Cultivating Collaboration

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Cultivating Collaboration: 10 new ways to connect ideas and grow the future of nursing
Welcome to the University of Utah 2012 nursing report! We’re excited this year to present examples from our journey in collaboration. Although we’ve always thought of ourselves as collaborative with other departments, we’ve begun a concerted effort to be highly inclusive much earlier, and more fully than before. The result has been better ideas, rapid buy-in, and such positive outcomes that we wanted to share them with you.

On the next pages you’ll see collaborations with multiple people in multiple departments, some who have been involved in our nursing innovations before, and others who are new collaborators. I hope you will find something that is helpful to you and your organization in our examples.

This year, we’ve included some projects that are still in their pilot phase. We’re so excited about our outcomes to date that we want to get the information out right away. We’ve also included additional online features on our nursing report web site, including discussion forums for each story, video interviews, and other project materials. Visit NursingInnovation.UofUHealth.org for fun and interesting details on all our stories. We’ll be updating our progress during the year, so you can check back and see how things are going with the projects long term.

Finally, as you review or implement any of our ideas, please send us feedback via email at nursinginnovation@hsc.utah.edu. We would love to hear what you’ve done and discover some great new ideas to implement ourselves. Thank you for taking the time to review our progress. We look forward to hearing from you.

Margaret Pearce, RN, Ph.D.
Chief Nursing Officer
No one can build a thriving academic medical center alone. One bold idea must be combined with others, built upon, and refined to create the kind of solutions that break through the clutter and change things. Simply put, innovation takes teamwork.

But how do you create a place where thousands of nurses, physicians, and staff can put aside their individual priorities and work together for the greater good of the institution, and ultimately, the patient?

It starts with the individuals themselves. It’s the leader who embraces change—from the CNO who encourages her staff to take calculated risks to the charge nurse who proposes a brand-new solution to an age-old problem. It’s the nurse who transcends traditional boundaries, working with everyone from housekeepers to medical directors to transform the patient experience. And it’s the medical assistant who knows that his voice will be heard, his ideas can effect change, and his contributions will be recognized.

So how do you get these stellar people on your team? You start by offering a clear vision of what you want the future to look like. Then, you remove any barriers that stand in the way of that future. By giving your employees the gift of trust, they can learn by doing, gain self confidence, create innovative solutions, and take ownership of the results. Bolstered by their own success and personal growth, they give back the gift of accountability, saying “you can count on me” and showing your organization that they mean it. We call this process the Positivity Cycle.

We’ve seen this Positivity Cycle pay off in incredible new ways this year—from creative business ideas that have saved our organization millions of dollars to patient-centered initiatives that have boosted our overall satisfaction scores to the 95th percentile. Read on for specific ideas and stories that can help you create a collaborative culture—and transform your nursing department.

Nurture collaboration, build innovation.

There are concrete steps you can take to build your own nursing dream team. Here are the basics of what we’ve discovered—and put to the test—in our own organization.

+ Hire for attitude, and train for the technical components of the role.
+ Set high expectations and measure outcomes.
Collaboration drives results.

- Have and show confidence in the team’s ability to drive change.
- Do not dictate the methods; provide leeway for creativity and innovation. If the team creates the solution, they will own it and will make it successful.
- Make it okay to make mistakes.
- Publically reward and recognize great work, and always give credit to the team.
- Trust the team to come up with the right solution—they will surprise you with solutions that you would have never imagined!

What does accountability mean to you? Visit NursingInnovation.UofUHealth.org to hear our leaders share their experiences in creating an accountable culture—and share your own ideas with our community.

You can have it all. Our numbers for nursing in cost efficiency, patient satisfaction, and volume all head in the right direction. And as for quality, the University of Utah achieved top 10 status for academic medical centers nationally for the past 3 years.
Margaret Pearce, our CNO, had a single and clear request: Bring patient satisfaction pain care scores up by at least two percent. To make it happen, she gave three suggestions: involve all stakeholders on the team, conduct a thorough assessment of the problem, and be creative with the solution. What she didn’t tell us was how to do it. And this gave us the freedom to reimagine and reinvent everything—most significantly, the 0-10 pain scale.

“Bringing the whole pain experience to one number wasn’t accurate or meaningful,” says Brenda Gulliver, quality improvement specialist. “We didn’t completely value the pain scale, and we weren’t using it in our daily practice.” The question was, what would be better?

To begin grappling with this question, we assembled a team of nurses, pharmacists, physicians, educators, advanced practice nurses, and physical therapists from our hospital. At the same time, on the other side of our campus, two investigators at the Pain Research Center had been asking very similar questions. “When we learned about their work, we knew we wanted them on board with us right away,” says Brenda.

Take a multidimensional perspective.

Gary Donaldson, director of our university’s Pain Research Center, was eager to join the project. Along with colleague Richard Chapman, he’d been working for years on the problem of how to advance the measurement of pain, both in theory and in practice. “By joining forces with the hospital project, we had an opportunity to put some of our thinking to the test in a meaningful context,” says Gary.

“We created a community centered around a common goal. It was the perfect union of collaborative thoughts and ideas.”

—Brenda Gulliver, Quality Improvement Specialist

While Gary and Richard brought years of research and knowledge of pain care literature to the project, our nurses, physicians, APRNs, educators, and physical therapists brought the practical, hands-on expertise. Meanwhile, our pharmacists brought their comprehensive medication insight.

“We fearlessly put ourselves out there, made

02. Give patients a voice, not a number.

Creating a multidisciplinary, patient-centered conversation about pain management.
connections, and found people who could help,” says Shantel Mullin, our clinical pharmacy manager and one of the pain management project leads. “There’s already a culture of collaboration in place here at the University of Utah, so it felt natural to open new lines of communication between departments, to benefit from each others’ expertise, and to focus on shared wins for our patients.”

Create meaningful conversations.

The team developed a series of pain care questions designed to replace the 0-10 pain scale in the pilot project. The questions focused on getting a description of the pain and an understanding of the patient’s ability to function throughout the day. “The beauty of the project was that better communication about pain permitted objectively superior measurement, and better measurement led to improved pain management,” says Gary.

