Welcome to the inaugural edition of the Elliot Health System (EHS) Nursing Annual Report! I am pleased and proud to have this opportunity to showcase nursing excellence throughout the system and to highlight some of the many initiatives underway to enhance patient outcomes and strengthen our professional practice environment. It has been exciting and fulfilling to be a part of the tremendous forward momentum that I have experienced at Elliot since assuming my role in January of 2009. This is a time of unprecedented challenge and opportunity for healthcare providers everywhere. Nurses in all roles and settings across EHS are stepping forward to meet those challenges and maximize the opportunities to create the best possible future for our patients and our profession. Nursing’s full engagement in each of the many exciting initiatives related to the expansion of Pediatric Services is but one example that reflects the high level of professional commitment that defines the Elliot nurse.

Open, active lines of communication between direct care nurses and nursing leaders are more important than ever. We resumed participation in the National Database of Nursing Quality Indicators (NDNQI) in 2009. Elliot data from the NDNQI RN Satisfaction Survey and details emerging through subsequent “deep dive” analysis sessions have enabled us to prioritize our improvement efforts based on feedback from direct care experts at the bedside. The “Ask Executive Nursing Leadership” online forum is gaining popularity as a means for nurses to pose questions pertaining to patient care or professional practice 24/7. Most recently, the Clinical Nurse Managers have implemented twice monthly Leadership Rounds on the night shift. Numerous initiatives and advances highlighted on the pages to follow are rooted in the ideas and suggestions of Elliot nurses offered through these venues.

Our story would be far from complete if I failed to acknowledge the exceptional interdisciplinary and interdepartmental partnerships evident throughout the system on a daily basis. As clinicians we are all truly interdependent, and no one discipline can stand alone in achieving optimal patient outcomes. We also rely upon a wide array of ancillary support and administrative services to ensure smooth operations. Time and again, I have been witness to stellar examples of patient focused collaboration between nurses, physicians, members of all other clinical disciplines and non clinical departments. As a team we have made tremendous progress towards breaking down the silos that have traditionally hampered optimal use of our collective wisdom for the betterment of patient care.

On a special note, I would like to extend my sincere appreciation to all Elliot nurses for the outstanding care provided to thousands of patients this past year. I am truly honored to be part of such a skilled and caring team.

As you review the pages of this annual report, I encourage you to appreciate not only our accomplishments, but equally as important the spirit of caring, pride and commitment that has been captured in so many photographs of Elliot nurses and colleagues. As the saying goes, “a picture is worth a thousand words.”

Beth Hale Campoli, MS, RN
Vice President Patient Care Services and Chief Nursing Officer
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On January 12, 2010, several hundred EHS staff, medical staff and board members stopped by a day long kickoff event to mark the official start of Destination Excellence, Elliot’s journey to achieving Magnet® Recognition. The Magnet® Recognition Program® was developed by the American Nurses’ Association in 1990 to recognize healthcare organizations that demonstrate a level of excellence in nursing practice. The first Magnet® designation was awarded in 1994, and since then over 350 healthcare organizations across the country and internationally have achieved this recognition. While there is no single best “roadmap” to achieving this goal, many organizations have learned over the years that Magnet® designation is truly a reflection of the quality of care, services and the work environment throughout an entire organization, not limited to nursing.

The Destination Excellence logo was designed to represent Elliot’s goal to utilize the Magnet® standards, known as “Sources of Evidence,” as a framework to elevate and exemplify the practice of all who play a role in providing care and services to all of our patients. “Today we see countless examples of excellence in all aspects of our daily operation and practice,” states Joanne Welch, MS, RN, NE-BC, Director, Nursing Practice, Education and Research. “Regardless of a staff member’s role, Destination Excellence is about exceptional patient outcomes, each individual’s role in providing excellent care and services and the work environment that helps to make that excellence possible,” she adds. The overarching theme of the Destination Excellence kickoff was the importance of partnership among all disciplines as Elliot strives to achieve, demonstrate and sustain a level of excellence that will enable us to earn public recognition as a Magnet® organization.

“The Magnet® Recognition Program® provides us with an ideal framework not only to elevate the practice of all nursing staff, but also to achieve true integration as an interdisciplinary team in striving to provide the best possible care to our patients,” states Beth Hale Campoli, MS, RN, Vice President Patient Care Services and Chief Nursing Officer. “It has been very exciting to see a tremendous level of support and engagement as we begin this journey,” she adds.

Following the main kickoff, a special event was held for Elliot Physician Network staff on the evening of January 28. The event included a presentation on the Magnet® Recognition Program® as well as an opportunity for staff to discuss the application of selected Magnet® standards to the physician practice setting. The event was very well attended by EPN/EPS staff in all roles and there was great enthusiasm among the participants.
As discussions were underway to officially begin Elliot’s journey to Magnet® Recognition, two intense, half day sessions were held to examine the organization’s strengths and opportunities in relation to each of 88 "Sources of Evidence" required by the Magnet® program. “The Gap Analysis provided a great opportunity for us to collectively identify many strengths and accomplishments that we are proud of, as well as some of the areas where we need to intensify our efforts in the months and years to come,” states Beth Hale Campoli, MS, RN, Vice President Patient Care Services and Chief Nursing Officer.

Session One of the Gap Analysis was conducted with the Nursing Leadership team. Many members of the Medical Staff and interdisciplinary team joined the group for Session Two, which focused on the Sources of evidence related to interdisciplinary collaboration, quality improvement and patient safety. “Our philosophy at Elliot is that the journey to Magnet® Recognition should be truly interdisciplinary,” states Joanne Welch, MS, RN, Director, Nursing Practice, Education and Research. “The participation of several key physicians and other members of the interdisciplinary team was invaluable. Everyone was incredibly engaged, and their input added a whole new dimension to our action plan,” she adds.

Following the Gap Analysis sessions “speed huddles” were held throughout the house and on each shift to gather input on priority Sources of Evidence selected by direct care RNs. An overview of the Gap Analysis findings is currently posted on the Destination Excellence page of IKE, the EHS intranet.
DEPARTMENT EXCELLENCE

CO-LABORATION

NURSING ANNUAL REPORT
Communication: The Key to a Safe and Healthy Work Environment

Nursing and healthcare leaders in general are being challenged as never before to implement effective communication strategies in our increasingly fast-paced, highly complex environment. During two process improvement activities over the course of the past several months, “Speed Huddles” conducted as a part of our Magnet® Gap Analysis and “Deep Dives” to identify priorities and develop action plans regarding our NDNQI RN Satisfaction Survey results, a consistent theme emerged. Frontline nursing staff shared that there were opportunities to improve communication. Based on this feedback, two strategies have been implemented, an “Ask Executive Nursing Leadership” (Ask ENL) Q&A Forum on IKe, and formal nursing leadership rounds. “Ask ENL provides an opportunity for a nurse on any shift, at any location, to pose a question to a specific member of the executive Nursing Leadership Team or generically to the group. Our focus has been on questions pertaining to nursing practice, and our goal is to post a response within two weeks. Some questions have been more complex than others, requiring consultation with other departments or individuals outside of nursing,” explains Beth Hale Campoli, MS, RN, Vice President Patient Care Services and Chief Nursing Officer. “The site has gained popularity as a supplement to our face-to-face communication, certainly not a replacement,” she adds.

In order to help ensure that frontline staff has regular access to the nursing leadership team and opportunities for face-to-face communication, especially during off shift hours, the Clinical Nurse Managers implemented Leadership Rounds in April. Pairs of managers will be in house twice monthly from 12 midnight to 4 AM, devoting the first portion of their time on their respective units and the remaining time to rounding house wide as a team. “Leadership Rounds will provide a wonderful opportunity for us to get to know staff from other units and hear what’s on their minds. Staff will get to know us as well which will be a benefit as we cover for each other. I’m really looking forward to open dialogue and proactive sharing,” states Carol Long, MS, RN, PCCN, Clinical Nurse Manager, CICU.

