Nursing Report

Accomplishments for 2016
The Power of One Idea

“When you’re confronted with a problem, don’t get down — get excited, get involved. A problem is an opportunity to do something generous or positive for the world.”

— Heidi Wills, author

It is an honor to present Sharp Memorial Hospital’s 2016 Nursing Annual report. These stories reflect only a small selection of the amazing work accomplished over this past year, and they demonstrate the significant improvements that groups of like-minded people can achieve. Our successes not only impact patients and staff at Sharp Memorial, but they reveal learnings that can be shared with other hospitals within and outside of Sharp HealthCare.

In many cases, these projects began as one idea, from one individual. I am continually impressed by the number of times a Sharp Memorial nurse confronts a challenge and makes the conscious decision to work on solving that problem for the betterment of our patients, staff and community.

Sharp HealthCare’s journey to become a High Reliability Organization depends upon sharing concerns and challenges. And it is best served by the active involvement of those closest to the issues. These stories demonstrate our commitment to this high-reliability mindset.

To our nurses, I hope this report makes you feel proud to work for an organization that values continual learning, problem solving and improvement. I encourage you to read each story and share the report with your peers and interprofessional colleagues. We are making a difference, and I’m grateful for the opportunity to share your accomplishments.

Finally, I hope these inspirational successes will prompt reflection and additional ideas to improve our practice environment and care.

Pam Wells, MSN, MSA, RN, NEA-BC
Chief Nursing Officer
Vice President, Patient Care Services
Sharp Memorial Hospital

COVER:
(From left) April Henderson, Ellen Schroeder, BSN, RN, CNOR, Gisela Ruvalcaba-Sanchez and Lindsey Lown, RN, CNOR, helped coordinate the launch of SurgiNet in Surgical Services (see page 6).
Transformational Leadership identifies and communicates vision and values, and asks the involvement of the work group to achieve that vision.

Michele McCluer, BSN, RN, CNOR, Sharp Memorial Outpatient Pavilion Surgical Services, and Joe Pieper, BSN, RN, PCCN, 4 West, were recognized with Nurse of the Year awards in 2016.
Change Your Tune: Strategic Planning Decreases Sepsis Mortality

Sepsis affects hundreds of thousands of patients per year. The condition can lead to high morbidity and mortality as the syndrome progresses through severe sepsis and septic shock.

A review of patient outcome data revealed that the rate of sepsis mortality at Sharp Memorial Hospital was higher than at similar hospitals. Sharp Memorial leaders formed an interprofessional team of nurses, physicians, and representatives from Quality and Pharmacy to increase understanding of the key drivers of sepsis mortality and to design new tools to improve identification of sepsis.

The team investigated best practices and developed guidelines for sepsis identification, including signs and symptoms of Systemic Inflammatory Response Syndrome (SIRS), sepsis, severe sepsis and septic shock; early intervention based on three-hour and six-hour bundles (sets of evidence-based practices); and badge cards with sepsis-identification information for easy reference.

Subsequently, the team implemented the following improvements in clinical practice:

- Added septic shock bundles for the Emergency Department
- Launched sepsis order sets for the electronic medical record (EMR)
- Updated the emergency standing orders standardized procedure
- Enhanced unit hand-off communication related to sepsis
- Designed and disseminated education for nurses on early recognition of patients with sepsis and treatment protocols

In June 2016, a new EMR Sepsis Early Warning Alert went live at Sharp Memorial. This tool aggregates critical values and alerts nurses and providers of at-risk patients.

Outcome:
Following implementation of sepsis interventions, fewer patients diagnosed with sepsis died. Sharp Memorial’s sepsis mortality rate decreased from 18.8 percent to 11.2 percent.

“I hope that what I leave behind will grow through someone else and become better than where I was able to take it.”
– Stevie Wonder
Ring a Bell: Greater Awareness of Opioid Management Leads to Reduction in Adverse Drug Events

Sharp HealthCare is on a journey to become a High Reliability Organization aimed at achieving zero harm to patients. An intensivist shared a concerning observation with Chief Nursing Officer Pam Wells that an increasing number of patients either “bounced back” to the intensive care unit or required a higher level of care, which he suspected was associated with over-sedation from opioids.

An extensive chart review on 72 patients who required a reversal agent (medication used to reverse the effects of over-sedation) revealed significant opportunities to improve opioid management and reduce adverse drug events (ADEs). The data also revealed a higher than expected rate of ADEs.

An interprofessional team — comprised of physicians and representatives from Pharmacy, Quality, Clinical Informatics, System Safety and Nursing — identified key focus areas for improvement, including education, electronic medical record tools, and alternatives to opioids for pain management. The team created and disseminated education to physicians and nurses about the results of the chart review and opioid ADE data.

Education for nurses emphasized how to safely administer opioids, how to avoid the risk of dose stacking, and how to monitor for over-sedation. Physician education concentrated on increasing situational awareness about this patient safety issue.
Outcome:
Efforts to increase awareness and understanding of opioid management risks among physicians and nurses resulted in a reduction in opioid-associated adverse events at Sharp Memorial.

Figure 2:
With greater awareness of opioid management risks, adverse drug events in patients receiving opioids decreased from 0.77 percent to 0.40 percent in seven months.
Fit as a Fiddle: SurgiNet Implementation Streamlines Surgical Care

In 2015, Sharp HealthCare began implementing SurgiNet across all Sharp hospitals. This information system for surgery and anesthesia integrates perioperative, procedural and anesthesia care into the patient’s electronic medical record.

The goal of the project was to improve handoffs and eliminate gaps among the surgical care teams by storing case information electronically in a single system.