To make the most of the new model, nurses were instructed to ask the new pain care questions in a casual and natural manner, rather than using a strict checklist format. “Everything we did was an effort to move away from the drive-by pain assessment,” says Brenda.

Deborah Watkins, one of our clinical nurse educators, participated in the pilot and immediately reported excellent results. “Asking for a pain number is a closed question,” she says. “Asking a patient to describe their experience opens up a dialog, so that a therapeutic relationship can form. Patients thanked me for listening and caring, but I don’t think I was suddenly caring more. I just had the tools to communicate more effectively.”

Don’t just discuss, document.

While the pain discussion with patients was purposefully casual, the documentation of their responses needed to be highly structured—so that pharmacists, physical therapists, physicians, and anyone else involved in the patient’s pain care could access our latest pain assessments and use them to make better decisions about medications, treatments, and interventions.

To make this possible, we brought IT experts into the project early, so they had time to think through our documentation needs. This allowed them to become true team players in our process, so they could create a fully realized, easy-to-use tool that integrated seamlessly with the hospital’s regular documentation workflow. “We couldn’t have done it without early and ongoing collaboration with our IT people,” says Brenda. “They were just as invested as our clinicians.”

Spark a revolution with us.

Patients on all our pilot units can see how much we care about helping them heal and getting them home. And they’re sharing the love with us, too. In one quarter after starting the pain management pilot, our patient satisfaction pain care scores leapt from the 45%tile to the 92%tile on the pilot units. Now the new pain management tool is in place throughout our system, and we’re just getting started.

After thoroughly working through the new pain management protocol at our own hospital, we believe that patients everywhere deserve to have their pain recognized sympathetically, evaluated thoughtfully, and treated carefully. Brenda confidently asserts that our pain management initiative will have a ripple effect far beyond our own hospital walls, with nurses everywhere tossing out numbers in favor of conversations. “We hope this will be revolutionary on a national scale.”

See what patients think of our new pain management protocol. Watch videos at NursingInnovation.UofUHealth.org, and tell us how you’re improving the conversation about pain at your hospital.
92nd percentile for pain care satisfaction

Did the staff do everything they could to help manage my pain? Prior to our pain management pilot, our hospital scored in the 45th percentile in Press Ganey on this question. One quarter later, after implementing our new assessment tool, our scores in the pilot units went up to the 92nd percentile in Press Ganey.

Changing the conversation: Quality Improvement Specialist Brenda Gulliver asks pointed, specific questions to get to the heart of each patient’s pain experience.
Crossing boundaries: Critical Care Nursing Director Colleen Connelly, Nurse Manager Julia Beynon, and Huntsman Cancer Hospital Nursing Director Sue Childress combined forces to create one unit with two locations.
03. Think like a system.

*Bridge the gap between hospital units and nursing staff to boost efficiency.*

Coming together isn’t always easy. Especially when you’ve got over 3,000 nursing staff working in four different hospitals, 10 dispersed community clinics, and more than 50 separate medical units. In this decentralized environment, we found that our teams naturally formed their own independent domains. But this was causing duplication in staff, management, equipment, and other costly services. So we decided to think differently—and to start working together as a system.

**Connect distant units with similar specialties.**

To kickstart our transformation to systems thinking, we created a pilot project with our orthopedic hospital to transform two independent units into one synchronized unit with two different sites. This involved merging our intermediate care University Orthopaedic Center with our higher-acuity Ortho Trauma and Surgical Specialty unit, which was two miles away at our University Hospital.

Although the distance wasn’t far, the two locations had been functioning as separate islands in a vast sea, even as they both struggled with a similar problem: fluctuating census levels and unpredictable staffing needs. “We were definitely faltering,” says Janiel Wright, nurse manager at the UOC. “But we weren’t asking for help.”

It was a perfect opportunity to try a systems thinking approach. We knew that if we could train all our orthopedic nurses to work seamlessly at either location, we could keep staff from getting called off when things were too slow—and we could keep both sites from becoming understaffed when things got too hectic. But before we could make it work, new levels of collaboration and coordination would have to be achieved.

**Train your team for a new clinical setting.**

Although the nurses on both units had experience in orthopedics, they worked with distinctly different patient populations with disparate clinical needs. To be successful at our OTSS location, where patients are typically sicker, the UOC nurses cross-trained on site before they actually started working there, learning to handle complex emergency care and intensive orthopedic procedures they simply hadn’t seen at the UOC.

Training OTSS nurses to work at the UOC site posed different challenges altogether—small things like how to get into the building at night, critical details like how to admit a new patient, and life-or-death issues like how to handle an emergency. Lance Littledike, nurse manager on our OTSS unit, worked with Janiel to orient OTSS nurses to every little detail within the new setting. “We made sure that no one was sent into the unknown,” says Laura Adams, nursing director for acute care and rehab at our University Hospital.

**Standardize policies, supplies and staff.**

To further remove cognitive dissonance at both locations, best practices were identified and standardized across UOC and OTSS, float nurse coordination and
scheduling was centralized with the help of our resource nursing team, and supplies were stored and tracked consistently on both units. This created two predictable and safe clinical environments, where nurses had the constant support and stable infrastructure needed to make smart decisions.

The result? Both units fortified their financial strength, relying on skilled internal nurses instead of expensive agency nurses who were less familiar with our orthopedic settings. And the nurses got the hours they needed to stay productive—all while building their orthopedic skills. “Now, our nurses float effortlessly between the two sites, without any grumbling,” says Laura. “It’s like going from the family room to the living room. It’s home.”

300% reduction in turnover

By integrating orthopedic nursing staff, we have reduced RN turnover at our small UOC unit by 300% over a two-year period, saving $111,600 in actual training and orientation and an estimated $525,000 in turnover and recruitment costs (based on the industry average of $35,000 per vacancy).

Use existing resources to solve new organizational challenges.