In addition to Leadership Rounds, Beth has implemented a more formalized schedule of rounding with members of the Executive Nursing Leadership team and also rounds on occasion with other members of the Senior Leadership team. “Two-way communication is critical to the success of any endeavor we undertake,” she adds. “The voice of frontline staff is essential in order to provide excellent patient care. Lines of communication must be open and accessible for that voice to be heard.”
Spotlight Award 2009: Exceptional Elliot Nurses

Each year during national Nurses’ Week EHS recognizes Elliot nurses whose pride in the nursing profession shines through in all that they do. On May 12, 2009, seventeen Elliot nurses were presented with Spotlight Awards at a special tea reception attended by colleagues, family members and members of the Nursing and Senior Leadership teams. Those in attendance also had the pleasure of sharing this special event with several members of the Elliot Hospital School of Nursing Alumni Association.
Congratulations to the following 2009 recipients:

**PASSION FOR NURSING**
- Sherina Otero, RN  
  Medical Surgical Services
- Heidi Kuhn, RN  
  Critical Care
- Sharon Breidt, RN  
  Emergency Services
- Susan Nicholls, RN  
  Women’s Children’s Health
- Carol York, RN  
  Elliot Physician Network
- Sarah Bemish, RN  
  Behavioral Health
- Leah Chandler, RN  
  VNA Personal Services

**EXPERT PRECEPTOR**
- Catherine Burpee, RN  
  Medical Surgical Services
- Gail MacKinnon, RN  
  Critical Care
- Jennifer Thompson, RN  
  Emergency Services
- Cynthia Sokul, APRN  
  Elliot Physician Network

**NOTABLE NOVICE PRACTITIONER**
- Lindsey Paciello, RN  
  Medical Surgical Services
- Kara Doberstein, RN  
  Critical Care
- Michelle Baca, RN  
  Emergency Services
- Nicole Gamester, RN  
  Behavioral Health

**CRITICAL CLINICAL SUPPORT**
- Elizabeth Williams, RN  
  Social Work/Case Management
- Stacy Merrill, RN  
  Information Technology

And Kudos to the Following EHS Nurses for Clinical Advancement in 2009:

- Pamela Bedford, RN, C, NIC, NICU – CN IV
- Aimee Ingalls, RN, Fuller Unit - CN III
- Maureen Lemay, RN, NICU – CN III
- Deborah Pothier, RN, CNOR, Elliot 1 Day Surgery - CN III
- Diane Sweeney, RN, ICU – CN III
INSPIRATION
Nursing Across Elliot Health System...

- Over 900 Registered Nurses, including Advanced Practice RNs (APRNs)
- 38 Licensed Practical Nurses
- Highest Level of Educational Preparation:
  - 13% hold a Diploma in Nursing
  - 42% hold an Associate's Degree in Nursing
  - 35% hold a Bachelor’s Degree in Nursing
  - 4% hold a Bachelor’s Degree in another field
  - 5% hold a Master’s Degree in Nursing
  - 0.9% hold a Master’s Degree in another field
  - 0.1% hold a PhD
- Close to 200 RNs hold national certification in one or more specialty areas
Specialty Certification: A Hallmark of Professional Commitment

As of April 2010, Elliot Health System proudly recognizes close to 200 registered nurses who have achieved certification in their areas of specialty practice. This represents a 50% increase over the course of the past few years, a remarkable statistic given the time and effort involved in achieving and maintaining certification.

National or international nursing certification is a reflection of significant commitment to ongoing professional development and excellence in one’s specialty. Prior to sitting for a rigorous exam, the nurse who decides to pursue certification must meet minimum eligibility criteria which typically include years of experience and education within the specialty. “Awaiting results reminded me of waiting to hear if I had passed my RN licensure exam,” recalls Deb Bell-Polson, MS, RN, Clinical Nurse Manager, Maternity Services. Deb recalls a favorite quote from a Maternity Center RN. When congratulated on her new certification, she replied, “Thank you, I am so proud. This is one of the first things I have done just for myself in a long time. It shows how far I have come in my professional life.”

Tina Lorenz, RN, BCG, Clinical Leader, Geropsychiatric Unit, comments, “I view certification as an indication of pride in ownership of my profession. It enhances my sense of accomplishment as well as certainty that I am well qualified to provide the best possible care to our patients on GPU.”

Once achieved, certification must be maintained through an ongoing process which typically involves continuing education, and may also involve meeting other designated criteria and/or retesting at specific intervals. It is this kind of dedication and commitment that will help to transform healthcare as we know it.

There are multiple professional bodies that offer specialty certification for nurses. One of the most well known and recognized is the American Nurses’ Credentialing Center (ANCC), a subsidiary of the American Nurses’ Association. ANCC, along with numerous other specialty organizations, offers certification in dozens of nursing practice arenas. A nurse may hold multiple certifications depending on his or her role and areas of expertise.

Over her twenty years as a nurse at Elliot Hospital, Deb notes, there has been a significant increase in focus, support and recognition related to certification and she views this as a reflection of growth in the profession. This support has helped nurses to prepare for and successfully complete the certification exam. Recent efforts in support of certification have included increased educational offerings and the availability of the CE Direct online learning product. The level of support provided demonstrates an organizational commitment to professional development and a high regard for maintaining quality care.

“Above all, the greatest benefit of certification is the growing evidence that it contributes to better patient care,” states Joanne Welch, MS, RN, NE-BC, Director, Nursing Practice, Education and Research. “It is a tangible expression of our accountability for ongoing professional growth.”

Please join us in saluting our nationally certified RNs!
CERTIFICATIONS

ANN M. ADAMS, RN, CAPA
DEBORAH ALLEN, RNC-OB, EFM
DELLA AMBROSE, RN, C, NIC
BETTY-JANE ANZ, RN, CDE
CHANDAR ARGERIOU, RNC-OB
SHERYL BANUSKEVICH, RNC, MNN
CYNTHIA BAXTER, RNC-OB
PAMELA BEDFORD, RN, C, NIC
LISA BEERNAERT, RN, OCN
LUCYNE BELANGER, RNC-OB
DEBORAH BELL-POLSON, RNC-OB
PAULA BENNETT, RNC-OB
LYNDA BERNIER, RN, CCRN
KATHLEEN BOWDMAN-FEENEY, RN, CNOR
SYLVIA BORTZ, RN, C, NIC
DIANE BRACE, RN C M
MARGARET BREW, RN, C T
PATRICIA BROWN, RN, BC, PM
SANDRA BUCKLEY, RN, CNOR
WENDY BURBINE, RNC, MNN
MARY BURDET, RN, C, NIC
LYNDA CAINE, RN, CIC
CHRISTINE CAMPANELLA, RN, CNOR
KAREN CARDOZA, RN, CCRN
RHONDA CARMODY, RNC-OB, EFM
YVONNE CARROCCINO, RN, C C
SUZANNE CASHIN, RNC, MNN
MICHELLE CHALIFOUR, AE-C
CAROL CHAMBERLAND, RN, C P/M
KRISTINE COLLINS, RN, CAPA
COLLEEN CORRIEVEAU, RN, C, NIC
TRACEY CROTEAU, RN, CPEN
INA CRUITE, RN, CNOR
KATHLEEN CULLEN, RN, PCCN
CHRISTINA DAWSION, RN, CCRN
Sylvia DEFEO, RN, CCRN
LISA DEMOS, RN, CCRN
DIANE DESMARais, RN, CNOR
DENISE DOHERTY, RN, CPN
LAURA DOLLOFF, RN, CCRN
LINDA DOUVILLE, APRN, BCG
SUZANNE DOWD, RN, C T
KATE DUBOS, RN, CCRN
PAMELA DUKE, MS, RN, CNOR
AMY DUMONT, MSN, RN, CCRN
ELLEN EDES, RN, IBCLC
VALERIE ELFRETH, RN, CPN
WENDY ENGLAND, RN, CCRN
REGINA FALTADO, RN, C NIC
ANNE FRECHETTE, RN, CCCRN, MNN
JUDITH FREITAS, RN, CEN
NANCY FRIEDBERG, RN, CCRN
LINDA GAGNE, RN, CPN
MARY ANNE GARRITY, RN, CEN
JENNIFER GAUDRET-ESSENWINE, RN, CNOR
DEBORAH GIFFORD, RNC-OB, EFM
ROBERT GIROTTI, RN,C
CLARICE GIROUDARD, RN, CCRN, CPAN
WENDY GODDARD, RN, CNOR
DEBRA GRANT, RNC-OB
CYNTHIA GRAY, NEA-BC
KIM GRANT-NEARY, RNC-MNN
MICHELLE GRANVILLE, RN, BC, MS
LINDA GREEN, RNC-MNN
LAUREN GREENE, RN, ONC, CNOR, CRNFA
MELISSA GREGOIRE, RNC-OB
JENNIFER GROULX, RN, C M
CAROL ANN GUERTIN, RN, C M
JANET GUTNER, RN, BC, CA
JOYCE HAGGETT, RN, CNOR
KRISTINA HANSON, RN, C, NIC
MAUREEN HARGREAVES, RN, COHN/CM
FLORENCE HAWES, RN, CCRN
ANN HEBERT, RNC-MNN, IBCLC
PAMELA HEGGLELAND, RN, BC G, CNOR
KELLY HEINDL, RN, C NIC
DONNA HEVERN, RN, C M
KELLIE HINES, RNC-OB
CERTIFICATIONS CONTINUED