Prior to implementation, all perioperative nurses and Operating Room (OR) staff completed online learning modules about documentation within SurgiNet. Staff received handouts specific to their role in the surgical process and hands-on training from Clinical Informatics Specialists and Super Users. During huddles and staff meetings, OR leaders reviewed SurgiNet plans with staff and listened to concerns and feedback.

To ensure the transition to SurgiNet went smoothly, a user guide was created and posted in each operating room suite as well as on the hospital’s intranet. Additionally, an extra 20 minutes were added to room turnover times during the implementation period to allow time for circulating nurses to finish documentation in the new system. Additional nurses and a circulator staffed the OR suites, and an Information Systems support team was available 24 hours a day.

When SurgiNet launched at Sharp Memorial in June 2016, OR leaders held at least two meetings each day for the first three weeks to address issues and listen to concerns and suggestions. The OR leadership team also rounded regularly with staff. Issues were addressed as much as possible in real time and updates were presented to staff during huddles.

Outcome:
The transition to SurgiNet went smoothly at Sharp Memorial. Nursing documentation by the OR team is now immediately accessible for all disciplines caring for each surgical patient.
Music to My Ears: Improvement to Electronic Medical Record Removes Charting Redundancies

In 2008, Sharp Memorial became the first Sharp HealthCare hospital to implement the Cerner Electronic Medical Record (EMR). As additional hospitals launched the EMR, Sharp HealthCare leadership established a requirement that all hospitals must agree to any EMR change.

Following the launch of the EMR, Sharp Memorial nurses expressed frustration with redundant charting and excessive time spent in documentation, pulling them away from direct patient care. The Sharp HealthCare Information Systems team in charge of overseeing changes to the EMR knew about this challenge, and had identified that improving the Adult Initial/Ongoing Assessment in the EMR was the first step in optimizing documentation. However, competing priorities across the system slowed progress on this work.

When Chief Nursing Officer (CNO) Pam Wells joined Sharp Memorial in 2013, she initiated a discussion at the Sharp HealthCare CNO Council regarding continuing feedback she heard from clinical nurses related to charting redundancy. The other CNOs voiced similar concerns from their nurses, and the Council formally asked the newly promoted Director of Sharp HealthCare Clinical Informatics to share their concerns with the Sharp HealthCare Information Systems leadership.

After receiving feedback from the CNOs, Information Systems leadership agreed to reprioritize their projects, enabling the redesign of the assessment tool to move forward.

(From left) Jocelyn Stewart, RN, BSN, OCN, 1 West, and Gretchen Hiegel, RN, Clinical Informatics, worked closely with Information Systems to reduce charting redundancies in the electronic medical record.
Outcome:
The new Adult Initial/Ongoing Assessment launched in the EMR in February 2016. The redesign streamlined documentation and significantly reduced redundant charting. The impact on nursing time was considerable given the number of redundancies identified and eliminated.

Figure 3:
After the redesign of the Adult Initial/Ongoing Assessment, charting redundancies decreased 86 percent.

March to the Beat of Your Own Drum: Remote Video Interpretation Improves Patient Satisfaction

Literature suggests that 20 percent of hospital staff do not use formal interpreters when communicating with patients who need language interpretation. Also according to literature, staff who are familiar with interpretive services are more likely to use those services.

After noticing patient satisfaction scores related to nurses communication had room for improvement, members of a Sharp Memorial Clinical Practice Council subgroup surveyed frontline staff on their knowledge and satisfaction with the hospital’s interpretation policy and procedure. Feedback from study participants revealed a preference for in-person translation rather than the policy-guided practice of using the phone. Participants also recommended exploring other options, such as remote video interpreters.

These results were shared with Sharp HealthCare leaders responsible for interpretation services across the system. They asked Sharp Memorial’s Emergency Department to conduct a pilot of remote video interpretation services, which resulted in positive feedback from both staff and patients. As a result, Sharp HealthCare leaders decided to contract with a remote video interpretation service for the entire system.
Outcome:

Sharp Memorial launched its video interpretation program in March 2016. Through the remote service, patients can use an electronic tablet to speak with a live, trained interpreter 24 hours a day in sign language and many spoken languages. At least one remote video interpretation tablet is available in each patient care area.

Patient satisfaction with nurse communication improved after remote video interpretation went live.

Figure 4:
After the remote video interpretation service launched, patient satisfaction with nurse communication increased from the 24th percentile rank to higher than the 80th percentile rank.
Structural Empowerment develops strong partnerships to improve patient outcomes and the health of the communities we serve.

(From left) Susan Moore, MSN, RN, CNS, Short Stay/Observation, and Heather Bongiovanni, BSN, RN, CBN, CMSRN, 6 North, were recognized with Nurse of the Year awards in 2016.
March to the Same Tune: Developing a Delirium Protocol for Hospitalized Patients

In early 2015, nurses from hospitals across the Sharp HealthCare system came together to improve the recognition and treatment of delirium, a state of mental confusion that can occur from illness, surgery or use of some medications. Delirium can contribute to longer hospital stays, a higher cost of care, long-term cognitive impairment and even death.

Physicians had used Sharp Memorial’s established delirium treatment plan for the intensive care units (ICU) only twice in six months. Across Sharp HealthCare, there was no standardized assessment tool in place for delirium outside of the ICUs.

Through a review of the literature, the team of nurses discovered that assessment tools such as the Confusion Assessment Method (CAM) help identify patients with delirium, leading to earlier treatment and improved outcomes. Two forms of the method — CAM-ICU and brief CAM (bCAM) — can be used to assess delirium in verbal and non-verbal patients.