We used a similar one-unit, two-sites plan when our Huntsman Cancer Hospital decided to establish an on-site intensive care unit. Because they’d never built or managed an ICU, they were, fundamentally, starting from scratch. They needed to know everything from where to position monitors in critical care patient rooms, to what types of workspaces to provide for nurses who rarely sit down. They needed ICU experts—and they needed them fast.

With the success of our orthopedic pilot, we felt confident that a similar approach could work at the Huntsman Cancer Hospital. So we connected our experienced SICU nurses with the fledgling Huntsman team and began developing a systems thinking plan for managing and staffing the new ICU.

Take the burden off individual shoulders—and put it on the team.

We asked Julia Beynon, our SICU manager, to be nurse manager for both sites. It was, admittedly, a daunting task. For starters, she was busy enough on the SICU.
“Academic medical centers can’t be about individual people or personal agendas. They can’t be about one leader trying to build a kingdom. They must always be about coming together to do what’s right for the patient.”

—Colleen Connelly, Critical Care Nursing Director

What’s more, the new ICU would be in a different hospital altogether, a 10-minute walk from her unit, through a labyrinth of tunnels. And then there was the issue of asking her staff to float between two sites—and explaining to them why it mattered.

To overcome real and perceived barriers, Julia talked openly about her concerns with Colleen Connelly, critical care nursing director and Sue Childress, Huntsman Cancer Hospital nursing director. “Sue asked me what we needed to be successful,” says Julia, “and I realized that the burden wasn’t just on my shoulders. No one person was expected to know everything. If we all worked together as a team, we’d have everything we needed to get the job done.”

$1.7 million saved
By combining SICU and Huntsman ICU staffing, we avoided $1.7M in additional staffing costs.

93% patient satisfaction
From January-September 2012, 93% of HCAHPS survey respondents rated the Huntsman ICU as a 9 of 10, and 100% said they would “definitely” recommend it.

Stay focused on what’s best for the patient.

With the support of both hospitals’ leaders on her side, Julia accepted the difficult mission and set off to accomplish her first big task: communicating the plan to SICU and Huntsman nurses. She spoke candidly with her team about the challenges, but framed the discussion around what was best for patients, not what was best for individual nurses. After that, everything began to fall in place. “My nurses agreed,” says Julia, “because it was the right thing to do for our patients.”

Colleen, who serves as Julia’s director, was pleasantly surprised by the universal staff buy-in. “ICU nurses are particular; they have strong personalities and they’re really attached to their units. These are nurses who tell it like it is. But not a single one of them questioned why we were doing this.”

To make the cultural exchange a little smoother, Julia and Colleen focused on respecting the differences between the two groups of nurses. Instead of challenging the culture or trying to change it, the SICU team helped the Huntsman Cancer Hospital build its vision. And the Huntsman team welcomed the help. “Sue let us into her home,” says Colleen. “And she trusted us to rearrange the furniture.”

As our nurses continue to float between ICUs and learn from each other, the distance that once seemed so vast has become insignificant. “With this project, we’ve created the building blocks for system-wide thinking,” says Colleen.

Sue is equally positive as she looks toward the future of the Huntsman Cancer Hospital and the entire University of Utah Health Care system. “There’s not a border we can’t cross,” she says. “After all, we’re doing it every day.”

See more lessons in collaboration from our Huntsman ICU. To hear secrets from the people who made it happen, and to share your own systems-thinking ideas, visit NursingInnovation.UofUHealth.org.
When we decided to standardize our OB telephone triage system, we wanted to get some ideas from an established program. Problem was, we couldn’t find an established program. Our literature research came up cold. Our conversations with colleagues at other institutions led nowhere, and we learned that many OB departments like ours didn’t triage by telephone at all— they simply told everyone to come in to the hospital.

We knew there was a better way—a telephone triage middle ground that would reduce unnecessary hospital visits and costs—but our current system wasn’t it. The questions we asked patients and the advice we gave had the potential to vary depending on the practitioner. The notes we took during triage were jotted only on paper. It just felt a little too loose.

“‘In this day and age, when we know that standardized care leads to better outcomes, we just couldn’t keep working with such an unstructured system,’” says Janet Fisher, labor and delivery nurse. At the same time, we also realized that if we wanted a truly forward-thinking telephone triage system, we’d have to invent it ourselves.

**Step outside of your department.**

It’s easy to get stuck in the status quo. Breaking out requires the help of others—people who can look at something you’ve been looking at for years and see it completely differently. That’s where our Quality department came in. With their help, we began forming

“‘When nurses get introduced to the interdisciplinary world, we can break through self-imposed barriers and solve seemingly impossible problems. Other people bring more pieces of the puzzle, so that together, we’re able to complete the picture.’”

—Janet Fisher, Labor and Delivery Nurse
a vision for a computerized system: a tool that could leverage our best clinical thinking to deliver consistent patient advice.

“We started wondering if there could be an algorithm for telephone triage,” says Janet. But it wasn’t a question that the OB nurses or the Quality team could adequately answer on their own, so they brought in more collaborative thinkers from the IT department. “We discovered a whole new level of resources that we didn’t know existed,” says Janet. “And they helped us expand the way we looked at our day-to-day practices.”

Make IT pros your new best friends.

Our OB nurses and midwives understood the clinical situations that came up during triage, and our labor and delivery physicians helped refine them, but it was our IT team that turned it all into an efficient workflow. “We had the concepts figured out to a certain degree,” says Amy Nelson, a certified nurse midwife in our OB department. “They made it into a useful product.”

Working with systems application analysts Jake Hendriksen and Pearce Danner to create a standardized decision tree, our OB team looked carefully at all clinical scenarios, pinpointed the critical questions that needed to be asked, and assigned an acuity to each scenario based on patient responses. For instance, if a patient mentioned decreased fetal movement, a new dialog box would come up to help the triage nurse probe more, with specific questions about the movement or lack of movement, and instructions to give to the patient, so she could try and increase movement.

“We started to think of general questions leading to the next set of more specific questions that impacted our final outcome of advice,” says Amy. “With Jake and Pearce’s help, we began to think in a more organized way.”
Invite junior staff members to be central players.