AMIE HOLT, RNC-MNN
THERESA HOUSTON, RN, IBCLC
REBECCA HURLBERT, RNC-OB
KRISTINE IRWIN, MSN, RN, BC N
SHIRLEY JACKSON, MSN, RN, CCRN, CCNS
ELIZABETH JACQUES, RN, PCCN
ANN JANIAK, RN, BC MS
SERENA JAWORSKI, RN, PCCN
JASONNE JEANNETTE, RNC, COHN-S
KIM JEANTY, RN, PCCN
ANGELA JOHNSON, RN, CNOR
KATHY JORDAN, RN, CRNI
TANYA KAMPHUIS, RNC-OB
CARLA KANE, RNC-MNN
CHRISTINE KAUFMAN, RNC-OB
MARY ELLEN KING, RN, CPN
KATHERINE KING, RN, CCRN
SUSAN KLEIN, MSN, APRN, PMHNP-BC
MICHELLE KLEINER, RN, CCCE
PATRICIA KREBS, RN, C T
CHERYL LAFERRIERE, RN, CNOR
CELESTE LAFOND, RN, C NIC
KATELYN LAMONTAGNE, RNC-OB
HANNAH LANDRY, RNC-MNN
THOMAS LAROCHELLE, RN, CCRN, CEN
SUSAN LAVERTU, RNC-OB
ANDREA LEE, MSN, RN, CCRN
MARY LEIDEMER, RN, CRNI
MARTHA LEIGHTON, MS, RNC
KATHYRN LEVESQUE, RN, CPN
CAROL LONG, MS, RN, PCCN
THERESA LORENZ, RN, BC G
LINDA LOVELL, RNC-OB
CYNTHIA LULA, RNC-MNN
KAREN LUTZ, RN, CEN
ELIZABETH MACLELLAN, RN, CCRN
MICHELLE MALETTE, RNC-OB, RNC-MNN
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MICHELE MCMURRAY, SANE-P
MELINA MCNAUGHT, RN, C NIC
DEBORAH MICHAUD, RN, CEN
CYNTHIA MILLS, RN, CNOR
KELLY MOLINARI, RN, C T
COLEEN MOLONEY, RN, IBCLC
SUSAN MOORE, RN, CEN
DONNA MORRILL, RNC-OB
JOANNE MORSE, RNC-LRN, RNC-OB, EFM
SIRI MOSHER, RN, CCRN
SUSAN NICHOLLS, RNC-MNN
NANCY NOGA, RN, C T
KAREN O’DONNELL, RN, CAPA
MICHELLE O’KEEFE, CLC
SALLY O’NEILL, RN, COHN-SCM
AMANDA ORTIZ, RNC NNP
CHERYL OUTLAW, RN, CPN
ALISON PALMER, APRN, RNC W
STEVEN PARADIS, RN, OCN
UZANNE PARODI, RN, IBCLC, CCCE, RNC-MNN
KAREN PARR DAY, MSN, RN, CCRN
JOYCE PEARSSALL, RN, C NIC
LORI PELLETER, RN, CAPA
JANE PETERS, RN, CPN
ELIZABETH PHELPS, RN, BC MS
MARC PHILLIPS, RN, C P/M
STEPHANIE PIET, RNC-OB
DEBORAH POTHER, RN, CNOR
SHARON POWERS, RN, CAPA
NANCY PRESTON, RNC-OB
GAIL PRITCHARD, RNC-MNN
KRISTIN PROCTOR, RNC-OB
NANCY RAMIREZ, RN, IBCLC
JANET REAGAN, RN, BC MS
JEANNE REED, RN, CNOR
CHRISTINA REYNOLDS, RN, CCM
KIMBERLY ROGERS, RNC-OB
LORRAINE ROY, RN, BCP
KAREN RYAN, RN, CCRN
JANE SARGENT, RN, CWCN, CHRN
CERTIFICATIONS

JENNIFER SCHWARTZ, RN, CGRN, CRNI
MICHELLE SCOTT, RN, IBCLC
BARBARA SCULLEN, RN, CCRN-N, RN, C NIC
SANDRA SHEERAN, RN, CDE
JANE SHERWIN, RN, PCCN
DIANA SHIRLOCK, RN, CEN
JANE SIEFKEN, RNC-OB
CATHERINE SKOBY, RN, C NIC
REBECCA SMALL, RNC-OB
BARBARA SMITH, RN, CNOR
BRENDIA SMITH, RNC-OB
NANCY SNELL, RNC-MNN, IBCLC
JANE SOBOLOV, RN, C P/M
NIMFA SOBOZENSKI, RNC-MNN
PATRICE SPICER, RN, CGRN
HEIDI ST. HILAIRE, RN, C P/M
DAWN STEVENS, RN, CNOR
MARY SULLIVAN, RN, CPN
THOMAS SZOPA, MSN, RN, CWON
DARBY THOMAS, RN, C P
KATRINA THOMPSON, RNC-MNN
ERIN TROTT, RN, CNOR
MICHÉLE TURNER, RNC-OB
PAMELA URICK, RNC-MNN
REBECCA VAILLANCOURT, RN, CCRN
JENNIFER VATTES, RNC-OB
SUSAN VERMETTE, RN, CT
MIA VOVERIS, RN, BC, MS
JEANETTE WALSH, RN, CCRN
JENNIFER WARANOWSKI, RN, CPN
ANDREA WASZCZUK, RN, C NIC
JOANNE WELCH, MS, RN, NE-BC
KATHLEEN WILEY, APRN, BC
ELAINE WILK, RN, BC PE
LINDA YELL, RNC-OB
PIA ZASLOWE, RNC-MNN
CORINNE ZE MAN, RN, CEN
Nursing Scholarships Sponsored by the EHS Medical Staff

Thanks to the generosity of the EHS Medical Staff, (5) $1000 scholarships were awarded to EHS nurses in 2009. Eligibility requirements included enrollment in an education program leading to a Baccalaureate or higher degree in Nursing or a Healthcare related field and a minimum of one year of employment at EHS. Each applicant submitted an essay addressing his or her philosophy of nursing, and how skills and knowledge gained through the program would be utilized to support the mission of Elliot Health System. Recipients were selected by a panel of direct care RNs, nurse leaders and physicians. “The provision of this scholarship is a tangible reflection of tremendous support on the part of medical staff to advance nursing practice,” stated Beth Hale Campoli, MS, RN, Vice President Patient Care Services and Chief Nursing Officer. “It is professionally rewarding to experience the benefit of such a strong partnership between Nursing and Medicine,” she added.

The Medical Staff sponsored scholarships were first offered in 2008, and the application process for 2010 is underway at the time of this publication.

CONGRATULATIONS TO THE 2009 RECIPIENTS!