Nurses across Sharp HealthCare learned the two methods through online and in-person classes, as well as one-on-one instruction. The tools are now embedded in Cerner — Sharp’s electronic medical record system — and nurses are expected to perform an assessment on every patient, every shift. The team also developed a protocol in Cerner for physicians to initiate once a patient is determined to be CAM-positive. This protocol includes nursing interventions and medications for preventing and treating delirium.

“When you hit a wrong note, it’s the next note that makes it good or bad.”  
– Miles Davis
Outcome:
Sharp Memorial nurses continue to use the new delirium assessment methods and protocol, leading to increased identification and treatment of patients with delirium.

Figure 5:
Nurses are now assessing patients for delirium and implementing prevention and treatment plans.

Eric Turrubiartes, BSN, RN, 7 West, and Tracy Nanthavong, BSN, RN, OCN, CHPN, 1 West, serve as co-chairs on the new Night Shift Practice Council (see page 13).
Music of the Night: New Night Shift Practice Council Expands Nurse Participation in Collaborative Governance

Periodically, Sharp Memorial nurses complete a survey on their perceptions of — and commitment toward — the hospital’s collaborative governance (CG) structure and processes. Surveys conducted in 2014 and 2015 revealed lower-trending scores across all items.

To address this concern, hospital leadership held a “CG 3.0 Retreat” with interprofessional staff, frontline nurses and leaders. Participants identified and prioritized several themes to enhance the CG structure and processes. One theme that emerged was the lack of opportunity for some nurses to participate in collaborative governance, particularly for clinical nurses on the night shift.

In June 2016, Chief Nursing Officer Pam Wells launched the first Night Shift Practice Council, comprised of night shift nurses and interprofessional staff. The new council created a charter, identified priorities and established workgroups. Pam attends each meeting, which are held eight times a year.

Outcome:
The Night Shift Practice Council enables nurses and interprofessional staff to have direct access to the Chief Nursing Officer and to communicate issues specific to the night shift practice environment. Since the inception of the council, the following nurse practice environment issues have been addressed:

- Opened a second parking lane into the employee parking garage to ease congestion for oncoming night shift staff and prevent tardiness
- Added more variety to menu options for evening meals in the cafeteria
- Improved responsiveness of Environmental Services regarding trash collection and bed cleaning
- Increased inventory of isolation storage caddies to enhance recognition of patients in isolation
- Identified safety issues:
  - Highlighted an issue related to a look-alike medication in Pyxis, the medication-dispensing system
  - Alerted Pharmacy leadership and the venous thromboembolism task force about an ordering and timing issue for the medication Lovenox
Clear as a Bell: Aligning Expectations for Discharge Readiness

Sharp Memorial continued to receive lower-than-desired Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction scores in the discharge information domain. Data and comments from survey respondents revealed dissatisfaction with discharge communication, timing issues and gaps in discharge preparation.

A subgroup of the Clinical Practice Council studied this issue and determined that a discharge readiness tool could help patients and caregivers better prepare for discharge.

Nurses on the subgroup drafted a new tool and discharge process. The tool included six steps that must be completed before the patient can be discharged. These include understanding medications that a patient needs to take after leaving the hospital and identifying someone who will help care for a patient at home.

During a pilot on 4 North, an acute care unit, nurses within the subgroup obtained staff perceptions of the tool and used their feedback to make adjustments. They also created and disseminated an “elevator speech” to all staff that framed the change in practice, and the nurses provided engaging inservices to staff on the discharge readiness tool.

(From left) Mykal Fernandez, BSN, RN, OCN, 1 West, and Yvonne Vargas, MSN, RN, ONC, 4 North, helped launch a discharge readiness tool on their units.
Outcome:
Patient satisfaction improved in the discharge information domain following the launch of the 4 North discharge readiness process and tool. Following 4 North’s success, another acute care unit, 1 West, launched the tool and achieved similar outcomes.

Plans are developing to spread this best practice across all units in the hospital.

Figure 6:
Following implementation of the discharge readiness tool on 4 North, patient satisfaction in the discharge information domain reached the 99th HCAHPS percentile rank.

With Bells On: Annual Career Expo Offers Guidance on Nursing Advancement

Sharp HealthCare’s seven Pillars of Excellence set the foundation for achieving the organization’s vision of transforming the health care experience. The “People” pillar is focused on creating a values-driven culture that attracts, retains and promotes the best and brightest people, who are committed to and aligned with Sharp HealthCare’s mission and vision.

Each year, nurses from across the Sharp Metropolitan Medical Campus, which includes Sharp Memorial Hospital, sponsor a joint nursing career expo. This annual event is open to any employee or community member interested in becoming a registered nurse. Current nurses who attend the expo can receive information about advancing their nursing education.
Outcome:
The 2016 nursing career expo was held August 18. Of the 162 participants, 70 non-nurses attended, including 13 community members and volunteers interested in becoming registered nurses.

Fourteen nursing schools sent representatives to the event. Attendees had the opportunity to speak with these nursing school representatives about the application process, curriculum and financial aid. In addition, attendees learned about Sharp HealthCare’s tuition reimbursement benefit and scholarships as well as professional development opportunities.

Jazz It Up: Nursing Education and Certification

Quality patient care depends on a knowledgeable and well-educated nursing workforce. Sharp Memorial leaders encourage nurses in their efforts to seek baccalaureate and graduate education, as well as nursing certification, which allows individual nurses to demonstrate their specific knowledge base in a specialized area of practice. The nurse becomes certified by taking and passing an initial exam, usually after two years of experience in a practice area. Nurses maintain their certifications through ongoing professional development.

Figure 7: More than 78 percent of direct-care nurses at Sharp Memorial have earned a nursing degree at the baccalaureate level or higher.
Figure 8:
Nearly 40 percent of direct-care nurses at Sharp Memorial have earned a nursing certification.
Exemplary Professional Practice

is an overarching conceptual framework for continuous, consistent, efficient and accountable patient care delivery.