It’s great to collaborate with experienced experts, but inexperience can be an asset, too. That’s why we also gave our Quality intern, Danielle Freeman, a key role in the project. “We tend to get muddled in the systems we’re used to,” says Danielle. “And that makes it hard to think outside the box.” With her combination of youth and inexperience, along with the fact that she wasn’t on the clinical side, Danielle could see the project from an outsider’s view and contribute a fresh perspective. She also had undivided time to work on the nuts and bolts of the project, and keep it on track.

55% reduction in unnecessary hospital visits

Our clinical decision-making algorithm, which ensures that patients are given appropriate advice on whether to come to the hospital, has reduced unnecessary hospital visits by 55 percent. There have been no instances where a patient was misdirected using the new algorithm, which demonstrates that it is a superior patient safety tool.

Once the new computerized triage system was complete, Danielle developed staff education for 70 nurses, midwives, and medical assistants, teaching them how to navigate the computer program, systematically run through the questions, and document the patient call in the system.

Trust the system.

Transitioning from intuitive to rules-based practices requires more than a new computer system and staff training. It also requires a change in mindset. We must acknowledge that a well-defined set of rules goes much further than individual instinct when it comes to ensuring patient safety. “It’s a hard shift, but our triage nurses are learning to trust the system,” says Pearce. “It eliminates subjectivity and reduces variables, so our patients get the best possible advice.”

Janet agrees, and also acknowledges that this best-in-class advice couldn’t have been delivered to patients without bringing together clinical, technological, and quality perspectives. “Even now that we’ve made it happen, we’re still in awe of this new tool,” she says. “This huge hospital is just brimming with ideas, and we can do great things when we bring different minds and skill sets together.”

Not just a systems analyst, but a soon-to-be dad.

See Jake Hendriksen’s perspective on how his wife’s pregnancy affected his thinking during the telephone triage project. Visit NursingInnovation.UofUHealth.org.
05. Share nursing resources far and wide.

Creating one core staff to cover 4 hospitals, 10 community clinics, and hundreds of square miles.

The most successful collaborations often start casually. One person has the seed of an idea, another germinates it, and together something bigger takes root and grows. That’s how resource nursing manager Karen Nye and community clinics nursing director Natalie Manolakis transformed the nursing resource pool for our academic medical center: with a single idea, shared over lunch.

“I had a vision for merging our hospital and community clinic resource pools,” says Natalie. “But I didn’t know exactly how it would work, and I didn’t want to overwhelm Karen.” As it turned out, Margaret Pearce, our CNO, had already been discussing an outpatient pool with Karen, because specialty service outpatient areas were using significant inpatient resources trained for acute and critical inpatient services. And so they started with a simple conversation—and a few ambitious what-ifs. By the end of their first lunch date, they were both convinced that an expanded, centralized resource pool was the right thing to do.

But doing what’s right isn’t always easy.

Create an environment where everyone wins.

Karen and Natalie worked together to create a proposal for joining their two teams as one, considering everything from cross-training nurses and medical assistants to centralizing scheduling for them all. And while it was clear that nursing leadership supported the plan, and could see the big picture of how it would maximize efficiencies and improve patient care, convincing the hospital and community clinics staff that it would truly work was another challenge altogether. Would resource nurses from the “big house” be interested in the lower acuity patient care and completely different pace of the clinics? And would community clinic nurses be comfortable building the necessary skills to float through specialized units in the hospital?

“We had a very optimistic perspective,” says Natalie. “The challenge was to get everyone to that place of optimism that we felt.” To do this, Natalie and Karen focused not only on how the plan would be better for the organization and patients, but also how it would be better for the staff. With an expanded pool of nurses and MAs, community clinic managers would have more resources to draw from on a day-to-day basis. With centralized scheduling, vacations and family leave needs could be covered proactively, and day-to-day sick calls could be filled. With staffing opportunities on both the clinic and hospital sides, nurses wouldn’t lose hours when one location’s census was low. And with specialty training opportunities for all resource nurses and MAs, everyone would have a clear pathway for career advancement.
Joining forces: Community Clinics Nursing Director Natalie Manolakis and Resource Nurse Manager Karen Nye teamed up to improve patient care and increase operational efficiencies.
patients received the exceptional care they deserved, wherever they were within our system.

Focus on continual improvement.

Just nine months after first proposing an integrated inpatient and community clinic resource pool, the project is now up and running. Staff fear and uncertainty have been replaced with a common sense of purpose—with people who once worked with fierce independence coming together as a single, focused entity. “My personal mission was to show that we are really one system,” says Natalie. “After all, our key goals of quality, patient satisfaction, and efficiency are the same in every clinical setting.”

1,401 hours covered

In the few months since the new resource pool has been in place, the resource nurses and MAs have already covered 1,401 hours of unfilled shifts for the community clinics.

But Natalie and Karen aren’t resting on their early wins. Instead, they’re looking forward to the next steps, including further expanding the resource pool to cover a clinical call center, urgent care clinic and specialty clinics, too. “We’ve taken a great step toward thinking like a system,” says Karen. “But we can have an even bigger impact on patient care moving forward,” adds Natalie. “We’ve only begun to chip away at the iceberg.”


Karen and Natalie also gave staff the gift of time. They had meetings, picnics, and retreats so that nurses and MAs could get to know each other. They talked over the additional training that all resource nurses and MAs could receive, and they asked for feedback on how to make the process better, so that everyone had a voice before the plan was implemented. “We didn’t just throw a new manual at them,” says Karen. “We created a safe zone for communicating change, and we kept an open mind about how to shift to a larger system.”

Develop a single set of expectations.

Once staff bought in to the plan, the next step was to fully prepare them for the transition. With a significant reduction in inpatient agency use from the prior year (see Idea 05, 2011 Nursing Report on our website), Karen was able to expand the inpatient nurse coordinator position to cover community clinics staffing as well. The staffing coordinator created a streamlined, consistent process for resource requests, and worked directly with our IT department to ensure that scheduling software was standardized across all clinics and integrated with the hospital system, so that no one made requests via email or phone that could be easily overlooked.