Jana (Mitchell) Pirie, RN
Operating Room

Bryan Fisher, RN
Geropsychiatric Unit

Laura Dolloff, RN
Intensive Care Unit

Deborah Beck, RN
Fitch Unit

Eva Barger, RN
Fuller Unit
Enhanced Access to Continuing Education for EHS Nurses

Elliot Health System supports and promotes the growth and continuing development of the nursing staff via several different channels. “This year we have seen the implementation of two endeavors that allow nurses from all EHS departments to meet their education needs for licensure and professional development” recalls Yvonne Carroccino, RN, Unit Educator of the Cardiac Intermediate Care Unit and co-chair of the Clinical Nursing Council. Both endeavors were implemented in direct response to requests from nurses for increased access to continuing education opportunities.

The first endeavor is access to CE Direct, an online learning resource offered through Nursing Spectrum. EHS nurses have the ability to access a vast array of courses and acquire contact hours at no personal cost. “CE Direct allows nurses to learn at their convenience; the courses are accessed through the Internet,” explains Kris Irwin, MSN, RN, Manager of Nursing Practice and Education. The ease and convenience of accessing the courses allows nurses to find interesting and informative programs; CE Direct gears learning toward individual needs.

The second endeavor is the development of the Education Council, a subgroup comprised of representatives from Clinical Nursing Council. The Education Council has developed a process in which a nurse can submit for funding, provided by Fitch Funds, to attend a one-day workshop. Hazel Fitch, RN was a Superintendent of Nursing at the Elliot Hospital from 1929-1933. Upon her death in 1973, her husband Leon followed her wishes in creating a trust; the income from which would be used to encourage and improve the skills and abilities of the nurses at the hospital. The council reviews each application, which must speak to how the nurse will share knowledge gained with others through a “pass it forward” type of process, by conduction of a class, poster presentation, or provision of some other creative mechanism. By utilizing a process implemented by peers, a nurse may have the opportunity to attend a workshop that they may not have been able to afford. Cynthia Gray, RN, Elliot Physician Network Clinical Nurse Educator and co-chair of the Education Council states “This endeavor results in patient care being provided by a knowledgeable, committed nursing workforce.”

“Promoting learning, and the opportunity to do so, enhances the quality and performance of all nurses. We are very fortunate to have resources that allow us to grow within our profession. As we continue to learn and grow as professionals we remain committed to our patients, and to providing the best in nursing care,” affirms Ellen Murphy, RN, Post Anesthesia Care Unit nurse and co-chair of Clinical Nursing Council.
**Simulation:**
Using State-of-the-Art Technology to Enhance Clinical Competence, Teamwork and Patient Safety

Nurses and other clinical staff at Elliot Health System are fortunate to have access to two simulation labs: one on the first floor near Radiology and another on the third floor near Labor & Delivery. Nurses are able to interact with the manikins (Sim Man, Noelle, and Baby Hal) in response to scenarios. “Simulation is more than high tech equipment. It is about providing a safe environment for staff to practice clinical scenarios, work as a team and, most importantly, reflect on and analyze their actions,” explains Shirley Jackson, MS, RN, CCRN, CCNS, Critical Care Clinical Nurse Specialist.

The Institute of Medicine’s 2000 report, “To Err is Human: Building a Safer Health System” suggested that close to 90% of all medical errors result from failed systems and procedures. The Joint Commission cites team training as an essential factor in reducing the risk of medical errors.

The Clinical Simulation lab has been used in competency days. The nursing staff found the scenario with a tracheotomy patient to be helpful and rewarding. “The simulation gave us an opportunity to recognize when the patient was in trouble, and to work as a team to rectify the situation. It was a highly valuable experience,” states Anita Critz, RN, Clinical Leader on the Cardiac Intermediate Care Unit.

Nurses in the Transition to Practice program for new graduates attend several education days throughout their first year of nursing practice; education is provided both in a classroom setting and in the simulation labs. New nurses faced with a simulated clinical scenario have the opportunity to apply critical thinking skills in a non-threatening environment. “Simulation is a key component of the Transition to Practice program,” explains Kris Irwin, MSN, RN, BCN, Manager of Nursing Practice and Education.

The simulation lab in the Maternity Center is regularly used for interdisciplinary simulation drills. By the end of FY ’10 (June 2010) 75% of all team members that care for patients in the Maternity Center will have participated in at least one simulation drill. “Simulation in Labor & Delivery at the Elliot focuses on team performance, not individual performance. Through simulation and team training we have been able to practice emergency situations the way we want to perform when they actually do happen” describes Martha Leighton, MS, RNC-OB, Clinical Nurse Specialist, Maternity. “I think it is helpful that the nurses understand what the doctor is trying to do in an emergency and that the doctors understand what the nurses are trying to do. Simulation has accomplished this,” commented a nurse after participating in a scenario.
Transforming Care at the Bedside (TCAB): EHS Fuller Unit chosen to participate in nationwide two-year program 2009-2011.

In 2001, the Institute of Medicine published Crossing the Quality Chasm: A New Health System for the 21st Century, which recommended that our healthcare system be redesigned to be more patient-centered, safer, effective, efficient, timely and equitable. Research has shown that the majority of errors in hospitals result from badly designed systems of care. For example, communication among healthcare providers and between departments can break down, work flow processes have too many steps, and the work space is not well-organized, requiring that nurses spend time “hunting and gathering” equipment and supplies that are inconveniently located and/or inadequate. The result is that nurses spend more time doing paperwork and other tasks, and less time caring for patients and families at the bedside. Increasing the time nurses spend with patients decreases errors, and gives nurses more time to better assess the patient’s condition, to teach and counsel patients and families about the illness, medications, and treatments, and to support patients and families emotionally. The result is better quality care, improved patient satisfaction and improved nurse satisfaction.

In response to these challenges, the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement (IHI) developed the Transforming Care at the Bedside (TCAB) initiative in 2003. Transforming Care at the Bedside has four themes: patient-centered care, safe and reliable care, vitality and teamwork, and value-added care processes. Its goal is to empower nurses and other front line staff on medical/surgical units to redesign work processes in order to improve the quality of patient care. In 2007, the American Organization of Nurse Executives (AONE) took the lead with an initial group of 67 hospitals nationwide.

In April 2009, the Fuller Unit, a medical/surgical unit in the Elliot Health System, was chosen to be in the second group of hospitals. Pauline Turner, MS, RN, the Clinical Nurse Manager on the unit is the project leader. The program involves attending national conferences at intervals throughout the two-year program, plus monthly conference calls with other participating hospitals. Our aims are to improve the patient experience at the Elliot Hospital, enhance the professional development of our front line nursing staff, and to standardize how interdisciplinary staff communicates with one another.

Some of the strategies that the Fuller Unit has implemented include: having RNs and MDs round together at the patient’s bedside, including the patient and family in the discussion; adding an admission nurse to the afternoon shift to admit patients while nurses continue to care for their patients; placing a computer in every patient room to decrease the time nurses spend looking for a computer on wheels; and developing a system for making the nurses’ daily patient assignment based on how sick the patient is and not just on the number of patients the nurse will care for, as sicker patients require more time.

Other activities related to TCAB have been time-motion studies of the nurses in order to determine the percent of time that the nurses spend at the bedside as opposed to non-patient related tasks. The staff on Fuller Unit also completed a team vitality survey. Each month Clinical Nurse Manager Pauline Turner files reports with AONE about the number of patients on the unit who have been injured after falling, the number of admissions and inpatient days, and the prevalence of pressure ulcers among patients. The Fuller Unit nursing staff have stated that they “are very excited about being part of this new opportunity. TCAB is giving us the ability to make decisions, implement changes and improve the effectiveness of the entire care team.”
Unit Practice Council activities: selected highlights

Unit Practice Councils (UPCs) are composed of RNs, LNAS, aides and unit secretaries who form the core work teams on clinical units. UPCs develop a playbook for how they structure the work of their group, such as meetings, membership and how decisions are shared with the nurse manager and staff of the unit. They use a systematic process for setting aims, developing and implementing strategies, and measuring outcomes. Here are some highlights.