(From left) Jess Schroeder, BSN, RN, CWOCN, Wound Healing, Vince Christensen, BSN, RN, CWON, Home Health, and Janet Buenaventura, RN, Sharp Memorial Outpatient Pavilion Surgical Services, were recognized with Nurse of the Year awards in 2016.
Strike the Right Note: Advanced Illness Management Program Improves Quality of Care for Patients at the End of Life

Sharp Memorial had experienced an increase in physician requests for consultations with patients at the end of life. Consultations include discussions about advanced care planning, completing Physician Orders for Life-Sustaining Treatment (POLST) forms, and hospice referrals. However, only one nurse was assigned to this role. At the same time, the hospital’s inpatient mortality rate was higher than expected, resulting in penalties from the Centers for Medicare and Medicaid Services (CMS).

Hospital leadership believed a formal Advanced Illness Management program at Sharp Memorial could help address these challenges. They authorized an additional 3.2 full-time equivalent (FTE) employees to form an AIM team, one of which was a program manager.

As an initial step, the team launched a pilot project in the Emergency Department (ED) for palliative care and hospice consultations. For four months, the new AIM program manager rounded with ED physicians and staff to help identify patients and family members who could benefit from a discussion about palliative care and end-of-life options.

The AIM program manager’s constant presence in the ED and the staff’s increasing support of end-of-life services led to an increase in consult requests in both the ED and inpatient units.

Outcome:
In 2016, the AIM team facilitated more than 400 hospice referrals and met with nearly 750 ED patients to discuss end-of-life care goals. Total inpatient visits by the AIM team increased 55 percent. ED physicians are now initiating up to 45 percent of AIM consults.

Recognizing the increased need for consultations, hospital leadership authorized an additional 1.7 FTEs to join the team in fiscal year 2017.

In addition, other Sharp HealthCare entities are establishing AIM programs based on Sharp Memorial’s model.

“To play a wrong note is insignificant; to play without passion is inexcusable.”
– Ludwig van Beethoven
Eddie Wagner, BSN, RN, CCRN, Rapid Response Team, helped establish an inpatient STEMI code and protocol for patients experiencing a heart attack while in the hospital (see page 21).
The Beat Goes On: Inpatient STEMI Protocol Improves Outcomes for Hospitalized Patients

The American Heart Association (AHA) identifies specialty standards and guidelines for many diseases, including heart attacks. These include defining criteria for early recognition and treatment of patients with signs and symptoms of narrowing or blocked arteries.

At Sharp Memorial, nurses and physicians incorporate these specialty standards into their care to ensure that care delivery for this patient population meets the AHA guidelines. A “door-to-balloon” time of 90 minutes is the AHA gold standard for patients with ST Segment Elevation Myocardial Infarction (STEMI), the most common form of heart attack. Door-to-balloon time measures the time between a patient arriving to the Emergency Department (ED) to the time a percutaneous coronary intervention device is used to clear the blocked artery.

A cardiologist at Sharp Memorial reviewed cases of hospitalized patients with STEMI. He discovered patients who experienced an in-house STEMI did not have the same successful outcomes as patients in the ED, where a STEMI protocol had been in place. The cardiologist recommended the Rapid Response Team (RRT) incorporate the STEMI criteria into the inpatient setting because of the team’s pivotal role in early recognition of patient deterioration.

The Rapid Response Team, comprised of frontline clinical nurses, worked with physician stakeholders to define the critical elements for nurses to assess and treat hospitalized patients exhibiting signs of STEMI. The team developed an in-house STEMI protocol, which included an “EKG-to-Catheterization Lab” time of 60 minutes and an “EKG-to-Balloon” time of 90 minutes.

Within the protocol, either the bedside nurse (in intensive care or progressive care units) or the RRT nurse (in acute care units) can order an initial electrocardiogram (EKG), or, if a STEMI is occurring, place the patient on oxygen therapy and administer medications. An RRT nurse would then call a Code STEMI, which would activate the team in the Catheterization Lab, where the procedure to clear the blocked artery is performed.

The new protocol went live in March 2016. Nurses received education on the practice change. Units that care for non-cardiac-monitored patients were educated on atypical signs of a heart attack.
Outcome:
Since implementation, nurses have activated the new STEMI protocol on six inpatients.

One of these activations occurred in July 2016 when a patient went into ventricular fibrillation. Once the patient was successfully resuscitated, the RRT nurse recommended a 12-lead EKG be completed. The EKG revealed a STEMI was in process and a Code STEMI was called. The patient was taken to the Catheterization Lab within 30 minutes of the EKG. The blockage was successfully removed and the patient left the hospital for home within six days of the event.

(From left) Boni Bogart, BSN, RN, PCCN, and Julie Tarbell, BSN, RN, helped address staffing and workflow challenges on 7 West (see page 23).
Chime In: Nurse Participation in CSI Academy Leads to New Staffing Model on 7 West

During Sharp Memorial’s annual budgeting planning process, nurses on 7 West, a progressive care unit, provided input to their nurse leaders about limited unit resources, inefficient workflows and inconsistent teamwork related to support staff. The nurses recommended an analysis of unit staffing patterns and skill mix.

To help address these challenges, the unit applied to the Association of Critical-Care Nurses Clinical Scene Investigator (CSI) Academy. This 16-month, hospital-based nursing innovation and leadership program is designed to empower clinical nurses as leaders and change agents to improve patient and fiscal outcomes. Participation includes a $10,000 grant to support the launch of a project.

Four nurses from 7 West were selected to participate in the program and work on addressing the staffing and workflow challenges on their unit.