Next, they worked with our nursing educators to create a consistent workflow throughout the system, so that every nurse and medical assistant could follow the same standard of practice, no matter which location they were serving. “We made it seamless,” says Natalie, “so that moving to another clinical setting didn’t feel like moving to a foreign country.” This made it easy for nurses and MAs to get up to speed quickly, and it ensured that
Coordinated efforts: Dr. Erin Clark, Labor and Delivery Nurse Janet Fisher, Dr. Zuzana Stehlikova, Certified Nurse Midwife Susanna Cohen, Nurse Educator Kim Meyer, and mock “patient” Kristina McAfee train as a team to ensure an efficient, synchronized emergency response.

Breaking down traditional hierarchies to build better emergency communication.

06. Train together so every team’s the “A” team.
“We had the ‘A’ Team today,” said the attending physician, after her OB emergency staff expertly resolved a frightening postpartum hemorrhage.

And while the procedure had gone particularly well, it left us wondering: Shouldn’t any aggregate team be able to come together and perform with skilled precision? Why did some emergencies go so well, while others weren’t quite as seamless?

“Response to an emergency shouldn’t rely on the ‘A team’,” says Janet Fisher, labor and delivery nurse. “Everyone on our staff should be able to work at that level of care.”

This philosophy was the driving factor behind our OB team training project, which brought together physicians, midwives, residents, anesthesiologists, nurses, and medical assistants—along with blood bank coordinators, hospital operators, and even graphic designers—to create a new emergency response system that was thorough, targeted, and highly coordinated.

Train as a team.

Instead of zeroing in on individual heroes, our team training focuses on how all responders function as a group. From the most senior attending physicians to the newest MAs, interdisciplinary teams train together in simulated environments, practicing group communication skills that can make the difference between life and death. Bringing everyone together is a coordination challenge of epic proportions, but according to Janet, it’s worth it.

“It’s about the community coming together, and all of us working as a team.”

—Bernice Tenort, Nurse Manager, Labor and Delivery

“Collaboration isn’t just prep and response. It’s training. It’s each person understanding their specific role and how they fit into our rapid response system,” says Bernice Tenort, nurse manager of the Labor and Delivery Unit. This translates to a single person communicating orders, so that no one gets conflicting directives and the noise level in the room stays low. “It’s hard to be quiet in emergency, but it’s critical for everyone to hear what’s being said.”

Think out loud.

In our simulated training sessions, we learned that the MA is the responder who’s most likely to get bombarded with orders. In a typical emergency, they may be asked to do multiple things at once. We train them to assertively ask what the priority is. Otherwise, they’re trying to do it all, and that can bring the whole process to a halt.

To facilitate a more organized system, our training focuses on closed-loop communication, the same process that NASA and the aviation industry use. The practice involves repeating back instructions when one team member makes a request of another—so that all instructions are clear and consistently communicated, and there’s less of a margin for error.

“It all comes down to communication,” says Kim Meyer, nurse educator for Labor and Delivery. “It’s about breaking down the traditional hospital hierarchy so anyone can say something in an emergency that others may have missed.”

Collaborate beyond the clinical team.

Coordinating an emergency response doesn’t just involve synchronizing the responders. We also reached far beyond our OB training team to get help from the larger academic community. For starters, we worked with hospital operators to improve our system for declaring an emergency.

In the past, OB emergencies could see the whole staff rushing to a room at once—or worse, not enough staff showing up. To solve this, we created an OB Rapid Response system that included defining criteria for calling an emergency, creating a standardized code for OB emergencies, and sending out high-level pages to appropriate team members. “It’s all about getting the right people in the right room at the right time,” says Bernice.
We also recognized that training doesn’t stop after we’ve completed our simulation exercises. To stay on track for the long term, we worked with the university’s Communications Department and tapped students in an advanced graphic design class to develop signs and posters that reiterate our OB rapid response procedures, from our paging procedures to our closed-loop communication practices. “We’re used to communicating with health services academics,” says Bernice. “But this was a real step across academic boundaries.”

Create a safe learning environment.

At the end of the day, our training sessions aren’t just about practicing. They’re about improving. That’s why we create videos of each session and play them back, giving team members the opportunity to talk honestly and critically about the team’s performance—and how to make it better. “The videos are unforgiving,” says Kim. “They can be hard to watch. But we emphasize that everyone is vulnerable, and that our learning environment is a safe, confidential place.”

With time, staff have learned to give powerful constructive criticism—the kind of feedback that moves teams forward. “It’s a huge culture change,” says Janet. “It’s very hard to break traditional barriers about who is ‘right’ in any hospital setting. But there have been incredible breakthrough moments where people have said things that are really reflective, and vital.”

While speaking up isn’t always easy, it’s the right thing to do for our hospital and, most importantly, our patients. And every day, with every simulation, we’re learning to do it better.

How realistic is the training? Listen to our clinicians describe the experience and how it improves their practice. NursingInnovation.UofUHealth.org.

A Patient’s Story

It was supposed to be a routine prenatal visit. But when Laurie Nail’s OB examined her, he knew something wasn’t right. He told her to go immediately to our hospital to see perinatologist Dr. Jan Byrne. Realizing she might be admitted, Laurie quickly stopped at home to grab her bag and meet her husband. But before she could even leave her house, her water broke and she started bleeding.

“I knew Dr. Byrne was expecting me, so we drove straight to the University Hospital rather than going to a hospital closer to home,” she says. When she walked up to the Labor & Delivery nurse station, Laurie explained her situation. The nurse immediately stood up and told everyone at the nurse’s station to follow her and Laurie into one of the labor rooms. Staff quickly got Laurie into bed and within minutes, they were prepping her for surgery.

“Everyone seemed busy, but they were calm, so I was calm,” she says. “Clearly, they were not in a joking mood, but nobody was acting panicked either.”

And yet the team knew that Laurie and her baby were in danger. To avert potential tragedy, everyone in the C-section room worked together with intense focus—and a safe, rapid delivery was performed.