Cardiac Intensive Care Unit

The UPC meets every other week for two hours. In early 2009 a whiteboard initiative was launched in an effort to improve communication about daily patient care among staff, patients and family members. From that grew a short list of goals, such as identifying how much assistance a patient needs to get out of bed or what tests the patient is scheduled for that day. The UPC consulted with the unit staff in person again and again, and with some patients, to develop a standardized layout of the whiteboards and rules for their use, so that the posted information was most accurate and effective in delivering consistent patient care. An implementation date was set, staff was prepared, and results were audited. The UPC and nurse manager Carol Long are currently working together to purchase new boards.

Endoscopy

The Endoscopy Unit Practice Council is also a Clinical Microsystem team, by virtue of team members including nurse manager Jo-Ann O’Connell and Chris Daniak, MD. The team meets weekly for one hour. Over the past year, they have improved efficiency and increased the volume of cases by changing several workflow processes. For example, linen is delivered at the end of the day so that rooms can be set up the night before the 8 a.m. case is scheduled to begin. They have changed how they use the existing nursing staff, creating a role called the “nickelback” in the procedure room area of the unit. Color-coded tabs on procedure room doors indicate if the room is in use, needs prepping, or is ready for the next case. Working with the GI physicians, the team developed “rules of the road” regarding how patient scheduling decisions are made. The charge nurse is the traffic controller for the rules. Working with Joe Hyatt, MD from anesthesia, the team developed a process for handling certain delays. The team is working on its move to The Elliot at River’s Edge in April 2011. They plan to set criteria for which patients can undergo endoscopy at the ambulatory facility rather than at the hospital, and what processes need to be in place for this to work smoothly with referring physician offices.
Pediatrics
After a hiatus, the Pediatrics UPC reconvened in Spring 2010 and quickly settled on how they will structure their work flow. They have chosen a theme from their NDNQI deep dive assessment for their first initiative, which aims to clarify the roles and responsibilities of the clinical leaders and charge nurses regarding how staff assignments are made. They will begin by reviewing the policies for floating RNs to other units and for calling in “on call” staff. They meet every other week for about two hours.

Fuller Unit
Another unit regrouping this Spring was the Fuller Unit UPC. They also chose a theme from their NDNQI “deep dive” assessment for their first initiative, which is to improve communication regarding patient status among staff and with patients in order to increase patient satisfaction and safety. Their first strategy is hourly rounding by RNs and LNAs. They will consult with CICU about their implementation of hourly rounding, and have begun to develop a playbook.
EHS Professional Practice Model: I CARE

Healthy Work Environment

Professional Development

Shared Decision Making

Care Delivery System

Collaboration of Quality

Collaboration of Outcomes

Collaboration of Satisfaction

Care Quality

Innovate & Inspire

Adapt & React

P A T I E N T & F A M I L Y

Accountability

Efficacy & Effectiveness

Ethics of Integrity

N O T E S

D E S T I N A T I O N E X C E L L E N C E

I N N O V A T I O N

N U R S I N G A N N U A L R E P O R T
The Elliot Health System Professional Practice Model

The Elliot Health System Professional Practice Model was developed by a team of direct care clinicians representing all settings and clinical professional roles across the system. The model is a depiction of the professional values which guide all dimensions of our practice: Care Delivery, Professional Relationships, Professional Development and Shared Decision Making. The compass symbolizes our belief that practice consistent with these values will lead to safe, cost effective care, optimal clinical outcomes and patient satisfaction. The bidirectional compass points signify that a healthy, values based work environment supports and is in turn driven by excellent clinical practice and optimal patient outcomes. Our leaders are committed to and skilled in supporting all elements of a healthy work environment: communication, collaboration, participatory decision making, staffing to ensure appropriate competencies and fit, meaningful recognition and authenticity. Together we strive to ensure that the values herein are embedded within our practice culture.

Our Professional Practice Model is aligned with the Elliot Health System Code of Conduct, which provides the overarching structure within which we interact with patients, families, all health system coworkers and others.

Our Professional Values define who we are and what we do, and affirm our continual focus on the patient as the core of each discipline's practice. Our professional identity encompasses the commonalities we all share as healthcare providers as well as the unique perspectives of each distinct discipline. We commit as a community of healthcare professionals to strive to integrate these values in our daily practice, and to seek solutions when challenged by our healthcare environment or opportunities to improve.

The professional values which guide all dimensions of our practice are represented by the acronym I CARE:

Innovation and Inspiration
Challenge inspires us to seek innovative solutions. Our practice is evidence based and progressive. We are change agents and stewards of our professions for present and future colleagues, and those who will benefit from the care and services provided. We are partners in innovation, recognizing that our roles are interdependent and that optimal patient care is a team effort.

Collaboration and Continuity in Caring
We acknowledge and value the skills and strengths that each discipline brings to the care team. The art of being present is paramount in our interactions with patients and families, and also in our interprofessional relationships as we deepen our understanding of each other’s roles, contributions and challenges. Our greatest strength as a care delivery team lies in the diversity of our roles and in our ability to collaborate effectively in order to provide compassionate, seamless, holistic care to our patients. As members of the healthcare team, we each recognize our professional obligation to build and sustain open, trusting, inclusive interprofessional relationships which support optimal patient outcomes and a culture of patient safety.
The acronym I CARE CONTINUED

Accountability
Accountability is one of the hallmarks of professional practice and we hold it among our highest values. We are accountable to our patients for the quality of care and services we provide and for the manner in which they are provided. To that end, our Care Delivery Model is patient centric and provides a structure to ensure that each patient has access to the resources, professional expertise and presence necessary to achieve the best possible outcomes. We are accountable to our patients to ensure their safety to the best of our abilities, and to provide evidence based care which consistently meets or exceeds the relevant standards established by our professional organizations and regulatory agencies and other bodies of authority. We partner with our patients to ensure that they have the knowledge necessary to participate in decisions related to their care and to self-manage their health to the best of their ability.

We are accountable to our patients, ourselves, our colleagues, our professions and the organization for maintaining competency, a commitment to lifelong learning and the highest standards of clinical practice. Our professional development is interdisciplinary and team oriented whenever possible and appropriate.

We value the resources invested in our professional development and are accountable to develop others in return. We acknowledge and act upon our opportunities to improve, collaborate to problem solve, and celebrate our successes. Accountability implies full engagement in our professional practice and the conduct of our professional roles.

Respect/Role Modeling
We respect and are sensitive to the cultural and socioeconomic individuality of all with whom we interact in our professional roles, including patients and family members, coworkers and other healthcare providers. Our respect for others is reflected in our demeanor, our listening and communication skills and our efforts to be fully present in our interactions. We respect and acknowledge the unique strengths and skills that each individual brings to his or her practice, seeking to nurture the intrinsic motivators that inspire us to excellence. We recognize and respect the power we have to influence novice and aspiring colleagues and use that power to the betterment of our professions. We take pride in our roles as healthcare professionals and are mindful that each one of us represents our profession, our department and Elliot Health System in any professional interaction.

Ethics and Integrity
We recognize that membership on the healthcare team is a privilege, maintained in part through constant adherence to the codes of ethics and professional standards which guide our practice. The mandate to uphold ethical principles lies at the core of every patient/clinician and professional interaction.

1 American Association of Critical Care Nurses, AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence, 2005.
Building a Culture of Excellence: 
Designing the Elliot Health System Professional Practice Model

In January of 2010, a team of front line clinicians representing all disciplines and settings throughout Elliot Health System embarked on an intensive process to develop a Professional Practice Model for EHS. The team structure was determined based upon the belief that well-defined professional values, shared by all clinical disciplines and firmly embedded into the health system’s culture, will have the potential to drive excellence in patient outcomes and quality of the work environment. The team composition was the next logical and necessary step toward the goal of partnering with all clinical disciplines and other staff in the journey to Magnet® Recognition.