As part of the program, the CSI Team surveyed 7 West nurses on their perceptions of current staffing. With this information, they developed a proposal that would shift the role of 7 West nurses within the care delivery model. The number of nursing assistants would increase to one assistant per two nurses and nursing assistants would take on more tasks.

Traditionally, 7 West nurses maintained a 1:3 nurse-to-patient ratio, but it was increasingly clear that this model would be unsustainable long term, given trends in health care expense and reimbursement. Under the new staffing model, which the group named “Teamwork Leads to Dreamwork,” the nurse-to-patient ratio would expand to 1:4, creating a positive budget variance and enabling clinical nurses to take on a broader role in the care delivery model. With more nursing assistant support, nurses could focus more on care planning with patients and families, increasing patient education and improving quality outcomes.

“Teamwork Leads to Dreamwork” launched in June 2016. The CSI Team rounded daily with staff to obtain feedback and determine improvements to the model.

Outcome:
The launch of “Teamwork Leads to Dreamwork” on 7 West resulted in a redistribution of nursing resources, an enhanced care delivery model focused on the professional nurse role, and positive fiscal outcomes. Since June 2016, budget-to-actual dollar variance trends on 7 West shifted from unfavorable to favorable.
Fine Tuning: Acute Inpatient Rehabilitation Reduces Patient Falls After Enhancing Fall-Prevention Measures

Sharp Memorial’s Acute Inpatient Rehabilitation Unit cares for patients with spinal cord injuries, brain injuries, stroke and other complex medical issues. These patients face an increased risk for significant injury from a fall due to their functional limitations and other factors related to their condition.

The unit was experiencing an increasing trend of patient falls. Members on the unit’s Safe Patient Mobilization (SPM) Committee analyzed the increase and determined that proactive fall-prevention measures had lapsed, become less consistent, or were not completely understood by interprofessional team members.
Several strategies were implemented to address this challenge:

1. Reinstating rounding on patients with the health care team and SPM representatives, with a focus on strategies to mobilize patients and prevent falls
2. Adding a review of high-risk fall patients to the reporting structure of the unit’s daily patient safety and operations huddle
3. Revising the SPM risk assessment tool based on nurse feedback
4. Updating handoff tools to more easily identify patients at highest risk of falling

The committee established a rounding process during their monthly meetings to evaluate use of the new tool, risk documentation and risk communication practices. Members also tracked the impact of the revised practices on patient fall rates and communicated unit-level data to staff during huddles and staff meetings.

**Outcome:**

By the middle of 2016, the rate of patient falls on the Acute Inpatient Rehabilitation Unit decreased 66 percent.

*Figure 10:* Improvements to fall-prevention measures in Acute Inpatient Rehabilitation led to a decrease in patient falls.
And All That Jazz: Other Nursing-Sensitive Indicators

Figure 11:
Sharp Memorial outperformed the state benchmark for acute care injury falls in seven out of eight quarters.

![Injury Falls — Acute Care Diagram](image)

Figure 12:
Sharp Memorial outperformed the state benchmark for hospital-acquired pressure ulcers in seven out of eight quarters.

![Hospital-Acquired Pressure Ulcers (Category 2+) Diagram](image)
Figure 13: Sharp Memorial continued to show improvement in the rate of central line-associated bloodstream infections (CLASBI) for three of four quarters in 2016.

Figure 14: Sharp Memorial showed improvement in the rate of catheter-associated urinary tract infections (CAUTI) in three of four quarters in 2016.
Figure 15: Nurse satisfaction scores on the National Database of Nursing Quality Indicators (NDNQI) with Practice Environment Scale outperformed the national mean in four of five categories.

Figure 16: Sharp Memorial consistently met its goal to be in the top 10th percentile for patient satisfaction compared with all large hospitals.
New Knowledge, Innovations & Improvements are the integration of evidence-based practice and research into clinical and operational processes.

(From left) Leslie Barkley, MSN, RN, CNS-BC, CAPA, CMSRN, Surgical Procedure Area; and Naomi Miyazono, BSN, RN, CBN, CMSRN, were recognized with Nurse of the Year awards in 2016.
Face the Music: 5 North Improves Patient Satisfaction with Quietness After Launching “Question of the Night”

Patient satisfaction regarding the quietness of the hospital environment is typically the lowest-scoring measure on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Numerous nursing activities and devices in the care environment can generate loud noises, which have been shown to have negative impacts on patients (e.g., anxiety, stress, and sleep disturbances) and hospital staff (e.g., irritability, decreased productivity, and increased errors).

Hospital reimbursement from the Centers for Medicare and Medicaid Services’ Hospital Value-Based Purchasing Program is tied to several measures, including patient experience of care.

5 North, an acute care unit, experienced a downward trend in the unit’s HCAHPS scores regarding quietness at night. Nurses on the unit reviewed the literature to determine best practices, including quiet hours, minimizing conversations near patient rooms, posting signage, dimming lights, setting phones on vibrate, providing patients with ear plugs, and, if appropriate, closing patient doors.

They developed a “Question of the Night” prompt for patients using GetWellNetwork, the television-based interactive patient care system. At 9 p.m. each evening, patients using their televisions see a message asking if they feel it is quiet on the unit. Patients can select a response using their remote control.

If patients respond either “maybe” or “no,” an alert is sent to the dedicated charge nurse pager that displays the patient’s room number. With real-time notification, the charge nurse can follow up immediately with the patient, evaluate the environment and resolve issues, if possible. Discussions with patients may also include ways to promote rest and relaxation, including utilizing routines, music, eye masks, ear plugs and aromatherapy.