“I had no clue how serious the situation was until after delivery,” says Laurie. The whole emergency, from valet parking Laurie’s car to the birth of her baby, took only 35 minutes. But those 35 minutes made the difference between life and death.

Today, both Laurie and her new baby are happy, healthy, and thriving. “I feel great about the decision we made to come up to the University Hospital,” says Laurie. “From the moment we arrived, we knew we were in good hands.”
03. For patients, the little things mean a lot.


It’s a typical evening at a hospital, but a totally atypical environment for peace, rest, and healing. “Hospitals just don’t sleep at night,” says Colline Prasad, nurse manager on our Surgical Specialty Transplant Unit. “It’s like trying to sleep in downtown New York City.”

For many hospitals like ours, this environmental noise is on the rise. With every new piece of equipment that helps patients, there’s an alarm that disturbs them. And the more equipment we add, the louder things get. With no ability to turn off all the beeps and dings, solving the issue of hospital noise can seem hopeless, but we knew we had to take it on for the greater good of our patients.

With our Shh! project, we found workable solutions to a seemingly unsolvable challenge, and it all started by making patients your key collaborators.
talking with our patients—and really listening to what they had to say.

**Acknowledge your limitations.**

“We always want to bring the patient’s voice to our decision making,” says Chrissy Daniels, our Exceptional Patient Experience director. When it came to the Shh! project, this meant acknowledging the issue with patients, talking with them about why hospitals are noisy, discussing the importance of quiet and sleep in the healing process, and asking for their ideas to help create a better environment.

“We meet regularly to review our patient satisfaction surveys and talk about what patients are saying,” says Kathryn Schumann, clinical nurse coordinator. “If we aren’t maintaining the gain in our scores, we discuss possible interventions, and the solutions are truly collaborative.”

1,000 sets of earplugs distributed in the past six months.

**Bring together diverse voices.**

To spark more innovation, we challenged staff from different departments—including custodians and telephone operators—to share their solutions to our environmental noise problem. “They thought of things I never would have thought of,” says former team member Mara Dykstra, then a supervisor in the Customer Service department. Our custodians purchased quieter floor buffers. And our telephone operators created new workflows to limit overhead paging.

Individually, their ideas might have seemed small, but together they had the power to change the experience for our patients. And so we kept going, working through months of ideas, suggestions, and the initial pilot, until our quieter environment began to take shape. We created “daytime quiet hours” individualized for each patient, dimmed lights and shut doors in patient rooms more often, and developed Shh! posters to remind staff, family, and patients of our protocol.

**Align your values.**

To keep all of our diverse ideas from unraveling into chaos, our project stayed focused on the patient at all times. “We knew we wouldn’t agree on everything,” says Mara. “But we all viewed the patient as the most important element in our process, and that brought a sense of community and purpose to our group.”

Under the larger concept of creating an exceptional patient experience, we were also given the freedom to experiment with different ideas, rather than following predetermined directives or mandates, and that gave us the power to create truly meaningful solutions. “Change
happens at the unit level,” says Chrissy. “Managers couldn’t just say we’re not going to clean floors after 9 p.m. We had to listen to our custodians’ ideas to come to the best solutions. We would never have thought of purchasing quieter floor buffers.”

5% increase in patient satisfaction

Since implementation, the percent of our patients who select Always to the question “During your hospital stay, how often was the area around your room quiet at night?” has increased by 5%.

This emphasis on collaborative design and execution has empowered us to turn down the volume in our busy hospital, making it a better place to heal. Colline acknowledges the power of getting the right people, asking the right questions, and listening—even when you don’t want to hear it. “It’s not for sissies,” she says.

Chrissy agrees, adding that their group collaboration went far beyond getting together and brainstorming. “We’ve developed a keen ability to edit and refine ideas together. And that’s truly innovative.”

We all want our charge nurses to see the big picture. But how can they fully view it when we give them such a narrow lens? This is the question we began asking ourselves when we noticed that many of our charge nurses were relying too heavily on agency staff, avoiding crucial conversations on their units, and making decisions without considering their impact on the hospital as a whole.

It was the kind of setting that can impact unit operations, and we knew it needed to change. But the problem wasn’t the charge nurses themselves, it was the training we were giving them. Like most hospitals around the country, ours had always trained new charge nurses on the unit level, with information passed down from one charge nurse to another. It was an intimate and personalized approach, but it was also seriously limited.

Tap into the hospital’s knowledge base.

To change the culture, we moved from using a large pool of nurses who charged periodically to designating a few charge nurses who could be dedicated to the role. Next, we piloted a new charge nurse orientation program on one of our busiest acute care units. Instead of orienting charge nurses in the pilot based on one person’s individual view of the hospital, we incorporated ideas and perspectives from across the organization to create a truly collaborative training and mentoring program. This allowed our newest leaders to see beyond the unit, so they could begin to understand our health system from a global perspective.

“We wanted to empower our charge nurses to think creatively,” says Laura Adams, the nursing director over the pilot unit. To begin broadening the charge nurse mindset, Laura worked with a multidisciplinary team to create a full-day training program with sessions conducted by senior leaders in our administration, finance, human resources, staff development, and patient experience departments. Together, they brought data, stories, advice, and passion from all corners of our health system and shared it with our new unit leaders.

Teach the true costs of labor.

One of the biggest lessons from the training came from Nursing Finance Director Eric Allen, who showed charge nurses the true impact that labor decisions have...
on a unit’s operating margin and our hospital’s financial health. He explained that if charge nurses call off just one agency nurse per shift, the extra costs add up to $450,000/year. It’s enough to deplete a unit’s contingency budget—impacting everything from equipment purchases to staff raises.

“Before, adherence to a staffing grid was something you just did or else your manager would be mad at you,” says Trevan Biddulph, the nurse manager on the pilot unit. “Now, our charge nurses embrace the philosophy.” They’ve replaced angst over grids with daily financial stewardship, coming up with new ways to rearrange patient assignments, evaluate close observation patients, and reallocate staffing to work more efficiently than ever before—all while providing the same excellent care. What’s more, as nurses on an acute care unit, they’re actively seeking out patients from the ICU and ED to improve the transfer process and decrease “dead bed” time.

