each vendor's system capabilities to familiarize the team with the core clinical workflow functionality. After the demonstrations, staff members were asked to fill out a brief survey to gather initial feedback which was included in the overall evaluation process. To facilitate participation, sessions were scheduled at multiple times throughout day and night for accessibility to accommodate a broad audience. Because of Marilyn's advocacy and support for nursing participation in this process, over one-third of the participants in these sessions were nurses.

Step 4: Review vendor inputs, demo evaluations and RFP response to aggregate data for decision on vendor of choice

- Based on eight key data points, the core leadership group did a comprehensive review of data in order to make a final decision on which vendor to select. Some of the data points included items such as staff feedback, site visit information, technical evaluations, and business assessments. Data on each key decision making point was presented, and ranked by the leadership group, ensuring the preferred vendor was selected.

As noted, Marilyn was one of the steering committee chairs during our efforts to select a new vendor for an electronic health record (EHR). *(Refer to Original Evidence TL4b-1 CS 2.0 Announcement)* Also included in the initial submission was evidence of clinic nurses' participation in several ways, including VMG Staff Nurse Council Meeting *(Refer to Original Evidence TL4b-2 Clinic Staff Nurse Mtg Min- Feedback CS 2.0 5.6.15)*

Marilyn was also a member of the Executive Oversight Committee. *(New Evidence TL4b-1 VUMC Selection Governance 4.23.15)* Marilyn was present, ensuring the nursing voice (clinics) was heard during every step of the process. She participated in site visits as a key nursing representative. *(New Evidence TL4b-2 UNC Site Visit; New Evidence TL4b-3 Univ of Missouri Site Visit)*

The actual decision was made on "Validation Day" which was a scripted look at all the evidence and input, including the clinic nursing staff. *(New Evidence TL4b-4 Validation Day Nursing Attendees [second excel tab includes Marilyn])*

The outline for Validation Day follows: *(New Evidence TL4b-5 VUMC CS 2.0 Evaluation Day Session Process 8.24.15)*

- Feedback results from the RFP review, Technical Architecture Evaluations, Summary of Site Visit scores from each participant, feedback from current vendor clients, evaluation summaries from participants for both vendor demo days; feedback from Dr. Balser, Kevin Johnson and Marilyn Dubree from their meeting with the CEO of both companies regarding the ability to have a successful partnership, analysis of the 2 vendors' implementation approaches, other feedback from focused groups (including clinic nursing).
- Content for each element was reviewed and scored on a continuum, from strongly A to strongly B.
- These results were summarized to show initial prevailing attitudes.
- Participants were invited to make a case for or against either vendor.
- Then each individual did a final composite evaluation on continuum of strongly A or strongly B.
- Results were shared, which clearly showed we were on the Epic end of the continuum.
- Then each individual was asked to say if they supported Epic as the vendor of choice.
- Epic was the vendor of choice.

Marilyn's advocacy and support for clinical nurse involvement in key decisions lead to the success of a project of this magnitude. Marilyn demonstrates the characteristics of a true transformational leader by conveying this sense of advocacy for nursing staff, as ultimately she knows that a successful project for the nurses will impact the care provided to each of our patients.

During this process and continuing, regular reports are sent out to staff in email communications, Marilyn's Newsletter and in the weekly VUMC paper, *The Reporter*. This keeps all the staff informed of progress and next steps. The nursing influence for this work will continue with Karen Hughart, MSN, RN, NE-BC, CNI being named the Senior Director of Nursing Informatics. Karen will be the lead for implementation of the new system. TLb-3 CNO News Aug 2015 CS 2.0; TLb-4 Hughart Announcement; TLb-5 Vendor Selection

TL5

Advocacy and Influence

TL5: Nurse leaders lead effectively through change.

- *Provide one example, with supporting evidence, of the strategies used by nurse leaders to successfully guide nurses through unplanned change.*
  AND
- *Provide one example, with supporting evidence, of the strategies used by nurse leaders to successfully guide nurses through planned change.*

Example a

Unplanned Change – Ebola Epidemic

The 2014 Ebola epidemic was the largest in history and impacted healthcare workers in the United States and challenged clinicians across the country to be prepared. The situation became urgent when an American physician returned back to the United States for treatment. On September 30, 2014 the situation intensified with the first Centers for Disease Control (CDC) laboratory-confirmed case of Ebola diagnosed in the United States. The Ebola response across the country escalated when a healthcare worker who cared for this patient tested positive for Ebola.

Being the only academic teaching hospital in a wide region, Vanderbilt realized that we would most likely be the recipient of any suspected or confirmed cases of Ebola in our area. Although we had an appointed committee that had only begun to address the institution's general preparedness plan, we were severely under-prepared for an Ebola patient and certainly not an epidemic in the United States. With the confirmed diagnosis of a patient in the United States, Vanderbilt went into urgent preparedness mode. An interdisciplinary team, with nurse leaders at the forefront, provided a unique opportunity for the nursing community to address the immediate priority for VUMC to ensure the nursing staff's success in caring for an Ebola patient.

Nurse Leaders

Many nurses, in various roles, were members of the interprofessional Ebola Virus Disease (EVD) team. As news of the Ebola virus epidemic continued to escalate, the obvious need to have the right environment, right equipment and educated and prepared nurses became the focus. We were acutely aware of the need to quickly provide a safe environment for our nursing staff to deliver care. At this time, the CDC was updating their recommendations for caregiver and environmental safety on a daily basis.

We had nurse and other professional executives who sponsored and supported the nurse leaders who carried out this work. For the adult hospital, Vanderbilt University Hospital (VUH), Jeanne Yeatman, BSN, MBA, RN, EMT, Administrative Director Emergency Services and Michele Hasselblad, MSN, RN, NE-BC, Associate Nursing Officer, Medicine Patient Care Center were the nurse leaders responsible to ensure the

Adult Emergency Department and the Medical Intensive Care Unit (MICU) nursing staff were prepared for Ebola patients. The thought process was that most likely any potential EVD patients would present to the Emergency Department and due to the severity of the illness and the level of care required, the MICU was the designated unit. Other nurses and nurse leaders on the team are shown below along with their roles on the EVD team. TL5a-1 10-10-2014 Ebola Team Meeting 1 Minutes

Name	Credentials	Role in Organization	Role on the EVD Team
Jeanne Yeatman	BSN, MBA, RN, EMT	Administrative Director of Adult Emergency Services	Facilitator- Ebola Preparedness & Response Team; EVD Drills; Adult Emergency Department training; LifeFlight air and ground transport preparedness;
Emily McBride	MSN, RN	Manager, VUH Emergency Services	Ebola Preparedness & Response Team member; Adult ED training and preparedness; EVD drill
Kate Copeland	MSN, RN, CPN	Director, Pediatric Emergency Services	Ebola Education; Preparedness & Response Team member; Ebola Preparedness Taskforce Member; Pediatric Emergency Department training; Angel transport training
Veronica Elders	MSN, RN	Manager, Pediatric Emergency Department	Ebola Education; Preparedness & Response Team member; Pediatric Emergency Department training
Chris Wilson	MSN, RN-BC	Director, Nursing Education and Professional Development, Vanderbilt Hospitals and Clinics	Ebola Preparedness Taskforce Member; Staff education and training
Michele Hasselblad	MSN, RN, NE-BC	Associate Nursing Officer, Medicine PCC	Ebola Education and staff preparedness training, MICU; Preparedness & Response Team member
Julie Foss	MSN, RN, NE-BC	Manager, MICU VUH	Ebola Education & Preparedness & Response Team member; MICU staff training; EVD drill
Susie Leming-Lee	DNP, MSN, RN, CPHQ	Manager, Special Projects	Ebola Preparedness Project-Recorder for the Ebola Preparedness Taskforce
Barbara Meriweather	MSN, RN	Information Technology	Ebola Preparedness Project-Recorder for the Ebola Preparedness Taskforce