The American Nurses Credentialing Center (2008) defines a Professional Practice Model as “the overarching conceptual framework for nurses, nursing care, and interdisciplinary patient care. It is a schematic description of a system, theory or phenomenon that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality care for those served by the organization” (p.14) A Professional Practice Model may serve as a tool for change; clarify expectations authority and accountability for practice; focus and prioritize the work; help improve patient outcomes; and “connect the dots” for practice (Wolf, 2009). While there is no “one size fits all” template for development of a Professional Practice Model, Hoffart and Woods (1996) define the essential elements as:

- Professional Values (what attributes are most important to us, what will take us into the future of healthcare, what will guide our patient care decisions and professional practice)
- Management/Governance (how will our voice be heard, how will we effect change, clarifies authority and accountability)
- Care Delivery (what structures will we use, what standards will guide our practice)
- Professional Development (rewards, recognition, education)
- Professional Relationships (collaboration with other members of the healthcare team to improve work processes and quality of care)

The Professional Practice Model Design team, co-chaired by Joanne Welch, MS, RN, NE-BC, Director, Nursing Practice, Education and Research, and Matt Gendron, RRt, Director, Respiratory Care Services, met weekly for 10 weeks following a process road map developed in collaboration with Denise Place, Organizational Development. Although Professional Practice Model references are most readily located in the nursing literature, the definition and elements above quickly resonated with all members of the team. As the process evolved, members experienced a unique opportunity for each participant to explore and celebrate the values and behaviors essential to the core of each discipline’s practice.

The resulting model, represented by the acronym “I CARE,” provides a framework for optimal interdisciplinary collaboration. The co-chairs agree that this was an exceptional experience that owes its success largely to the professionalism and engagement of the design team. Next steps include implementation of a comprehensive action plan to ensure that the model is truly embedded in our culture and used to drive practice.

REFERENCES
American Nurses Credentialing Center (2008). The Magnet® Model Components and Sources of Evidence. Silver Spring: ANCC.
Professional Practice Model Design Team:

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NDNQI Activities

The National Database of Nursing Quality Indicators (NDNQI) tracks two types of data from more than 1,500 hospitals: patient outcomes that are sensitive to nursing care (e.g., patient falls) and the quality of nursing care (e.g., the number of nurses who are certified in their area of clinical expertise). One important indicator is the RN Satisfaction Survey.

In the Fall of 2009, 65 percent of eligible nurses in the Elliot Hospital took the NDNQI RN Satisfaction Survey online. The survey was anonymous, and asked nurses how satisfied they were with the following aspects of their work:

- Time for patient care
- Autonomy in daily practice
- Teamwork between co-workers
- Physicians’ appreciation for what nurses do
- Status of nursing
- Supportive Nursing Management and Nursing Administration
- Participation in decision making
- Salary
- Career development opportunities

After results of the RN Satisfaction Survey were tabulated, nursing staff on each unit chose the top three areas on the survey that they wanted to improve upon. Then, the clinical nursing managers and nursing staff did “deep dives” into those areas to better understand what to do. Two common areas for improvement emerged across most units: “time for patient care” and “teamwork.”

In discussions about what “time for patient care” meant to them, three themes were repeated over and over again: time to assess patients more thoroughly; time to teach patients and families; and time to support patients and families emotionally. The next step was to ask what was keeping nurses from doing these three things. The most common response was that patients are sicker than they used to be and so require more care, leaving the nurse with less time per patient, especially when combined with multiple admissions and discharges per shift. The two other topics were the time it takes to “hunt and gather” supplies and equipment, and inefficient work flow related to documentation in a patient’s chart and medication administration. Aims for improvement included: decreasing nursing workload by changing how RN assignments are made and adding an admission nurse during peak times; decrease hunting and gathering by developing systems to inventory and track equipment; and improving work flow for medication administration.

“Teamwork” included nurses, physicians and other disciplines. Three aims emerged from these discussions: improve formal systems of communication, improve working relationships among all staff, and clarifying roles on the healthcare team. Several strategies fall under improving communication: whiteboards, hourly rounding by RNs/LNAs, daily rounding by MDs and RNs, charge RN rounds, huddles, and standardizing shift to shift report.

We will use common aims for improvement across units and disciplines as the foundation for planning and implementing strategies on individual units. This way, we will be able to coordinate our efforts, standardize some communication processes unit to unit, learn from each other, and sustain improvement while building teamwork.
Elliot on the Move: An Exceptional Partnership Between Rehabilitation Services and Nursing

The Elliot on the Move program is an initiative promoting safe patient handling using equipment to move and transfer patients. Evidence based practice indicates that the use of safe patient handling equipment reduces patient and staff injuries, increases patient satisfaction with care, increases staff satisfaction with their jobs and assists in retention and recruitment of staff.

Providing proper equipment and implementing minimal lift programs are becoming the standard in modern healthcare today. The American Nurses Association (ANA) endorses the implementation of these programs, and has launched a campaign for an industry-wide effort to prevent back and musculoskeletal disorders in the workplace. Its principal points are that (a) manual patient handling is unsafe and directly responsible for musculoskeletal disorders among nurses; (b) patient handling can be performed safely with the use of assistive equipment and devices, and; (c) there exists a reduction of risk for injury among nursing staff and improvement in quality of care for patients. (de Castro, A.B. Sept 30, 2004. “Handle With Care: The ANA’s Campaign to Address Work-Related Musculoskeletal Disorders” Online Journal of Issues in Nursing. Vol. 9 No. 3.).

Minimal lift policies are being implemented throughout the United States including most nursing homes and all VA facilities. Minimal lift has been standard in the United Kingdom for more than a decade and is quickly becoming the standard of care in the U.S. Organizations that endorse safe patient handling programs in addition to the ANA include OSHA, the American Physical Therapy Association, the Association of Occupational Health Professionals, and the Association of Operating Room Nurses.

The concept of Elliot on the Move was conceived by Nicola Beauregard, PT, Manager, Inpatient Rehabilitation Services, after attending the 7th Annual Safe Patient Handling and Lifting Conference. The initiative received administrative support early on as the potential benefits to patients and staff were well documented in the literature. Nicki convened a team and worked closely with Nursing Services to bring the idea to fruition, implementing phase I on Fuller Unit and in the ICU in the Fall of 2009. “The goal of this initiative is to provide a safe environment where patients are easily mobilized with minimal risk of injury to patients and staff alike,” Beauregard said.

The first phase of Elliot on the Move included equipment, training and fostering a “culture of safety” approach to the work environment. Training involved the nursing staff as well as the Rehabilitation and Transport staff to ensure continuity of care. The goal was to establish safety with patient handling for these units to be models for the rest of the patient care units to follow. Heidi Kukla, RN, Clinical Nurse II, has assumed a lead role in championing the initiative in ICU, partnering with Diane Sweeney, RN, Clinical Leader, Cathy Lucafo, RN, Clinical Nurse Manager to proactively address some initial challenges and foster a successful implementation. “The nursing staff is happy to have an opportunity to use this equipment to help facilitate the care of our patients,” Kukla said.
Currently, Fuller Unit has implemented the use of all of the equipment and is continuing to train staff. Trainers have had feedback from nursing staff who have expressed relief with the ease of transferring larger or difficult-to-move patients. The staff is amazed at how user-friendly the equipment is, said Julie Schleckser, RN.

“Not only has the equipment changed the way we move and transfer patients, it has made us more aware of safe patient handling. Anything that contributes to the health and safety of patients and staff is worth its weight in gold,” Schleckser said. The ICU has researched and trialed equipment and processes to safely move critically ill and sedated patients who also have many lines and tubes to manage. Staff members are now using ceiling lifts with repositioning sheets to transfer patients from stretcher to bed, to reposition and bathe them in bed, and even to lift vented patients into chairs. The ability to make these moves should reduce vent time and hospital-acquired illnesses such as pneumonia and pressure ulcers.

The team is currently anticipating expansion of the program to the remaining inpatient units as well as some ambulatory areas, with the goal of maximizing our culture of safety throughout the Elliot organization.
Endowment for Health Grant:
Developing a plan to implement a communal standard of care across the Elliot Health System for perinatal mood disorders for women.