And when their unit’s slow? They call charge nurses on other units and offer up the staff resources they’re about to send home, so that other units don’t have to call agency nurses, either. “It’s true collaboration in action,” says Laura. “They’re living it each shift, every day.”

“Now, our charge nurses are collaborating for the good of the whole hospital instead of just focusing on their unit.”

—Laura Adams, Acute Care and Rehab Nursing Director

Help charge nurses truly take charge.

The orientation didn’t just focus on fiscal responsibility. It also taught charge nurses how to handle difficult conversations with staff and hold them accountable for their performance. Staff Development Educator Derek Cook equipped charge nurses with the skills they needed to have “crucial conversations” with staff, so they could create open dialogue around high-stakes and emotional issues. “We don’t like to step on each others toes or
risk ruining relationships,” says Laura. “But sometimes we have to. It’s part of our responsibility. When you’re afraid to speak up, bad things happen, and ultimately, the patient suffers.”

**Charge nurses leading the way**

With comprehensive training and ongoing mentoring, we’ve helped our Lead Charge Nurses to:

+ Comprehend the financial consequences of staffing decisions
+ Gain the authority to take corrective action right on the unit
+ Learn to communicate effectively when the stakes are high
+ Understand how practitioners are graded in patient satisfaction surveys

Along with crucial conversation skills, Senior Employee Relations Consultant Rosemary Norton gave charge nurses the information—and authority—that they needed to handle low-level staff corrective actions immediately, instead of pushing every issue up to their managers. “It’s so much better than the old ‘wait-till-your-father-gets-home’ approach,” says Laura. “Behavior is best corrected when it’s directly observed and dealt with immediately, and these charge nurses can do it beautifully, because we’ve empowered them in their new role.”

The expanded role was also facilitated with a rewritten “Lead Charge Nurse” job description, a pay increase, ongoing mentoring from experienced charge nurses and nursing managers, and opportunities to take additional leadership classes. “This is the pool of people we’ll be looking at for our future leaders,” says Laura. “Those who excel will be our next nurse managers.”

$253,059 saved in the first eight months

With financially-savvy charge nurses running the shifts, the pilot unit has seen a labor savings of $253,059 in the first eight months.

**Make the shift from me to we.**

The Lead Charge Nurse Orientation program hasn’t just prepared our newest unit leaders for success—it has also connected our health system in surprising new ways, so that we can all learn and grow together. “The orientation has seeded other pockets of collaboration,” says Laura. “Our human resources representatives and patient experience team have learned from our nurses, too. They know each other much better now, and they routinely work together to solve problems.”

It all adds up to units that run better, and patients who are more satisfied. With more training and empowerment, our charge nurses have become experts at assigning the right nurse to the right patient, and creating open lines of communication between nurses, doctors and patients.

“We have a whole group of excellent, established leaders who can step up, speak with authority, and make decisions that are better for our hospital and better for our patients,” says Laura. “They’re the kind of charge nurses that every manager wants.”

*How much impact can multidisciplinary training have?* Listen to Maegan and Laura share their experiences at NursingInnovation.UofUHealth.org.
Jeremy Fotheringham had a question. The former bedside nurse and current director of Cardiovascular Services had discovered that a few forward-thinking hospitals were offering same-day discharge to some of their more stable cardiac patients, and he wondered why our hospital wasn’t doing the same. The research he’d found from the *Journal of American College of Cardiology* indicated that same-day discharge could work for select patients after simple coronary interventions. In fact, the patient outcomes were decidedly positive—and the costs were clearly lower.¹

So why wasn’t our hospital advancing the practice of same-day discharge? And why weren’t other hospitals around the country doing it, either? While there were issues of insurance coverage and protocol that had to be addressed to make it possible, the real issue came down to one simple truth: changing clinical care protocols in

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09. Coordinate care from hospital to hotel.

*Connecting everyone from hospital physicians to hotel staff, so cardiac patients can go home sooner.*
a large academic medical center isn’t easy. To succeed, Jeremy realized he’d need clear protocols, and creative partners throughout the institution—from administrators and physicians to nurses and support staff. His first step? Convincing physicians that it was the right thing to do for the hospital, and more importantly, for our patients.

**Develop evidence-based protocols.**

To get started, Jeremy partnered with one of our hospital’s most forward-thinking interventional cardiologists, Dr. Anwar Tandar, to create strict criteria for selecting patients. Based on published research about same-day discharge after coronary interventions, this evidence-based protocol showed the hospital’s physicians, administrators, and risk management specialists just how selective the process would be—and how little risk would be involved.

Next, they pulled in a nurse coordinator to identify same-day discharge candidates, educate them about the option of going home sooner, and work through any insurance issues with them prior to being admitted. “It’s so important to identify the right candidates,” says Jeremy. “The worst thing we could do is send a patient home and have something go wrong when we could have intervened. That’s always on our mind.”

But selecting candidates was just the beginning. Dr. Tandar and Jeremy also had to decide how a final determination for same-day discharge would be made. That’s where collaboration with the patient came into play. Although our team could pinpoint the best treatment and discharge option based on everything we knew about a patient’s personal characteristics and anatomy, the patient needed to be a key collaborator in deciding whether it was the right thing to do.

As the final collaborators in our same-day discharge project, our patients take their role seriously. After being informed that they were candidates for same-day discharge, most patients wanted to know the research behind it, just like our clinical team had wanted to know. They also did their own independent fact finding, so that the vast majority of candidates came to their procedures fully informed—and excited about the possibility of leaving the hospital before nightfall.

**Collaborate beyond hospital walls.**

As we worked through our protocol, we also realized that leaving the hospital doesn’t have to mean going home. And with cardiac patients coming from all over the region, the nation, and even the world, we needed a creative solution to make same-day discharge possible for anyone who qualified. We found our answer right down the street, at our University Guest House hotel.

“It’s a win for everyone,” says Dr. Tandar. “Our patients love it, and we like knowing that they’re nearby.” To make the process seamless, our nurse coordinators arrange all the details of the patient’s Guest House stay, and even better, patients don’t have to worry about an additional bill from the Guest House, because we cover these costs.