Mike Jorden	MSN, RN, NE-BC	Nurse Manager, Inpatient Cardiology VUH	Manager of the CDRT/Ebola Preparedness Taskforce Member; CDRT training; CDRU oversight; EVD drill
Vicki Brinsko	MSN, RN, CIC	Director Infection Control	Ebola Education; Preparedness & Response Team member

Strategies Used to Guide Nurses

When nurse leaders considered this urgent need to prepare the organization, and particularly the clinical nursing staff, to potentially receive EVD patients, several change management strategies came into play; however, two were critical: situational awareness and supporting structures. From this came the main ways the change was managed: education/training, communication, and the utilization of our structures that were in place for leveraging interprofessional teams for any type of work. Due to the urgent need to move quickly and the changing EVD environment, nursing leaders knew having all key stakeholders at the table for every step would expedite all processes and ensure greater success. There was a dual focus: to ensure suspected or confirmed EVD patients would receive optimal care and treatment and to ensure the safety of the staff that would come in contact with this patient population.

Specific areas of focus included policy and protocol development and distribution to staff, care delivery practice, Ebola patient flow algorithms, education and training, recruitment of volunteer staffing for Ebola patients, location of EVD unit, lab specimen handling, supplies and equipment, finance, diagnostics, physical plant preparedness, internal and external communications, security, internal and external transport, ethics, and waste management. Due to the need to move quickly, concurrent groups were developed to work on these individual parts of the plan. TL5a-2 12-5-2014 Ebola Team Meeting 5 Minutes

Education and Training

Education and training was a priority for nursing and this led to the development of the Ebola Education and Operations Committee, guided by Chris Wilson MSN, RN-BC, Director, Nursing Education and Professional Development for the entire organization. The team had weekly meetings with clearly identified follow up items outlined in the meeting minutes. This assured open communication and accountability to all nurses involved in the work TL5a-3 11-4-14 Educator Meeting – Ebola. Respective nurse leaders encouraged these nurses to participate in the development of this committee's work and assured their availability to support their engagement in the effort.

Susan Bosworth MSN, RN, FNP, Nursing Professional Development Specialist, Nursing Education and Professional Development and Jillian Russell MSN, RN, Nursing Professional Development Specialist, Nursing Education and Professional Development under the guidance of the nurse leaders were the centralized nurse educators who led the development of Communicable Disease Response Team (CDRT) specific care

delivery training. This training was launched December 2014 and has continued to evolve into three distinct phases of training:

- Phase 1 - PPE donning and doffing per CDC guidelines for Ebola patients, Waste Management/Spill Management, Toileting, and Lab Specimen Collection.
- Phase 2 - Point of Care Testing, Physical Therapy/Occupational Therapy, Radiology Management, and Respiratory Therapy.
- Phase 3 - Builds on the skills from Phases 1 and 2 in a simulation environment in the actual patient room of the Communicable Disease Response Unit (CDRU) with scenarios involving a standardized patient and simulation mannequin.

Best Practices and Resources

It quickly became evident that information regarding Ebola had a high rate of change and CDC recommendations were being updated on a daily basis. It was essential that the nurses involved had access to this information so that best practices could be developed and built upon in accordance with the best available evidence. Daily, the core group of nurse and infection prevention colleagues monitored the Ebola resources available on the CDC and World Health Organization's websites and had communication with leaders at Emory University Hospital. Nursing team members also attended the Tennessee Department of Health (TDH)/Tennessee Hospital Association (THA) Ebola PPE Training in November 2014 for interaction and resource sharing with Emory University Hospital nursing staff.

Utilizing the numerous resources, the project team was able to develop and communicate tools and activities based on the evidence from best practices to guide nurses in providing safe, high quality care to a suspected or confirmed Ebola patient:

- Screening questions were developed for the ED and clinic registration staff.
- Patient Flow for Patient with Suspected or Confirmed Ebola Infection was developed.
- Donning and Doffing of Personal Protective Equipment and PAPR for direct caregivers was identified, trialed, and revised after receiving feedback from CDRT members.
- Room Prep Protocol and Room Layout Blueprints for the MICU and Adult ED as well as Patient Transport and EVD/EMS Transport Protocols were developed by nurse and physician leaders.
- LifeFlight event medicine team was designated for transport of suspected EVD patients from the ED to the CDRU.
- Various Waste Management and Environmental Cleaning protocols were developed by Infection Prevention and Environmental Health and Safety nurse and physician leaders.
- Protocols were developed involving external vendors for waste removal, room and ambulance disinfectant. The waste removal vendor will have to request a permit from the Department of Transportation to remove the waste.

Nurse leaders also developed a plan for staffing in the event an Ebola patient would present to the institution. This plan includes:

- CDRT volunteer members were recruited beginning October 2014 and from that initial group, quick responders were identified on a volunteer basis and are trained to be the responding caregivers for any Ebola patient regardless of point of entry into the institution.
- On a given shift, four nurses for one Ebola patient would be staffed to provide quality and safe patient care for both the CDRT members and the patient.
- Nurse caregivers will rotate out of the patient room every four hours to minimize the number of caregivers in contact with the patient, and avoid fatigue. Depending on the needs and/or severity of the patient, one or two caregivers would be in the patient room at a time.
- One nurse is always in the observer role to monitor PPE integrity during patient care activities, while another nurse serves as a charge nurse liaison to the CDRT nursing team and physician colleagues.
- A schedule rotation is maintained by the CDRU Manager to ensure CDRT members are on-call to provide 24/7 coverage and nurse leaders support the importance of prompt reassignment of staff in their 'home' units if needed for the CDRU.

Communication

If a suspected Ebola patient is encountered, staff has been provided education to activate the Ebola Response Team Immediately via a designated phone number. This call would then activate a paging system to automatically notify nurse and physician leaders on the project team. This would trigger deployment of CDRT members on the schedule to assume care for this patient.

Transparency in communication was of significant importance to our nursing community. Frequent, multi-faceted communication took place among various groups of nurses, including:

- Nurse Alert Emails communicating facts and resources as they became available TL5a-4 News for All Nurses- Ebola.
- Guidance for VUMC providers concerning Ebola message was sent on August 8, 2014 to ED and clinic providers.
- MyVUMC article was released on August 14, 2014 to the Vanderbilt community.
- Within the Infection Prevention website, an Ebola Resources Intranet site was developed for easy reference of all policy, protocol, CDC references, and other educational opportunities pertaining to Ebola TL5a-5 Screen Shot Ebola Resources Website.
- Ebola Town Hall Meetings were held live, webcasted, and archived for all staff.
- CDRT volunteer email distribution list was initiated by Michael Jorden MSN RN, Manager, CDRU to communicate upcoming trainings, updates, traveler notifications, etc.
- On August 28, 2014 the State of Tennessee released the CDC Ebola Key Messages and the CDC Response Update.

- Ebola and the CDRU were highlighted in numerous educational sessions during the Spring 2015 Aprilfest events offered to all VUMC staff.

Project team nurse leaders also participated in drill coordination on September 15, 2014 and December 15, 2014. These drills involved nurses, physicians, and Emergency Services Personnel simulating a patient presenting with symptoms consistent with EVD at various access points. Debriefing took place following the drills to provide the project team with valuable feedback to best inform policy and protocol development. Nurse leaders also participated in the Health Care Coalition (HCC) Ebola Tabletop exercise on October 23, 2014.