In April 2010, the Elliot Health System was awarded a $5,000 planning grant from the Endowment for Health, a statewide, private, nonprofit foundation dedicated to improving the health of New Hampshire’s people, especially those who are vulnerable and under served. The grant proposal was submitted in December 2009 by Alison Palmer, RN, WHNP-BC, the clinical nurse specialist for perinatal mood disorders in the EHS Maternity Center, and Kathleen M. Thies, PhD, RN, the senior nurse researcher.

The work began in 2007, when Palmer surveyed women after giving birth in the EHS Maternity Center. Because statistically 20 percent of women will experience postpartum depression or other mood disorders in the first year after birth, the Maternity Center routinely screens new mothers to assess risk. Survey results indicated that most former patients appreciated the screening and education, and many were interested in other support.

Palmer then developed the Postpartum Emotional Support Program. The weekly support group for new mothers and telephone support started in Summer 2008. The inpatient screening was refined to sort women into low risk, moderate risk and high risk, with corresponding clinical pathways for intervention. In January 2009, the Perinatal Mood Disorders Task Force had its first meeting, with representatives from multiple clinical disciplines, as well as mental health providers in the community, a former patient, Child and Family Services, and the Upper Room, a family resource center in Derry. Dr. Thies helped the group to set aims for measuring outcomes. They identified a need for a list of mental health providers to whom women could be referred, and for outreach education to healthcare providers.

At the same time, Palmer became involved in a statewide task force, and she and Dr. Thies started a needs assessment about current practices in postpartum depression across EHS departments and affiliated physician practices. It quickly became apparent that there was no standard of care for perinatal mood disorders, that is, not all new mothers received the same care after leaving the hospital. Some obstetricians, pediatricians and family physicians followed up with formal screening, while others did not.

In December 2009, Palmer and Dr. Thies submitted a proposal to the Endowment for Health to fund a planning group. This small group will identify best practices in prevention, screening and treatment of perinatal mood disorders, and will then develop a plan to implement these practices in the hospital, the ED, and in obstetrics, pediatrics, and family medicine offices affiliated with EHS. The result will be a standardized approach to perinatal mood disorders, and a seamless system of care for women receiving healthcare for themselves and their babies through EHS and its affiliates.

The grant is for one year, and will support a series of meetings for the planning group. The Endowment for Health is very interested in this work, and intends to share our results with interested parties statewide. We plan to submit another proposal to fund the implementation phase of this effort.
NEW KNOWLEDGE, INNOVATIONS & IMPROVEMENTS
Research Activities

Pain assessment in the ICU:
Diane Sweeney, RN, Clinical Leader, ICU
Shirley Jackson, MS, RN, CCRN, Clinical Nurse Specialist ICU

ICU patients who are sedated and intubated cannot report their level of pain to nursing staff. The current practice in the Elliot Hospital ICU is based on the judgment of the RN assessing the patient’s pain on a scale of 1-10 (no pain to most pain). Recently, researchers from Montreal developed the Critical-Care Pain Observation Tool (CPOT), which uses a rating scale based on objective observation criteria, such as facial and limb movements. The only studies published about its effectiveness are those authored by the tool’s original developers.

The proposed study in the Elliot Hospital ICU will further validate the CPOT, as it will be used by our own nursing staff without training from the original developers of the tool. Two RNs will rate patients’ pain using the CPOT at three different times: when the patient is at rest, while the patient is being repositioned (a routine procedure that is usually painful for patients), and immediately after repositioning. Additionally, this study will gather data about the relationship between a patient’s score on the CPOT, the patient’s pain assessment score using the current practice of a rating scale of 1-10, and elapsed time since administration of most recent pain medication. Patients unable to move facial and limb muscles voluntarily will be excluded.

The proposal for this study will be reviewed by our Institutional Review Board, and the study will begin following their approval.

Discomfort following removal of urethral catheter in the OR:
Christine Campanella, RN, CNOR; Nabia Songer, RN, BSN; Michael Weidner, RN; Pamela Dudek, MS, RN, CNOR, Perioperative Clinical Nurse Specialist

Urinary catheterization is uncomfortable for most patients. After the catheter is removed, patients complain of urinary urgency and burning on first void. A topical anesthetic used to ease the discomfort of insertion is lidocaine hydrochloride jelly USP 2 percent, known as Urojet™. For surgical patients, the catheter is inserted following induction of general anesthesia in the OR; thus they would not feel the associated discomfort. However, some nurses and surgeons use the Urojet™ at the time the catheter is inserted in the OR because they believe it relieves the discomfort of urgency and burning after the catheter is removed. There is no evidence in the literature to support this common practice.

The purpose of this study is to determine if this is the case: will using the Urojet™ at the time of catheterization in the OR relieve urgency and burning after removal of the catheter? If it does not provide relief, then use of the Urojet™ at the time of catheterization is not necessary. If it does provide relief, then the use of the Urojet™ would be recommended practice. A key factor in the study is that the half-life of the Urojet™ is 90-120 minutes. If the effect of the local anesthetic wears off before the catheter is removed, there is no point measuring its effectiveness for relieving urgency and burning.

The study will be a randomized control trial design of men undergoing a routine inguinal hernia repair, a relatively short procedure. The proposal for this study will be reviewed by our Institutional Review Board, and the study will begin following their approval.
Pediatric Services Program Growth:
Setting the Standard for Excellence

One of the Elliot Health System’s strategic imperatives is to “advance clinical service lines” and develop “centers of excellence.” Pediatrics has emerged as an area of tremendous growth and has provided nursing with exciting opportunities to be part of an initiative to transform the delivery of care for children. “The enthusiasm and energy with which nursing has approached the challenges of expanding pediatric services across all areas is a true testimonial to their professionalism and their dedication to patient care” states Kevin Petit, MD, Executive Director, Pediatrics. “This initiative has the potential to positively impact nursing practice in so many departments and areas throughout the system,” states Joni Spring, MS, RN, Director, Patient Care Services. Spring adds, “Nurses in all roles and settings have stepped forward to meet the challenge of caring for higher volumes of more complex pediatric patients. There is tremendous excitement among the nursing staff about the opportunities this initiative provides first and foremost for our patients and community, but also in regard to professional growth.”

<table>
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<tr>
<th>Spring cites the following key accomplishments beginning in January 2009:</th>
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<tr>
<td>Nurses played an instrumental role in the highly successful opening of the first dedicated Pediatric Emergency Department in Southern NH. The “Pedi ED” opened in January of 2009, caring in the first year for over 12,500 children and their families.</td>
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<td>Recruitment of two Board Certified Pediatric Emergency Medicine Physicians. These physicians have partnered with nursing to provide tailored educational programs at a level previously unavailable on site.</td>
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<td>Tracey Croteau, RN, Clinical Leader in the Pediatric Emergency Department became the second nurse in NH to become certified as a CPEN (Certified Pediatric Emergency Nurse.)</td>
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<td>Improved care for children who utilize the Pediatric Intermediate Care Service.</td>
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<td>Renovation of two beds in the Adult Intensive Care Unit to care for critically ill children. In tandem with this renovation, nursing staff worked to design a collaborative model of care that pairs an Intensive Care RN and a Pediatric RN to care for these children.</td>
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<tr>
<td>Nurses participated in planning renovations in the Surgical Day Care and the Post-Anesthesia Recovery Units to provide child and family friendly care environments.</td>
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<tr>
<td>Recruitment of Rebecca Marden, MS, RN, Clinical Nurse Manager for Pediatrics.</td>
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<tr>
<td>Recruitment of Patti Laliberte, MS, RN, Clinical Nurse Specialist, Pediatrics.</td>
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<tr>
<td>Development of an Education Collaborative with Maine Medical Center to provide clinical and didactic education for Elliot nursing staff who care for pediatric patients.</td>
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<td>Recruitment of our first full time Pediatric Surgeon, Brian Gilchrist, MD. “Dr. Gilchrist is a great asset to the organization,” stated Shannon Dorman, BSN, RN, CPN. “He provides monthly education on Pedi and NICU to help us become more familiar with all aspects of the procedures he’s performing – pre op care, how he determines the diagnosis, details of the surgical procedure itself and then the post op care. As a result I’m better prepared to care for these patients and respond to parents’ questions as well. I recently completed the CPN certification exam, and the details I recalled from Dr. Gilchrist’s lectures helped me immensely,” noted Dorman.</td>
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<tr>
<td>Growth of our Pediatric Hospitalist Service to provide 24/7 coverage.</td>
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<tr>
<td>Recruitment of Kevin Petit, MD, Executive Director, Pediatrics.</td>
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Rebecca Marden, MSN, RN, Clinical Nurse Manager, Pediatrics, reflected on the evolution of Pediatric Services. “At one time when you spoke of pediatric patients, one would immediately think of those patients being on a pediatric unit. Nowadays that’s not always the case. Children are now being cared for in multiple settings such as OR, PACU, ED, ICU and Radiology. Each and every member of the organization, in all disciplines and departments, has valuable contributions to make in providing care and services to these patients. It is truly a collaborative effort. It speaks volumes to the passion and drive of the staff to create a Center of Excellence for pediatric patients and their families here at the Elliot.”
Safe Passage Home: The Role of the VNA Transition Nurse