Saying farewell to our same-day discharge patients doesn’t mean saying goodbye. Patients get a follow-up call the very next morning from the physician who did the procedure or the nurse coordinator who helped them through every step of the process. Issues are addressed immediately and proactively to further ensure the safety of the patient. We also call them at 30 days post-procedure to assess their progress.

“We made it happen by creating a great team from the very start,” says Jeremy. “All of us were able to break from tradition and do something new that made sense for our patients.”

**$375,000 saved**

Finding the right setting for the bedded outpatients to recover helped minimize losses that annually would cost the organization $375,000.


For hospital nurses and physicians, time is measured in minutes, even seconds. So when Dr. Courtney Scaife told us that she and her fellow physicians were losing precious time just trying to get the supplies they needed, and that nurse productivity was also being affected, we knew we had a problem. The culprit? An automated Omnicell supply cabinet that could only be opened by nurses.

“It was so inefficient,” says Dr. Scaife. “Imagine trying to see 30 patients during rounds, and having to constantly stop and interrupt nurses just to get simple things like gauze and tape.” And when they did get into the cabinet, residents often took more than what they needed, simply so they wouldn’t have to interrupt a nurse again for access. This led to a different kind of waste: expensive supplies were being thrown away at the bedside.

“It wasn’t just time that was being lost, but also hard, green dollars,” says Nursing Finance Director Andrew Wood. Although the Omnicell supply cabinet tracked
supply usage, the data wasn’t being translated into actionable information that physicians and nurse managers could understand. And when you can’t see exactly how much money is being lost, it’s hard to be conscientious about saving it.

We needed to hold every Omnicell user accountable for the supplies they took, while simultaneously allowing more staff to access the supply cabinet. It seemed like an insurmountable challenge—until we connected Dr. Scaife’s access problem with Andrew’s data issue and set out together to build a better system.

Turn frustration into collaboration.

Drawing attention to a problem can be a powerful first step to solving complex problems—especially when we take our own individual frustrations, connect them to other related issues, and come together to create comprehensive solutions. And that’s precisely how we solved our Omnicell conundrum. By initiating an open conversation between nursing, physician, and administrative leaders, new ideas began to take shape.

“Once we started talking together, the lines between disciplines began to blur. The problems suddenly seemed less difficult to transcend.”

—Dr. Courtney Scaife, Associate Professor of Surgery

We put those ideas into action immediately, forming a pilot project to give physicians the Omnicell access they needed. At the same time, we began creating powerful new supply reports that enabled unit managers to see exactly who was using supplies, what they were being used for, and how the supply charges were being attributed.

Build accountability with actionable data.

“A big glob of data doesn’t mean anything to anyone,” says Biomed Technician Curtis Mason, who teamed up with Andrew to turn unreadable Omnicell data into useful monthly supply reports. The new reports identified the employee IDs of staff members who were floor-charging supplies and pinpointed units that were having problems with lost charges. “Once we started tracking everything, staff knew that they were accountable every time they got into the Omnicell,” says Curtis.

But that was just the beginning. After sending out the reports, Curtis and Andrew met with unit managers to identify trends and discuss opportunities for improvement. Nurse managers took the data one step further, posting the reports right on their units, so everyone could see who had the most floor charges and lost charges. “People’s competitive nature came out,” says Andrew. “No one wanted to be on the top of that list.”

Educate staff on the whys and hows.

Change didn’t come just by implementing better reporting and communication. It required education, too. Our training team worked with Curtis and Andrew to create an online learning module that showed nurses and physicians why Omnicell tracking mattered, and how much the hospital lost when they overused supplies or charged them incorrectly. “Once we helped people connect the dots, they became passionate about doing the right thing,” says Curtis.

Staff also received an in-person introduction to the Omnicell system, so that physicians and nurses who were new to accessing it could quickly learn how—and start using it immediately. This combination of in-person and online training, along with the collaborative efforts of the nursing, physician, administration, and supply chain teams, allowed the project to go from an initial idea to full implementation in just six months.

Dr. Scaife and Andrew both attribute the project’s success to the willingness of our leadership team to try
the pilot, and the ability of diverse disciplines to come
together and think differently.

The results of all these collective actions have been
nothing short of transformational. Nurse managers
have been able to decrease nursing floor charges from
$155,171/month in August 2011 to just $4,673/month
in August 2012. This is a savings of over $1.32 million in
one year. As a result, our Emergency Department has also
been able to appropriately bill more supplies, adding
$929,323 in charges in 12 months. What’s more, many
people on the clinical team have even started identifying
less expensive supplies, working directly with Curtis and
Andrew to decrease costs in inventive new ways. And
residents have stopped stockpiling supplies and started
using only what they need, when they need it.

“It’s a huge positive culture shift,” says Dr. Scaife.

Andrew smiles. “And it’s a huge positive revenue
shift, too.”

Decreased nursing floor
charges housewide.

$2.2 million improvement

In 12 months, nurse managers have decreased
floor/lost supply charges from $155,171/month to
$4,673/month for a total of $1.32 million in improved
charging to patient accounts.  We have also been
able to appropriately bill our ED supplies, adding
$929,323 in charges.

See how one discovery turned into a million
dollar idea. To watch EMT Nate Roll share his

Increased ED supply
revenue per visit.
You’ve reached the end of our annual nursing report, but it’s only the beginning of our conversation about Cultivating Collaboration.

**The next collaborator in our report is YOU.**

We’ve created a Cultivating Collaboration community online where you can share ideas about everything from systems thinking to patient-centered collaboration. We want to know how you’re connecting ideas, crossing borders, and changing the game.

We’ll keep sharing ideas with you, too. Throughout the year, we’ll update our progress on the initiatives we’ve reported on here, and we’ll reveal exciting, new ideas that are just being seeded now.

Ready to grow the future of health care with us?

Join us online at: [NursingInnovation.UofUHealth.org](http://NursingInnovation.UofUHealth.org)

This is just the beginning.