Success

Measures of success:

- Development of protocols and procedures to manage the care of a suspected Ebola patient with staff safety measures in place.
- Early detection measures are in place to identify potential patients with Ebola.
- Established working relationships with state and local health department staff.
- EVD Walkthrough with Metro Health 12/23/2014 supporting our institution as an assessment hospital for travelers returning to the area who require a 21-day monitoring period.
- CDRT members (approximately 35 active volunteers currently trained).
- CDRU physical space has been constructed on site. Additional equipment and supplies are in the process of being ordered and stocked to assure the readiness of the space in the event of a patient presenting to our institution. The CDRU space is currently being used by Ebola project team nurse educator leaders to provide trainings to nursing and physician staff.
- A long term goal of the CDRU is to not only function as a space to provide care for an Ebola patient, but for various other communicable diseases such as MERS, SARS, etc.

Nurse leaders across the institution were vital to the development and implementation to guide nurses and other staff in the evolution of this unplanned change in caring for a suspected or confirmed Ebola patient. The nursing community was challenged to develop a plan to assure staff preparedness for high-quality patient care and ultimately staff competence and safety in a short time span.

Example b

Planned Change

Pre-planning results in safe and uninterrupted delivery of care for pediatric patients undergoing invasive cardiology procedures at Monroe Carell Jr. Children's Hospital at Vanderbilt (MCJCHV)

The Invasive Cardiology suites on the third floor of the children's hospital were scheduled for radiology and hemodynamic monitoring system equipment upgrades beginning the last quarter (fall) of 2013. The original pre-plan was for one suite to be

renovated while the other was used for both services. We would attempt to use other available operating rooms (OR) and the invasive radiology suite to perform procedures and maintain the current schedule as rooms were available. Initial planning included utilizing a day and evening shift, alternating which service would start early by days of the week. The pre-planning was based on the goal to provide safe, effective and efficient care with positive outcomes for pediatric patients undergoing invasive cardiology procedures, during a six month renovation period, while maintaining a full schedule.

Nurse Leader

The nurse leader responsible for this project was Barbara Shultz, MSN, RN, NE-BC, Administrative Director, Surgical Services, MCJCHV.

To ensure success, Barbara utilized the structures, tools and approaches essential to managing a project of this scale. Guiding principles that were evident throughout the change included: organization of a project team consisting of all the stakeholders including nurses at all levels that supported our philosophy that those closest to the actual work would be the experts to make those decisions, regularly scheduled meetings for check-in, progress updates and next steps, timelines, and contingencies for the unexpected and open, consistent communication TL5b-1 Design Team Meeting Minutes 11-25-2013.

Strategies Utilized to Guide Nurses through Change

Those closest to the work, the clinical staff nurses, participated in the process of how to staff one lab to accommodate both busy services, and the possibility of using the interventional radiology suite and available OR suites for the implant cases. Clinical staff nurses also developed a plan for stocking the supplies needed for both services in one room.

During the planning phase, it became evident that the renovations would not be able to start until after the holidays, with the first lab renovation beginning in early January 2014. This new start date coincided with the completion of the new Adult Invasive Cardiology suites on the fifth floor of the critical care tower. With this information, the leadership team, led by Barbara, of the Pediatric lab, along with the physicians, made a proposal to MCJCHV senior leadership to utilize the space the adult lab was vacating. The Pediatric EP lab would be relocated into that area for the entire duration of the renovations in MCJCHV. This proposal was accepted and work began, planning for the move by the clinical staff and the management teams of both labs. Barbara compiled a list of key personnel needed to plan and complete the move and developed a meeting schedule, timelines and communication tools TL5b-2 Renovation Time Line; TL5b-3 Purchase Time Line.

In order to ensure success, key stakeholders, as listed below (by role), were involved in the planning, implementation and evaluation of this change.

- Associate Nursing Officer of Vanderbilt Heart and Vascular Institute (Adult)
- Administrative Directors of the MCJCHV and VUH Invasive Cardiology Labs

- Managers and Clinical Staff Leaders from Adult and Pediatric Labs
- Staff RNs from Pediatric Invasive Cardiology
- CSTs from Pediatric Invasive Cardiology
- MCJCHV and VUH Pharmacy staff
- MCJCHV Holding and PACU staff
- MCJCHV Operating Room and Cardiovascular Operating Room staff
- MCJCHV Anesthesia physicians and CRNAs
- ECMO staff RNs
- MCJCHV ER Manager, VUH ER staff
- MCJCHV and VUH IT departments
- Biomed staff
- GE engineers
- VUH Computer and Phone Services personnel
- MCJCHV Perioperative Business Manager
- Medical Sourcing Officer
- Information Services Consultant
- Hospital Purchasing and Contracting staff
- Attending Electrophysiology Lab physicians

Finding a "Connection"
Prior to the Children's Hospital opening in 2004, the Pediatric and Adult labs were located together on the first floor of VUH under an interim manager, the current Pediatric Cath Lab Clinical Staff Leader (CSL). Barbara knew this prior knowledge was valuable and supported the CSL and staff to plan for a smooth transition into the area. Patients would be admitted to the MCJCHV hospital, transported to VUH for the procedure by Anesthesia and the RN staff, and return to the MCJCHV PACU for recovery. The team was able to trouble shoot and resolve issues prior to the move date in order to avoid patient scheduling delays.

Under the direction of Barbara and unit leadership, staff nurses worked with the service center to obtain mobile supply carts to transport and store supplies. Plans were made with the pharmacy to supply and stock an Accudose for the VUH labs the MCJCHV team would be occupying. The RNs worked with our CRNA counterparts to determine what type of supplies they would need at the new site. A call was made to linen services after the staff decided what type of linen they would need and the location to which the linens would be delivered. RNs also contacted the Extracorporeal Membrane Oxygenation (ECMO) team, provided a tour of the new location and helped them decide a location to store emergency equipment. The MCJCHV Cardiovascular Operating Room (CVOR) staff RNs duplicated their emergency carts and supplies, currently kept outside the pediatric suite, to have supplies for both locations. The MCJCHV OR staff was also given a tour of the new area. The Adult ER was notified of our presence, since they would be assisting with codes in this area and housekeeping was made aware for cleaning purposes. During this time of planning and additional work, the staff nurses were still providing care for our patients.

While the RNs were working on their items, the Manager and CSL were working with IT for computer moves and additional needed computers, the phone group to move current numbers across the street, the biomed and GE team that were going to relocate our GE systems, and the purchasing and contracting group to maintain a service contract on the aging Siemens equipment in the VUH lab. In addition to these items, both were attending adult and pediatric lab renovation meetings to have everything ready for the simultaneous moves.

After the adult lab moved upstairs, the staff RNs were given time without cases to get the VUH lab cleaned before moving all their equipment and supplies over. They spent time organizing the room and helped the CSL establish and organize the storeroom. Biomed moved the GE and anesthesia equipment over and worked with the VUH IT group to get the computers onto their network. Everything was completed within three days and systems ready for first patient case on January 13, 2014. Upon completion of the two days, the EP lab was set up to mirror the lab in MCJCHV and the team was prepared to provide care for the pediatric patients.

The team utilized multiple forms of communication to ensure that all team members were prepared for patient care in the alternate area. There were weekly meetings led by nursing leadership, email communication, announcements at the daily operational safety huddle for MCJCHV and phone calls. Team members were kept abreast of the project progress and patient volumes on a daily and weekly basis. Patient care was reviewed daily to ensure that all patient care standards and safety measures were in place.