Outcome:
Following implementation of the “Question of the Night,” 5 North’s patient satisfaction HCAHPS scores improved considerably. The unit experienced a one-time decrease in scores in July 2016, which was attributed to a lower response rate (average survey respondents decreased from 22 to 12).
Figure 17: Following implementation of the “Question of the Night” on 5 West, patient satisfaction scores increased to the 93rd percentile.

(From left) Reanna Cook, BSN, RN, PCCN, 5 West, and Maryette Ann Kumphet, PTA, Physical Therapy, helped design and establish a workflow for the No Falls Protocol on 5 West (see page 32).
It Takes Two to Tango: Launch of No Falls Protocol on 5 West Helps Reduce Patient Falls

Falls are a prevalent patient safety problem, with up to 1 million falls occurring in U.S. hospitals each year. Injured patients require additional treatment and longer hospital stays, resulting in higher health care costs. Fall prevention involves managing a patient’s underlying fall risk factors while optimizing hospital safety strategies.

By spring 2014, all Sharp Memorial Hospital inpatient units were equipped with the Hill-Rom NaviCare NurseCall and Smart Client programs. Within this system is a No Falls Protocol (NFP), which displays on a dashboard the status of certain bed safety features to assist with fall prevention. Patients at risk for falling can be placed into the NFP, allowing caregivers to check on bed-status indicators, such as bed exit alarms, rails, height and brakes, and be alerted if there are any changes.

There was an increased rate of patient falls on 5 West, a progressive care unit. The 5 West Unit Practice Council created a Fall Reduction Task Force to analyze the increase and develop an action plan. They discovered that for approximately 50 percent of patients who experienced a fall in the previous six months, staff had forgotten to set the bed alarm.

The task force determined the unit needed to leverage the NFP technology to assist with fall prevention and notification of bed-alarm status. The available technology had not yet been activated because several structures and processes were not yet in place.

Task force members designed a workflow to implement the new technology into clinical practice and educated nurses on the unit before the “go-live” date. Education included:

• Following the new NFP unit workflow
• Verifying the bed is connected to the call system
• Entering patients into the NFP
• Using only “alarm pause” to silence a bed exit alarm (and not turning the bed exit alarm off)
• Reading and monitoring the NFP dashboard
• Recognizing and monitoring dome light indicators located above entry into patient rooms (i.e., once a fall-risk patient is entered into the NFP, a yellow indicator light is illuminated)
• Responding when the alarm is activated
• Resolving bed safety issues indicated on the dashboard
Outcome:
Following implementation of the NFP, the rate of patient falls decreased on 5 West.

Figure 18: The patient fall rate on 5 West decreased 58 percent after No Falls Protocol went live.
Pull Out All The Stops: Emergency Department Expansion Helps Maintain Patient Throughput Goal

The Emergency Department (ED) experiences an increase in volume each year. Despite the growth, the ED works hard to maintain a median admit time of 60 minutes; that is, 60 minutes from the time a doctor completes an order to admit a patient to Sharp Memorial to the time the patient arrives in an inpatient room.

The ED had been reaching capacity due to steadily increasing volumes and was experiencing challenges in maintaining their throughput goal. Leadership and staff identified a need to expand the ED to accommodate the growing volume of patients, especially for patients who were less acute and required fewer resources.

An ED Lean team identified available space for expansion in the hospital’s original ED, which had been used as meeting space since the ED relocated to the new Sharp Memorial hospital in 2009. After hospital leadership approved the plan, the ED Lean Team analyzed how to best redesign the area for clinical use — from the location of blood pressure cuffs to the positioning of vital-sign monitors. The nurses met regularly with Engineering and contractors to design the space and ensure clinical care items were placed in the most efficient spots. Additional nurses, nursing assistants and physicians were hired to staff the new area.

“ED 2” opened in January 2016 as an expansion area to serve nine additional patients. Resources were reallocated to assist with efficiency, such as an admitting clerk to register patients, a laboratory technician to draw needed labs, a radiology technician to perform X-rays, and a computerized tomography (CT) transporter to take patients to the inpatient CT scanner.

Outcome:
The opening of ED 2 resulted in an improvement in the ED’s median throughput goal, despite increasing patient volumes.

Featured Research Study

Predictors of Septic Patient Outcomes

Introduction
Nursing plays a vital role in coordinating the complex care of septic patients. Because sepsis is a common medical emergency with a high rate of mortality, it is imperative for health care systems to improve. Careful observation by nurses is critical to detecting septic patients and applying specific care-management processes. The purpose of the study was to identify factors associated with mortality in patients with sepsis-related diagnoses.
Methods
Data were extracted from the electronic medical records of 482 patients admitted through the Emergency Department with severe sepsis or sepsis shock from July 1, 2014 through June 30, 2015. The sample was fairly evenly distributed by gender — 248, 51.5 percent male; 234, 48.5 percent female — and ethnically diverse. The principal investigator worked closely with Quality and Medical Record staff to gather necessary information and analyze the results.

Results
In general, patients who were female, older, and/or had increased comorbidities were more likely to die from their condition. Study findings revealed significant results between gender: males had longer hospital lengths of stay, higher comorbidity scores, arrived to inpatient units faster than females; were prescribed antibiotics faster; and had antibiotics administered in less time than females. The study also found statistically significant disparities in processes of care: more males received mechanical ventilation, central lines and vasopressor support.

Although not statistically significant, in this study males were more likely to have initial lactate and blood cultures drawn, and were admitted to higher levels of care than females (intensive care units vs. acute care units), despite the fact that lactate levels in females were higher than in males.
Table 1: Treatments initiated in 482 patients with severe sepsis or septic shock by gender.