For 15 of her 20 years in nursing, Susan Pedro has worked at the VNA. In her new role as VNA Transition Nurse – a first for the Elliot Health System – she is enjoying the opportunity to teach people about how the VNA can help them, and sees so much possibility and such enormous potential for positive patient outcomes.

This past year, the VNA implemented the Transition Nurse position in order to improve communication between patients, families, hospital and VNA staff. The primary purpose of the Transition Nurse is to educate families and patients about VNA home care services and assist in developing a plan to help patients safely and smoothly transition from the hospital to home care with the VNA of Manchester and Southern NH.

Through the development of a care plan, patients and families are often delighted to learn that a loved one can return home and remain there safely, comfortably and live as independently as possible, with the guidance of the VNA clinician. Pedro reports that it is only one of the many rewarding aspects of her new role as Transition Nurse.

Once a home care plan is set in place with their physician and VNA case manager, patients and families are often more confident. They are more able to identify a problem that requires a call to a VNA nurse or an appointment with the doctor. As part of the care planning while still in the hospital, Pedro educates patients and their families about new medicines the physician is adding, as well as medicines they might have been taking for years; she teaches them about disease management, how to identify symptoms of more serious problems, and what to expect when they transition to VNA services.

Pedro visits almost a dozen patients a day, primarily they are elderly with multiple medical issues. She gets to know them, their families, and develops an understanding of the strengths and weaknesses of their support system. Her greatest goal is to empower patients by creating individualized plans they can follow easily and independently. The plan might include something as simple as a medication planner or something as sophisticated as Telehealth, which is a home monitoring technology that monitors an individual’s weight, blood pressure, oxygen, and other measurable health conditions via an electronic unit placed in the home.

These plans are developed in conjunction with the VNA admitting clinician, and have a great impact on a patient’s continued progress once discharged, said Margaret Foley, RN, Director of the Social Work and Case Management Department.

“Susan is committed to improving transitions of care for our patients being discharged from hospital to home. She is working collaboratively with the Social Work and Case Management Department to ensure that a well coordinated discharge plan is in place for these patients and is beginning to focus on interventions to prevent readmissions such as medication reconciliation,” Foley said.

In fact, Pedro has introduced many patients to Telehealth. The results are transmitted via telephone and read daily by a nurse at the VNA. Telehealth is rapidly becoming a popular, cost effective, safe and efficient means of delivering home-based care that can help stabilize a patient in a few short months without bringing the patient back and forth to the hospital. Patients, families, and caregivers are enthusiastic about its potential.
The optimal outcome of the role of the Transition Nurse within patient care is to ensure a smooth transition and “hand-off” to the VNA, promoting stability for the patient and family when they return home. This should help reduce re-hospitalizations. If VNA patients are re-admitted, Pedro immediately makes contact with them to provide continuity during their stay and transition back to VNA. She also explores what opportunities there might have been to have avoided the re-hospitalization.

Pedro sees many high-risk patients who are struggling alone and have little knowledge about VNA services. She applies her expertise in home care to family and patient multidisciplinary meetings during which patients, families, physicians, social workers and case managers are trying to assist patients and families to establish a safe discharge plan.

It is the daily interaction with patients – and direct feedback – that reinforces to Pedro that what she’s doing truly makes a difference, and improves the quality of life, not only for patients but for those who care for them once they are discharged.

“One patient caregiver recently reported to me, ‘You are such a presence here at the hospital. I have come to trust you and believe you have our best interest in mind,'” Pedro said.

Pedro believes the VNA Transition Nurse program will be successful because it is patient based. When she sits at a patient’s bedside and educates him or her about VNA services, such as skilled nursing, physical and occupational therapy, social work, dietary services, speech therapy, and personal care, patients realize they can return home with help and are more hopeful about their recovery.
Expanding Horizons: 
The Role of Ambulatory Nursing

Elliot Physician Network has embarked on a Medical Home Pilot site at Elliot Family Medicine at Bedford Commons. The Medical Home is a team-based approach to primary care with the patient as an active member of the team. Our goals are to improve the health of the communities we serve by providing a higher quality of care and reducing the overall cost of healthcare. We are improving patient access to care, expanding our use of My e-Chart and providing enhanced support for our patients with chronic illnesses.

Working collaboratively with all the other healthcare providers our patients see is key to assuring they are getting the care they need.

“This pilot has been an exciting opportunity to enhance the role of nursing in the ambulatory care setting and empower the nursing and other clinical staff to redesign their roles within the practice,” said Elliot Physician Network Director Amy Dobson, BSN, RN, MPH, CMPE.

“The nurse is a critical member of the Medical Home team. The nurse brings his or her skills in patient assessment, education and care planning to the team as he or she works with the patients to help them maximize their health and wellness,” Dobson said. “Teamwork is at the heart of the Medical Home team approach; the nursing component is essential to its success,” said Dan Rosenbaum, MD, Elliot Primary Care at Bedford Commons.

“A tenet of the medical home model is practicing medicine via a team. No team would be complete, or even possible, without the role of nursing. The paradigm we hope to develop is away from treating nursing as a supporting role, and moving into an active, involved and integrated partnership with a physician,” Rosenbaum said.

The clinical team at Bedford Commons has been meeting weekly and discussing the concepts of the team-based approach to care and patient centeredness. They also meet as a team with the physicians in a “morning huddle” each day to discuss the patients to be seen that day. There has been a shift, from task oriented care to a patient centered focus. The team is reaching out to patients to learn what they want and need in their Medical Home. The clinical staff has developed a patient satisfaction survey which is given to patients to complete when they are seen in the office. The staff developed this tool because they realized that as they partner with patients to improve their health, they need to learn from them how to best meet their needs. Patient suggestions and team responses will be posted on a bulletin board in the waiting room to encourage an open dialog with patients. A patient advisory group has been established as another method of hearing patient needs.
A new nursing role has been implemented at Bedford Commons, the role of Health Coach. This nurse works directly with patients either in person or on the phone to provide support, education and guidance. This role has been a valuable addition to the office. The Health Coach has been focusing on patients with diabetes. Those who are newly diagnosed or starting a new medication meet with the Coach after their physician visit, and are provided with education and support to ensure that they understand their health condition, new medication and next steps. The Health Coach provides follow-up phone calls to ensure that things are going well at home. The Health Coach also reaches out to patients in the practice that have recently been in the Emergency Room or Urgent Care or have been discharged from the hospital, making sure patients have a follow-up appointment, and to answer questions as they arise. This role provides added support to patients that have many health needs or just need that extra support and encouragement.

Pamela Bannan, RN, who serves as Medical Home RN Health Coach at the Bedford practice said patients are receptive to this added service. “Our patients are so appreciative of the follow-up calls. It allows them to ask questions and address concerns they may have about their health or how it may have affected their chronic condition. While I am speaking with them I can share when they need to call for additional concerns or symptoms and provide them with information regarding afterhours access,” Bannan said.

Nursing in the ambulatory care setting will be an area of growth going forward, allowing nurses to fully utilize their nursing skills to develop ongoing relationships with patients seen in primary care. This level of partnership will be essential as we strive to improve the health of the communities we serve.