Outcomes

The difference between the six months in the VUH suite and the same time period in the renovated MCJCHV EP suite was six patients. Cases done in the MCJCHV OR suites (25) during renovations were staffed by CVOR RNs and CSTs. There were no reported infections in patients done in the VUH labs or incidents of patient harm. Cardiac cath case number totals did not vary due to the fact they remained in the open lab in MCJCHV.

By providing a duplicate area for EP, there was a positive financial impact for the organization as well.

TL7

Advocacy and Influence

TL7: Nurse Leaders, with clinical nurse input, use trended data to acquire necessary resources to support the care delivery system(s).

- Provide one example, with supporting evidence, where a nurse leader, with clinical nurse input, used trended data to acquire necessary resources to support the care delivery system(s).

Nurse Leader

Throughout 2014, Michele Hasselblad, MSN, RN, NE-BC, Administrative Director for both the heart and medicine patient care centers, identified a common theme while rounding in the medical and cardiac intensive care units (MICU and CVICU). She and the unit managers heard increasing staff dissatisfaction related to concerns with having enough time and resources to provide all necessary care for their patients within a twelve hour shift. Staff verbalized frustration with not being able to show the desired improvements in pressure ulcer prevention in these areas even in the face of strong unit improvement initiatives.

Use of Trended Data

The MICU is a thirty-four bed high acuity unit that cares for both critically ill patients as well as step down patients. The CVICU is a twenty-seven bed critical care unit specializing in cardiovascular patients. Throughout 2014, these two units were not performing at or above the National Database of Nursing Quality Indicators (NDNQI) mean of their academic medical center peer groups over an eight quarter timeframe. Michele heard from the clinical staff about ideas and ways to continue work on the problem of hospital acquired pressure ulcers (HAPU) during scheduled unit board meetings where the HAPU data was reviewed. TL7-1 MICU Unit Board Meeting July 10, 2014

Using trended data related to unit acquired pressure ulcers, the nurse managers for the units were able to substantiate the clinical nurses' concerns about being able to provide total quality care for their patients each shift. Through collaboration with clinical staff and leadership, they developed the idea of a turn team as a shared resource for both the MICU and CVICU.

Clinical Nurse Input

For the clinical nurse input to the nurse leader, Michele Hasselblad. On the attendance list for the MICU Unit Board Meeting (July 10, 2014) the attendance sheets do show Michele Hasselblad in attendance (attendees are captured in bold). These Unit Board Meeting Minutes were submitted with our first

submission. (*Refer to Original Evidence TL7-1 MICU Unit Board Meeting July 10, 2014)*

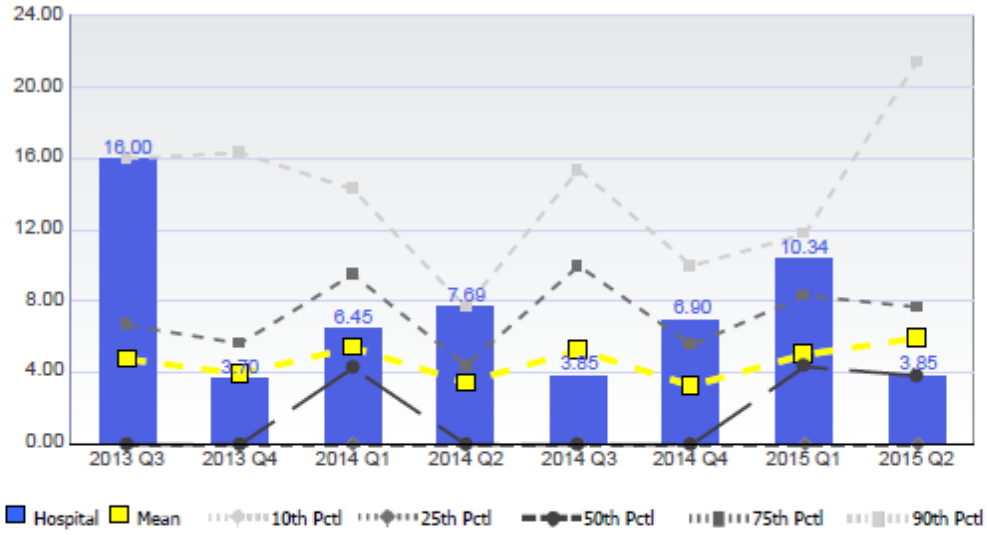
One of the other ways that Michele was made aware was by an email that came prior to the July date from Sonya Moore, MSN, RN, Quality Consultant for VUH. The email dated April 4, 2014 with two detailed grids shows how 5N CVICU was doing with HAPU stage 2 and above and overall. Their trended data showed they were not able to sustain any improvement over more than 1-2 quarters. *(New Evidence TL7-1 VUH Pressure Ulcer Outcomes Email 4.4.14)*

- Evidence to substantiate that the nurse leader (Michele Hasselblad) used trended data.

  The nurse leaders work with the nurse managers to develop a proposed budget for their units. There are business coordinators (Heather Campbell, MSN, RN) for the Patient Care Centers (PCC) that assist the Associate Chief Nursing Officer (Robin Steaban, MSN, RN, NE-BC) in compiling the budget for the PCC for review/approval. *(New Evidence TL7-2 Email re CP Budget; New Evidence TL7-3 Email CP Adjustment)*

Vanderbilt University Medical Center

Compared by: Teaching Status
Peer Group: Academic Medical Centers
Unit Type: Adult High Acuity
Unit: MICU
Measure: Percent of Surveyed Patients with Unit Acquired Pressure Ulcers

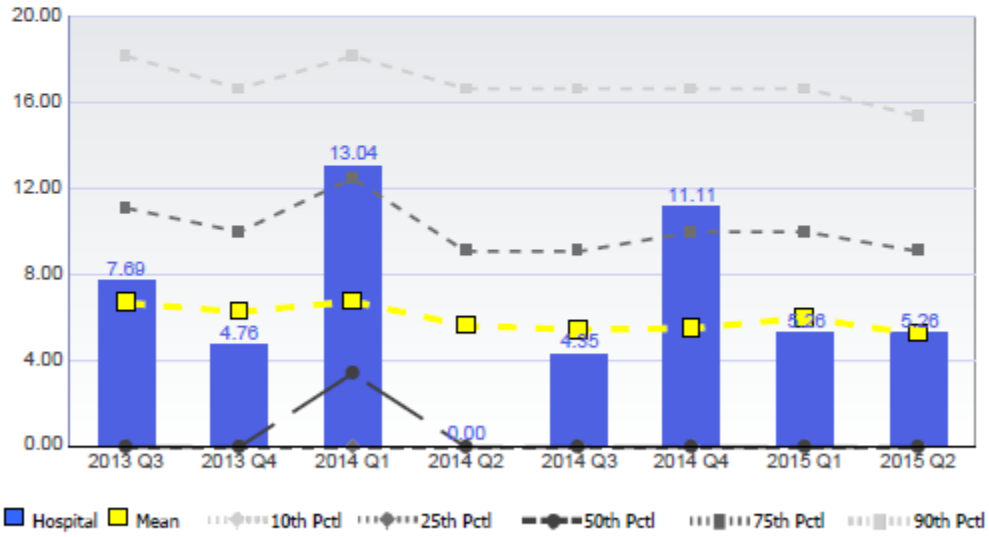


Quarter	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	Average
Unit	16.00	3.70	6.45	7.69	3.85	6.90	10.34	3.85	**7.35**
Mean	4.77	3.96	5.42	3.47	5.28	3.29	5.02	5.95	**4.64**