<table>
<thead>
<tr>
<th></th>
<th>MALE (N = 248)</th>
<th>FEMALE (N = 234)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Lactate Measured</td>
<td>89.5%</td>
<td>88.0%</td>
<td>ns</td>
</tr>
<tr>
<td>Blood Culture Before Antibiotics</td>
<td>93.9%</td>
<td>90.6%</td>
<td>ns</td>
</tr>
<tr>
<td>Adequate Fluid</td>
<td>26.4%</td>
<td>39.5%</td>
<td>*</td>
</tr>
<tr>
<td>Packed Red Blood Cell Transfusion</td>
<td>16.1%</td>
<td>18.1%</td>
<td>ns</td>
</tr>
<tr>
<td>Vasopressor Administered</td>
<td>63.3%</td>
<td>53.8%</td>
<td>**</td>
</tr>
<tr>
<td>Central Line Placed</td>
<td>57.3%</td>
<td>47.9%</td>
<td>*</td>
</tr>
<tr>
<td>Mechanical Ventilation Used</td>
<td>43.5%</td>
<td>35.1%</td>
<td>**</td>
</tr>
<tr>
<td>Initial Lactate Level, Mean, (SD), mmol/L</td>
<td>3.1 (2.8)</td>
<td>3.6 (3.1)</td>
<td>ns</td>
</tr>
<tr>
<td>Time of Initial Lactate,* (Median, IQR), Minutes</td>
<td>51 (31-137)</td>
<td>57 (32-140)</td>
<td>ns</td>
</tr>
<tr>
<td>Time ABX Prescribed,* (Median, IQR), Minutes</td>
<td>128 (67-252)</td>
<td>161 (89-313)</td>
<td>*</td>
</tr>
<tr>
<td>Time ABX Administered (Median, IQR), Minutes</td>
<td>179 (106-348)</td>
<td>226 (142-396)</td>
<td>**</td>
</tr>
<tr>
<td>Fluids Administered, Mean, (SD), ml/kg</td>
<td>20 (21.5)</td>
<td>27 (24.7)</td>
<td>**</td>
</tr>
<tr>
<td>Mortality</td>
<td>30.6%</td>
<td>32.1%</td>
<td>ns</td>
</tr>
</tbody>
</table>

SD = Standard Deviation; * Calculated from ED arrival; ABX = antibiotics; IQR = interquartile range; ns = not statistically significant; *p < .05, **p < .001.
Table 2: Logistic regression analysis predicting mortality (n = 423).

<table>
<thead>
<tr>
<th>PREDICTOR</th>
<th>B</th>
<th>SE</th>
<th>WALD</th>
<th>P</th>
<th>ODDS RATIO</th>
<th>95% CONFIDENCE INTERVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>Discharge Diagnosis</td>
<td>-.895</td>
<td>.288</td>
<td>9.65</td>
<td>.002</td>
<td>.409</td>
<td>.232</td>
</tr>
<tr>
<td>Gender</td>
<td>-.520</td>
<td>.259</td>
<td>4.03</td>
<td>.045</td>
<td>.595</td>
<td>.358</td>
</tr>
<tr>
<td>Age, (Years)</td>
<td>-.034</td>
<td>.009</td>
<td>14.86</td>
<td>&lt; .001</td>
<td>.967</td>
<td>.951</td>
</tr>
<tr>
<td>Charlson Comorbidity Index Score⁵</td>
<td>-1.70</td>
<td>.045</td>
<td>14.54</td>
<td>&lt; .001</td>
<td>.843</td>
<td>.773</td>
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<tr>
<td>Urinary Tract Infection</td>
<td>2.277</td>
<td>.961</td>
<td>5.61</td>
<td>.018</td>
<td>9.746</td>
<td>1.482</td>
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<tr>
<td>Intra-Abdominal Infection</td>
<td>1.697</td>
<td>.365</td>
<td>21.59</td>
<td>&lt; .001</td>
<td>5.458</td>
<td>2.668</td>
</tr>
<tr>
<td>Initial Lactate Level, (mmol/L)</td>
<td>-.213</td>
<td>.050</td>
<td>18.44</td>
<td>&lt; .001</td>
<td>.808</td>
<td>.733</td>
</tr>
<tr>
<td>Recommended Fluids</td>
<td>.684</td>
<td>.283</td>
<td>5.86</td>
<td>.015</td>
<td>1.982</td>
<td>1.139</td>
</tr>
<tr>
<td>Length of Stay, (Days)</td>
<td>.032</td>
<td>.012</td>
<td>6.65</td>
<td>.010</td>
<td>1.033</td>
<td>1.008</td>
</tr>
<tr>
<td>Χ²</td>
<td>118.38</td>
<td></td>
<td></td>
<td>&lt; .001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correctly Classified</td>
<td>77.3</td>
<td></td>
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</tbody>
</table>

Discussion
The results of this investigation suggest gender-related differences exist in the care of septic patients. Therefore, opportunities exist to address decision-making with regard to potential gender bias and to improve the processes of care for septic patients.
Toot Your Own Horn: Sharing Best Practices

The following list includes the involvement of nurses in scholarly activities. Bolded author names are nurses at Sharp Memorial.