NDNQI
A Press Ganey Solution

Vanderbilt University Medical Center

Compared by: Teaching Status
Peer Group: Academic Medical Centers
Unit Type: Adult Critical Care
Unit: 5 N CVICU
Measure: Percent of Surveyed Patients with Unit Acquired Pressure Ulcers



Quarter	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	Average
Unit	7.69	4.76	13.04	0.00	4.35	11.11	5.26	5.26	**6.44**
Mean	6.69	6.28	6.76	5.64	5.46	5.51	6.00	5.24	**5.95**

Resources That Were Acquired

Taking the trended data into consideration, Michele listened to staff input about ways to improve pressure ulcer prevention for these units. This leader advocated for additional care partners to provide more resources to deliver patient care. In January of 2015, an additional 4.8 care partner FTEs were approved for each of these units. TL7-2 Lift/Turn Team Posting for MICU/CVICU Team

The two intensive care unit (ICU) managers collaborated with clinical staff and presented a proposal to create a shared turn/lift team. Their nursing leader, Michele, was able to use their trended unit data to endorse the creation of these new positions to develop this novel approach to serve the patients and assist the nursing staff in these two ICUs. She gave the approval for this model, the first of its kind at Vanderbilt. The

4.8 care partner FTEs per unit were combined into a 9.6 FTE turn team as a shared resource serving both of these ICUs.

An inter-professional group was formed that included staff nurses, safe patient handling expert, nursing research experts, quality experts, human resources, nursing educators, and leaders. This project came to fruition after many hours of literature and best practice reviews, job description development, interviews, and orientation and training plans. With continued support from Michele, the ICU clinical nurses were an integral part of the formation of this team, from providing input from the inception to assisting with the development of the program. They wanted to be sure all aspects were addressed to help ensure the success of this new team. As the work evolved, the turn team became a lift/turn team as they would also be assisting with getting patients out of bed, transfers to wheelchairs, and other patient lifting needs. TL7-3 Turn Team Initiative Meeting Minutes January 27, 2015

How the Care Delivery System Was Supported

Both patients and nursing staff reap the benefit of this newly developed turn/lift team in these two ICUs. Hospital acquired pressure ulcers are expected to decrease as now there are more hands to assist in the delivery of safe patient care and prevention tactics each shift. Nursing satisfaction is expected to increase as the existence of this team provides the nurse with an additional resource to accomplish the care delivery needed for each patient each shift. TL7-4 Orientation Schedule & Lift Team Staff Schedule; TL7-5 Scheduling Guidelines Policy for Lift Team

References for Lift/Turn Team Proposal

Safe Patient Handling Programs: Effectiveness and Cost Savings. OSHA. Obtained 2/18/15 at http://www.ors.od.nih.gov/sr/dohs/Documents/DLib%203.5_SPH_effectiveness_508.pdf

Gallagher, Shannon et.al. Clinical Nursing Education Series: Rethinking Lift Teams. BT Online editor. December 23, 2010.

TL8

Visibility, Accessibility, and Communication

TL8: The CNO uses various methods to communicate, be visible, and be accessible to nurses throughout the organization. Provide two examples:

- Provide one example, with supporting evidence, of communication between the clinical nurse(s) and the CNO that led to a change in the nurse practice environment.
  OR
- Provide one example, with supporting evidence, of communication between the clinical nurse(s) and the CNO that led to a change in the patient experience.
  OR
- Provide one example, with supporting evidence, of communication between the clinical nurse(s) and the CNO that influenced a change in nursing practice.

Example a

Executive CNO communication with clinical nurses in clinic areas stimulates change in patient experience.

In March, 2016 Marilyn Dubree, MSN, RN,NE-BC, Executive CNO, attended the Ambulatory Nursing Staff Council and encouraged attendees to watch the video presentation "Compassionate Connected Care" presented at the Winter 2016 Leadership Assembly. The discussion in the meeting and the Executive CNO's commitment to the patient experience resonated with the group, particularly the Nursing Staff Council member representing the Brentwood Primary Care Clinic. The impact of the ECNO addressing patient experience as a major initiative of the Medical Center, engaging staff nurses in conversation about their roles in improving the patient experience, and discussing concrete ways that they can impact the individual patient cannot be overstated. *(New Evidence TL8a-1 NSC Meeting Minutes & Attendance)*

The ECNO's interest and recommendations about the patient experience were conveyed to the Brentwood Primary Care staff during staff meetings in March and April by their Nursing Staff Council representative. The goal for Brentwood Primary Care was to achieve a rank of 75 among UHC sites. In the second quarter of fiscal year 2016, the rank was 70. Staff seemed stuck in moving this number the few more points needed to achieve the goal. *(Press Ganey reports results as "rank" which is actually percentile. Rather than simply compare ourselves to ourselves, VUMC promotes monitoring the rank for each clinic.) (New Evidence TL8a-2 Brentwood Primary Care*

Staff Meeting 3.2016; New Evidence TL8a-3 Brentwood Primary Care Staff Meeting 4.2016)

The leadership of the ECNO and her recommendation of "Compassionate Connected Care" via clinical staff nurses made a difference in the patient experience at Brentwood Primary Care. The staff renewed efforts to acknowledge the patient's feelings. The staff focused on increasing the patient's role as partner in their healthcare, ensuring that teaching needs were met. The clinic staff committed to giving patients their total attention when in clinic; the courtesy and respect that they would expect for themselves or their family.

The following interventions resulted from the ECNO's influence in promoting the concepts of "Compassionate Connected Care". These interventions stimulated a change in the patient experience.

- Acknowledge Suffering – Every patient being seen with acute illness was told, "I'm sorry that are not feeling well." Every patient with acute illness was told as they left clinic, "I hope you feel better soon." Patients with chronic problems requiring maintenance visits were told, "I know it can be hard to manage (diabetes, hypertension, etc.) and you are doing a good job keeping your appointments." The scripting was specific and reinforced in writing and verbally.

- Autonomy reduces suffering - Every patient left clinic with a teaching sheet pulled from the Krames patient education library. For many patients, the education sheet was specific regarding their medication or problem for which they were being seen. For some, the education sheet was about their lab orders. The staff committed to every patient leaving clinic with an education sheet and the PSRs were enlisted to help monitor. If a patient was seen leaving the clinic without a teaching sheet in hand, the PSR (Patient Service Representative who performs the check in/check out function) would ask them if they had received a teaching sheet and if the response was negative, the patient was asked to wait until the nurse could be contacted. This check and balance improved adherence to the change in the patient experience.

- Courtesy and respect – The staff called every patient by name, gave all patients their total attention and made eye contact. Staff themselves noted that they often walked ahead of patients, expecting the patient to follow. The staff wanted the patients to have a different experience in the clinic. This behavior was altered so that the staff walked alongside the patient, still guiding them, but by looking at the patient and speaking to them as they would be walked to an exam room.

As a result of the change in staff behavior related to giving the patient a more positive experience, the rank score for patient satisfaction improved in the fourth quarter of fiscal year 2016, at Brentwood Primary to 77, among UHC sites (or the 77th percentile), exceeding the goal. The influence and communication by the ECNO made the

difference and provided a pathway for dialogue. *(New Evidence TL8a-4 Pt Sat 3rd Qtr Brentwood Prim Care; New Evidence TL8a-5 Pt Sat 4th Qtr Brentwood Prim Care)*

Example b

During the grand rounds, “Caring for the Elderly Patient,” care for the cognitively impaired patient, as well as other more generalized care for the elderly population was discussed. Wound care was a topic addressed and an identified need for more extensive resources was expressed. A staff nurse, as part of fulfilling her requirements for advancements in VUMC’s clinical ladder advancement program (VPNPP), developed a “wound prevention and protection” manual. An example of a change in nursing practice, resulting from the associated communication between the CNO and clinical nurses, involved the use of Mepilex dressing for our geriatric patients who may present with fragile skin that may potentiate to pressure ulcers. Prior to this education, nursing practice did not include the application of a protective dressing. As a result of this geriatric related education, Mepilex is now used in order to create an optimal healing environment for patients with these areas of potential skin breakdown. This practice minimizes the risk for maceration.

New Evidence
TL8c-1 New Wound Care Manual
TL8c-2 Email from VPH Nursing Education about New Manual

TL9EO

Visibility, Accessibility, and Communication

TL9EO: Nurse leaders (exclusive of the CNO) use input from clinical nurses to influence change in the organization. Choose two examples.

- Provide one example, with supporting evidence, of a change in the patient experience that was influenced by the clinical nurses' communication with a nurse leader. Supporting evidence must be submitted in the form of a graph with data table that clearly displays the data.

AND

- Provide one example, with supporting evidence, of a change in nursing practice that was influenced by clinical nurses' communication with a nurse leader. Supporting evidence must be submitted in the form of a graph with a data table that clearly displays the data.

Example a- Change in Patient Experience

Background

Vanderbilt University Medical Center's (VUMC) main campus Medical Center East, 7th Floor, has four internal medicine (IM) clinics providing care for pediatric, adult and geriatric patient populations. Among the four, is an acute adult medicine clinic (Suite #1), where a total of 8-10 patients per month will require an urgent evaluation by the Rapid Response team. Our Rapid Response team is comprised of an interdisciplinary team (critical care nurses, advanced practice nurses, respiratory therapists and residents) who respond to non-code emergent issues in an effort to facilitate appropriate care for the patient and prevent a code call.

Clinic RNs noted when a Rapid Response call was initiated, the stat team from the Medical Intensive Care Unit (MICU) responded to the call. Although evaluations requested were urgent, many were not emergent and, therefore, did not require that level of expertise. This was viewed to be inappropriate utilization and diversion of internal resources from patients who truly required high acute care responses. Additionally, transitions of care within the clinic environment were chaotic. Of most concern was the total time needed to complete a hand-over and assure a comprehensive care transition (time of responding team's arrival to clinic departure), which was averaging 30 minutes per patient. This team was not comfortable with this level of care for their patients and was concerned about patient safety.

Goal Statement

Reduce the total time for patient hand-overs and care transition processes.

Intervention

The clinic nurses took their observations and concerns to Katie Brennan MSN, RN, CDE, NE-BC, the Administrative Director for the medical clinics. The staff realized the changes for this problem would require advocacy and an organizational response and

change in how Rapid Response calls are made and responded to for their clinic areas; individualized as opposed to the current practice.

Dialogue and work for development and implementation of a structured process improvement began in the fall of 2014. Due to familiarity with patient flow and clinic processes, clinical nurses openly verbalized concerns and brainstormed process changes with nursing leaders. In turn, the Administrative Director, Katie Brennan MSN, RN, CDE, NE-BC supported and facilitated crucial conversations and actively networked to remove potential or real barriers related to standard operating procedures for Rapid Response Team utilization.

For example they identified that a problem existed with the process of assessment and action. When a patient was experiencing difficulty, the clinic RN notified the Patient Service Representative (PSR) to dial 1-1111, an internal emergency response number. The PSR, although a key member of the health care team, was not clinically trained to answer the dispatchers questions and therefore, could not communicate accurately to the dispatcher the patient‘s acuity. The hand-over based on the nursing assessment of patient acuity was not smooth and the wrong level of care was frequently requested by the dispatcher. For example, if a stable patient was short of breath, a stat team would be notified to respond versus an internal paramedic rapid response team from the VUMC Emergency Department (ED), which would typically be the best response team. Through Katie’s support and advocacy with other leaders, the clinic was able to initiate the changes they believed would create an improved and safer patient experience. Starting in December of 2014, an Internal Medicine Clinic RN, instead of a PSR, initiated the call and spoke directly with VUMC dispatch to provide clinically relevant information. This timely relay of relevant information now assures the most appropriate team (ED based paramedic Rapid Response or Stat MICU team) responds based upon the patient’s real-time assessment. Clinic RNs continued to orchestrate all care transitions to ensure prompt, accurate relay of verbal and written information to the responding team. Other non-clinical members of the team, such as a PSR, now have a defined role. When directed by the RN, the PSR promptly prepares a confidential information packet containing a face sheet with pertinent demographic and insurance information, lab results, diagnostics such as EKGs, recent history and physical, and progress notes depicting recent care interventions (administered meds and treatments). This critical information assists the Response Team and is transported with the patient to the appropriate level of care.

This change in process has changed patient experience by having the correct response team show up to further evaluate and support the patient and also in that the patient is more smoothly transported to another level of care if needed.

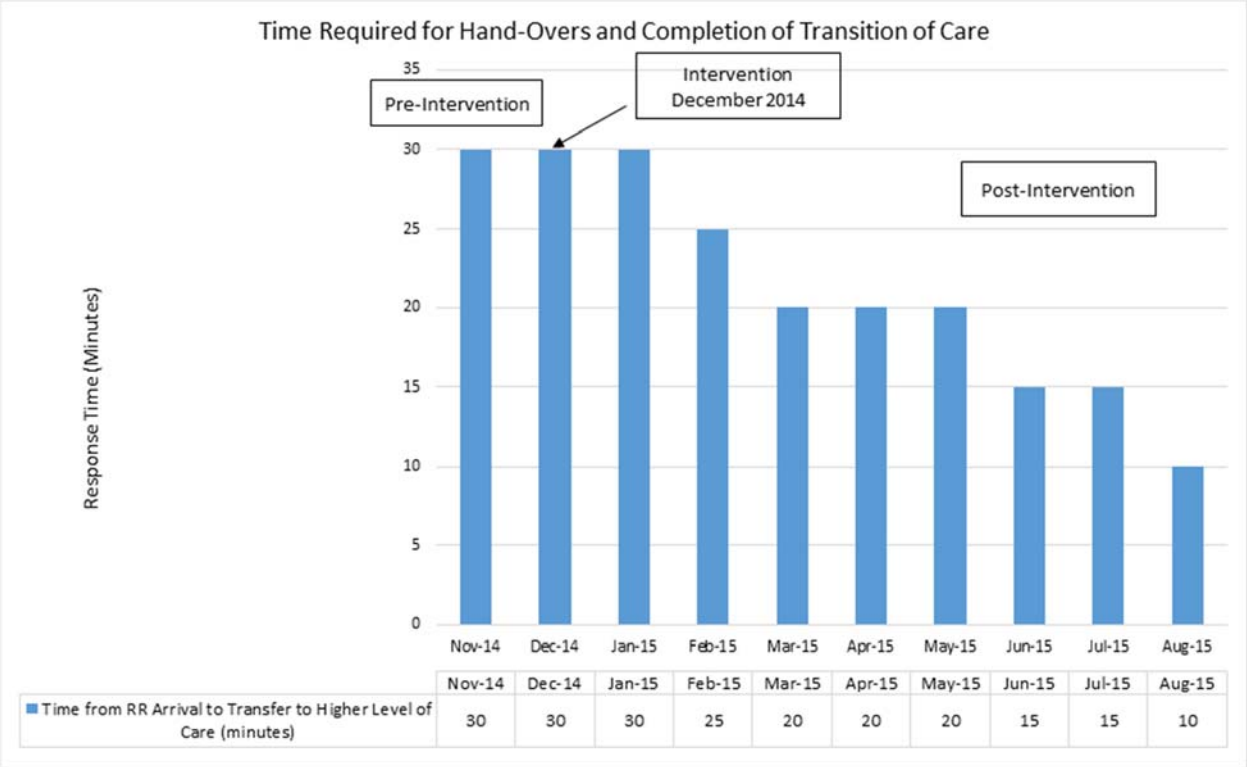
Participants

Name	Credentials	Role in Organization	Entity	Role in work
Teresa Milan	BSN, RN	Clinic Nurse Manager	VMG, IM, MCE 7th floor	Sponsor