Internal Presentations — Poster


Internal Presentations — Podium


**Chillcott, S.**, *HeartMate II LVAS Advanced Training — Discharge Planning and Team Building*, Thoratec On-site Education Training Program, Sharp Memorial Hospital, San Diego, CA, June 7, 2016

**Chillcott, S.**, *HeartMate II LVAS Surgical Training — Equipment Overview, Device Troubleshooting and Discharge Planning*, Thoratec On-site Education Training Program, Sharp Memorial Hospital, San Diego, CA, Aug. 5, 2016


**Donnelly, J.**, *Panel Discussion: Research Study Lessons Learned*, Share, Inspire, Transform Presentation Series, Sharp Memorial Hospital, Sept. 26, 2016

**Doolittle, T.**, *Avoiding Hospital-Acquired Conditions: A Qualitative Analysis*, Share, Inspire, Transform Presentation Series, Sharp Memorial Hospital, July 25, 2016
Ecoff, L., Colette, A., Reavis, K., Engaging Clinical Nurses in Research, Clinical Practice Council, Sharp Grossmont Hospital, San Diego, CA, Aug. 2, 2016
Ecoff, L., Nuggets of Knowledge from the Magnet Research Symposium, Share, Inspire, Transform Presentation Series, Sharp Memorial Hospital, Oct. 24, 2016
Failla, K., Predictors of Septic Patient Outcomes, Share, Inspire, Transform Presentation Series, Sharp Memorial Hospital, April 25, 2016
Moore, S., Wallace, M., Enriquez, V., Delara, J., Mastectomy Infection Reduction, Sharp HealthCare Do No Harm Conference, Sept. 9, 2016
Nasshan, S., Reducing HF Readmissions by Implementing Handoff Protocol, Share, Inspire, Transform Presentation Series, Sharp Memorial Hospital, July 25, 2016
Sitzer, V., Build Your Bridge as You Walk on It, Nurse Residency Program Cohort 16 Graduation Keynote Speech, Sharp Memorial Hospital, Feb. 12, 2016
Sitzer, V., The Basics of Meeting Agendas and Minutes, Interprofessional Council for Education Fuel Your Practice Series, Sharp Memorial Hospital, March 21, 2016
Wells, P., Fox, T., Building Resiliency Through Accountability, Sharp HealthCare Do No Harm Conference, San Diego, CA, Sept. 9, 2016

Internal Presentations — Webinar or Other
Failla, K., Predictors of Septic Patient Outcomes: Does Gender Matter?, Sharp HealthCare Quality Huddle, San Diego, CA, June 10, 2016

External Presentations — Poster
DeJesus, M., Smith, C., Bringing It Back To Basics, University of California, 9th Annual UC San Diego Nursing Inquiry and Innovations Conference, San Diego, CA, June 8, 2016


Doolittle, T., *Avoiding Hospital-Acquired Conditions: A Qualitative Analysis of Early Top Performers*, Western Institute of Nursing Annual Communicating Nursing Research Conference, Anaheim, CA, April 7, 2016


Failla, K., *Predictors of Septic Patient Outcomes*, Western Institute of Nursing Annual Communicating Nursing Research Conference, Anaheim, CA, April 6, 2016

Fox, T., *Bringing It Back to Basics: Reducing Clostridium Difficile Transmissions on a Surgical Acute Care Unit*, Academy of Medical-Surgical Nurses Annual Convention, Washington, DC, Sept. 30, 2016

Fox, T., *Bringing It Back to Basics: Reducing Clostridium Difficile Transmissions on a Surgical Acute Care Unit*, International Planetree Conference, Chicago, IL, Nov. 2, 2016


Pang, W., *Standardization of Nasogastric Tube Insertion Protocol Using Lidocaine Gel*, University of San Diego Research Conference, San Diego, CA, April 28, 2016


Reavis, K., Dalgren, L., *Brief De-Briefing of Critical Incidents with Medical Intensive Care Staff*, Western Institute of Nursing’s 49th Annual Nursing Research Conference, Anaheim, CA, April 8, 2016


**External Presentations — Podium**


Ecoff, L., Keynote Speaker, School of Nursing Pinning Ceremony, National University School of Nursing, San Diego, CA, June 10, 2016


Ecoff, L., Colette, A., Reavis, K., Rique, K., Engaging Clinical Nurses in Research, 9th Annual UC San Diego Nursing Inquiry and Innovations Conference, San Diego, CA, June 8, 2016
Failla, K., Predictors of Septic Patient Outcomes, Doctoral Defense Presentation, University of San Diego, San Diego, CA, March 15, 2016
Holsworth, C., Care of the Bariatric Patient, Alaska Nurses Association, Anchorage, AK, Jan. 15, 2016
Sitzer, V., Performance Improvement Using the A3, Guess Lecturer, School of Nursing, University of San Diego, San Diego, CA, Oct. 17, 2016
Tade, T., Wisler, S., Handoff Tool For Safety, Evidence-Based Practice Institute Conference, San Diego, CA, Nov. 8, 2016
Yager, M., Defend Against Delirium, Bonefide Orthopedic Nurses Education Seminar, University of California, San Diego, San Diego, CA, Oct. 21, 2016
External Presentations — Webinar


Publications


Call the Tune: Earned/Advanced Nursing Degrees in 2016

Janet Donnelly, Doctorate of Philosophy in Nursing, University of San Diego, San Diego, CA, May 2016

Tammy Doolittle, Doctorate of Philosophy in Nursing, University of San Diego, San Diego, CA, August 2016

Kim Failla, Doctorate of Philosophy in Nursing, University of San Diego, San Diego, CA, May 2016

Tricia Hicks, Master’s of Science in Nursing, Health Care Informatics, University of San Diego, San Diego, CA, May 2016

Josie McDowell, Master’s of Science in Nursing, Grand Canyon University, Phoenix, AZ, October 2016

Wei Pang, Master’s of Science in Nursing, University of San Diego, San Diego, CA, May 2016

Lori Rodgers, Master’s of Science in Nursing, Grand Canyon University, Phoenix, AZ, October 2016

Yvonne Vargas, Master’s of Science in Nursing, Western Governors University, Salt Lake City, UT, March 2016

Kim Failla, PhD, RN, NE-BC, Nurse Residency Program, earned her Doctorate of Philosophy in Nursing in 2016.