Holly Culley	BS, RN	Charge Nurse, Suite #1-4	VMG, IM, MCE 7th floor	Initiator and Lead RN
Lauren Hymel	BSN, RN	Clinical Nurse, Suite #1	VMG, IM, MCE 7th floor	Member
Amanda Coleman	BSN, RN	Clinical Nurse, Suite #4	VMG, IM, MCE 7th floor	Member
Amanda Laffey	AD, RN	Clinical Nurse, Suite #3	VMG, IM, MCE 7th floor	Member
Ken Horst	AD, RN	Clinical Nurse, Suite #3	VMG, IM, MCE 7th floor	Member
Louise Brown	AD, RN	Clinical Nurse, Suite #2	VMG, IM, MCE 7th floor	Member
April Guzman	AD, RN	Clinical Nurse, Suite #2	VMG, IM, MCE 7th floor	Member
Rita Noyce	AD, RN	Clinical Nurse, Suite #2	VMG, IM, MCE 7th floor	Member
Katie Brennan	MSN, RN, CDE, NE-BC	Administrative Director	VMG, IM and Primary Care Clinics	Nurse Leader
Neeraja Peterson	MD	Medical Director	VMG, IM, MCE 7th floor	Physician champion
Jan Delozier	MD	Attending MD, Acute IM	VMG, IM, MCE 7th Floor	Physician Champion
Julie Cole	PSR	Suite #1	VMG, IM, MCE 7th Floor	PSR representative
Ann Spooner	PSR	Suite #1	VMG, IM, MCE 7th Floor	PSR Representative
Melissa Hughes	LPN	Staff LPN, Suite #1	VMG, IM, MCE 7th Floor	Member
Martha Young	LPN	Staff LPN, Suite #1	VMG, IM, MCE 7th Floor	Member

Outcome

The total time for the hand-over/transition of care process has decreased from 30 minutes to 10 minutes since implementation of process improvements. Providers and response teams have verbalized satisfaction with improved triage, accurate and timely provision of verbal and written information, and re-engineered transitions of care.



Example b- Change in Nursing Practice

Background

The Pediatric Hematology Oncology Unit (PHO) is located on the sixth floor of the Monroe Carell Jr. Children's Hospital at Vanderbilt (MCJCHV). This unit has 19 beds and the primary patient population is cancer care, children receiving chemotherapeutic drugs, radiation and stem cell transplants. As a result of their treatment, these patients have severe suppression of their immune systems. This lowered immunity, in combination with the large number of antibiotics administered predisposes the patient to acquiring Clostridium Difficile (C-diff). C-Diff can be a devastating infection and increases healthcare costs, hospital length of stay and can lead to negative outcomes. PHO had the highest C-diff incidence rate in the institution at 56.93 in December 2014. C-Diff hospital incidence rate is noted per 10,000 patient days {(# incidence month x hospital days)/10,000 Patient Days)}. This incidence rate was elevated to the Administrative Director of PHO, Connie Ford, BSN, MHA, RN, NEA-BC by the clinical staff after review of the data with their Infection Prevention Specialists. Connie facilitated the development of an interdisciplinary team to identify strategies to mitigate negative patient outcomes, decrease length of stay and minimize healthcare cost. The nurse manager of PHO was empowered to lead the nurses' efforts by the Nursing Administrative Director, who facilitated the improvement process with other disciplines across the hospital and advocated for and acquired necessary resources.

Goal Statement

To decrease the C-diff incidence rate in the Pediatric Hematology Unit at MCJCHV to less than 25.0.

Interventions

The interdisciplinary team, consisting of the manager, nursing leader, PHO clinical nursing staff, Infection Prevention Specialists, Performance Management and Improvement Quality Consultant, Hospital Administration, Environmental Services and the Infectious Disease Team, discussed and identified strategies to eliminate hospital acquired C-diff occurrence. This effort would require significant changes in nursing practice for this nursing care team. The team determined that a standing meeting including each of the members of this team would be essential to the success of the improvement project. In addition to these meetings, real-time huddles were performed with the assistance of the Infection Prevention Specialist and Quality Consultant for all new C-Diff occurrences. The C-Diff huddle included nurses and environmental services staff who then could explore the apparent contributors to the infection.

Through these meetings and real-time huddles, several areas for improvement were identified. Clinical staff nursing concerns included the level of patient interaction within the clinic setting, the inconsistency of admission processes, the need for additional hand hygiene stations and the need for larger trash cans with lids in all patient rooms. Areas of concern elevated by the environmental services staff members included families refusing to have their rooms cleaned, difficulty cleaning all crevices of current bedside tables, the need for disposal of erasers for the dry erase boards due to inability to clean them, and families of patients on contact isolation utilizing common areas. Providers voiced concerns regarding the potential of colonization of current patients with C-Diff and potential that antibiotic administration may lead to diarrhea that is tested positive for C-Diff. This concern provided an additional focus regarding antibiotic stewardship in the PHO population. As the team gained more insight into the C-diff occurrence rate, action items were developed with assigned implementation dates. Strategies that aided in the success of this project and overall improvement of healthcare outcomes are as follows:

Clinical Nursing Staff Directed

- Development of admission education sheet
- Development of C-Diff education sheet
- Creation of a C-Diff bundle (Education sheet, purple top wipes, contact sign, lid to cover hand foam)
- Transition of patient to new room as needed
- Minimize supplies placed in supply bins of rooms

Environmental Services Staff Directed

- Scripting for EVS to facilitate room cleans on all rooms with support from nursing
- Disposal of erasers in room
- Quarterly to bi-annual deep cleaning of unit
- Cleaning of all patient care rooms daily

Unit Leadership Directed

- "Wipe Before You Walk" (clean surfaces you have touched before you leave the room) and "The Light is Right" (having families/patients use the call light instead of coming out into the hall and unit looking for the nurses) initiatives
- Approval for two additional hand hygiene stations on the unit
- Replacement of trash bins on unit to bins with lids
- Transition to motion-sensor faucets
- Replacement of all bedside tables
- Development of admission education sheet
- Development of C-Diff education sheet

Performance Management and Improvement Directed

- Daily reports of any patients being admitted with prior C-Diff occurrence, which increases vigilance and places patient on contact isolation based on symptoms
- Scripting for EVS to facilitate room cleans on all rooms with support from nursing
- Scheduling of C-Diff huddles and development of action plans
- Development of Tableau (electronic) dashboard to trend rates, identify room assignment during occurrence which correlates location of infections

Infection Prevention, Infectious Disease Team and Hematology Oncology Medical Leadership Directed

- Development of process to send stool for testing of colonization if there is a concern for specific patients or populations
- Development of antibiotic stewardship discussion with providers to attempt to prevent prescribed antibiotic regimens from contributing to C-Diff occurrence

Since the implementation of the changes in nursing practice and approach to patient care and the continuous support of the Nursing Administrative Director through assistance of procuring resources (financial and personnel) to support environmental changes, the C-Diff incidence rate has decreased to less than 25 by July 2015. These strategies have resulted in a sustainable practice that currently continues and has been ingrained in the culture of the unit and therefore directly impacts the quality of care that is provided and positive healthcare outcomes.

Participants

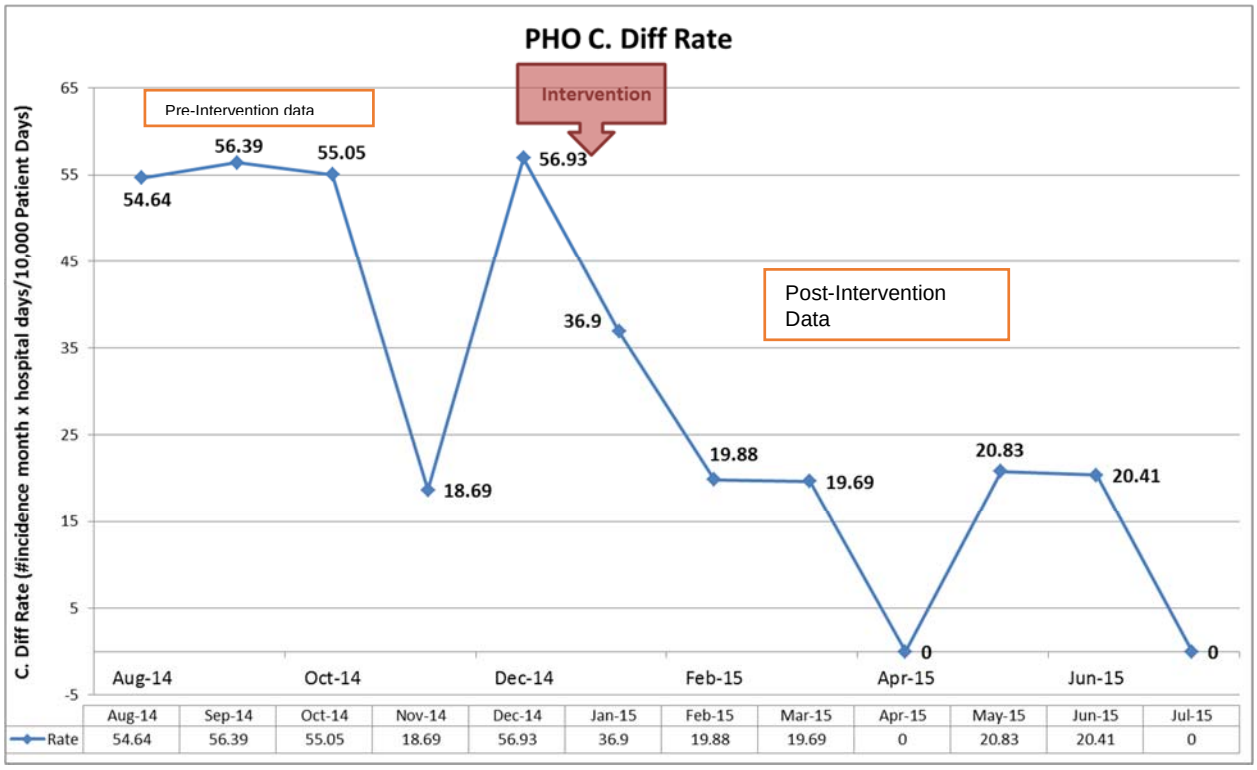
Name	Credentials	Role in Organization	Practice Area	Role on team
Connie Ford	BSN, MHA, RN, NEA-BC	Administrative Director	Inpatient Nursing	Nurse Leader
Roderic Armstrong	MSN, RN, CPN	Manager	Pediatric Hematology Oncology	Member - Development of educational sheets and staff roll-out; Monitor progress of work and status of action

				items; Staff education
Amanda Hart	BSN, RN	Clinical Nursing Staff	Pediatric Hematology Oncology	Member - Development of educational sheets and staff roll-out; Staff education
Hannah Chouanard	BSN, RN	Clinical Nursing Staff	Pediatric Hematology Oncology	Member - Development of educational sheets and staff roll-out; Staff education
Valerie Herndon	BSN, RN	Clinical Nursing Staff	Pediatric Hematology Oncology	Member - Development of educational sheets and staff roll-out; Staff education
Rebecca Warren	BSN, RN	Clinical Nurse; Unit Quality Improvement Analyst	Pediatric Hematology Oncology	Member- Interviews with staff that interacted with patients with new C-diff occurrence; Development of educational sheets and staff roll-out; Staff education
Cassandra Reed		Environmental Services Specialist	Pediatric Hematology Oncology	Member – Identification of opportunities for improvement from EVS perspective; with corresponding implementation of suggestions by group.
Howard Katzenstein	MD	Oncology Medical Director	Pediatric Hematology Oncology	Oncology Medical Director Sponsor
Deb Friedman	MD	Division Director	Pediatric Hematology Oncology	Hematology Oncology Division Director Sponsor
Carrie Kitko	MD	Stem Cell Transplant Medical Director	Pediatric Hematology Oncology	Stem Cell Transplant Medical Director Sponsor
Tanya Boswell	MSN, RN, CIC	Infection Prevention Specialist	Infection Prevention	Member – Leader of C- diff huddles, collation of opportunities of improvement, facilitated conversation regarding next step.
Patricia Throop	RN, BSN, CPHQ	Quality Consultant	VCH Performance Management and Improvement	Member – Leader of C-diff huddle session, development of EVS scripting, follow up regarding actionable items to ensure completion.
Greg Wilson	MD	Associate Professor of Clinical Services	Pediatric Infectious Diseases	Antibiotic Stewardship strategies in addition to researching literature regarding consolidation providing recommendations

Cecila DiPentima	MD	Associate Professor	Pediatric Infectious Diseases	Antibiotic Stewardship Strategies
Gale Thomas		Health Systems Database Analyst III	Quality, Safety and Risk Prevention	Development of Tableau system for tracking of infections and hand hygiene compliance
Meg Rush	MD	Chief Medical Director	VCH Executive Administration	Executive Sponsor
Jim Hollender	MBA	Associate Hospital Director	VCH Executive Administration	Executive Sponsor
Autumne Bailey	MSN, RN, PCNS-BC	Administrative Director, PM&I	VCH Administration	Executive Sponsor
Anita Adams		Supervisor	Environmental Services	Development and implementation of deep cleaning schedule, including unit rounding
Sharon Boyd		Manager	Environmental Services	EVS Sponsor
Mary Tharpe		Manager	Admitting/ED Registration	EVS Sponsor
Vickie Thompson	MSN, RN	Manager	MCJCHV Nursing, Sr. Nursing Projects	Order placement of 2 additional hand hygiene stations, trash bins, motion detected water faucets and new bedside tables.

Outcome

The C. Diff monthly rate decreased to less than 25 by February 2015 and has remained consistently below this goal through July 2015.


PHO C. Diff Rate
Intervention
Pre-Intervention data
Post-Intervention Data
C. Diff Rate (#incidence month x hospital days/10,000 Patient Days)
65
55
45
35
25
15
5
-5
54.64
56.39
55.05
18.69
56.93
36.9
19.88
19.69
0
20.83
20.41
0
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15
Rate 54.64 56.39 55.05 18.69 56.93 36.9 19.88 19.69 0 20.83 20.41 0