Path To Perfect

Step One: Imagine
Dear Colleagues,

Coach Vince Lombardi once said, “if we chase perfection, we can catch excellence.” Although perfection may seem out of reach, the nursing department at University of Utah Health has set out on the path to perfect, challenging each employee to imagine perfect care. As this report went to print, we had just surpassed 4 years with ZERO central line-associated bloodstream infections in our burn unit. At the same time, we continue to work on bedside report, committed to improve this valuable tool. The stories highlighted this year in our 5th annual nursing report illustrate our journey toward excellence:

STRATEGY
Challenge Staff to Imagine Perfect Care
*Inspiring innovation by imagining the impossible*
Make Perfect the New Normal
*Setting the standard at zero for CLABSI*

STAFFING
Don’t Just Survive, Thrive
*Retaining nurses with a bedside focus*
Re-Invent Rounding
*Improving leader-nurse communication*

CULTURE
Truly Connect with Patients
*Continuing the conversation at the bedside*

ENVIRONMENT
Remove Opportunities for Error
*Leveraging technology at the point of care*

SERVICES
Provide the Right Care at the Right Time
*Using sensibility—and other senses—to save lives*

What does perfect care mean to you? Please drop us a note at NursingInnovation@hsc.utah.edu and let us know how you imagine perfect care, the challenges you face along the path, and what is working well in your organization.

*Margaret Pearce*

Margaret Pearce, RN, PhD
Chief Nursing Officer
Perfect. It is a word we use regularly to compliment, to inspire. Subjectively, we are generous to label the perfect meal, perfect day, or perfect outing. But when applied objectively to tests, metrics, or outcomes, the word perfect is more intimidating. And in the healthcare industry, perfect is seemingly impossible. Yet it’s that perception of implausibility that has actually proven inspirational to the workforce at University of Utah Health. Is it really impossible to provide perfect care? With 4 years of ZERO central line infections, the nurses and providers in the Burn Trauma Intensive Care Unit are illustrating that perfect care is indeed possible.
The challenge to imagine perfect care came from former senior vice president, Dr. Vivian S. Lee, whose vision was 2-prong: expand the patient’s voice in all aspects of care, and harness the creative ideas of each individual member of the healthcare campus. Her call to action: How can each individual, team, and unit further improve our healthcare system by re-imagining the entire clinical care delivery system from the patient’s perspective?

One size does not fit all

Early in the Imagine Perfect Care initiative, project teams came together to gather and examine patient feedback, and to solicit input from the healthcare campus workforce. The patient satisfaction survey was considered the primary source of patient feedback. Yet, there were many other patient comments to consider and aggregate, including targeted focus groups, customer service department logs, customer survey data from the University’s health plan, hospital board member rounding notes, and a market survey from a large insurer in the region. The team then surveyed colleagues and patients, asking 5 open-ended questions that included “How do you define perfect care?” and information specialists at the health sciences library processed the results.

While there were many similarities in perceptions of perfect care between patients and the staff, there was sharp contrast in two areas: technology and patient empowerment. “Our staff ranked patient empowerment as the number one item in a list of 10 themes, but it wasn’t even in the top 10 for patients,” says Teri Olsen, senior director of executive projects. “Patients ranked technology as number 1, and technology was at the bottom of the staff’s list.” Patients also added 3 new categories: physical environment (beds, room temperature, noise), quality and patient safety (an assumed priority for staff), and finance and insurance (“perfect care is being an advocate for me with my insurance company; don’t leave me to fight it alone.”)

“Perfect care is being an advocate for me with my insurance company; don’t leave me to fight it alone.”
A nap, not an app

Especially intrigued by patients’ perception of technology, follow-up analysis and discussion revealed that the staff viewed technology as important, but assistive, and should not overshadow the caregiver’s interaction. Patients wanted to use technology to more quickly connect with caregivers, citing services like online self-scheduling and text reminders when a provider was running late. Fortunately, many of the technology services suggested by patients were already underway.

For nursing, inpatient room technology continued to be explored in preparation for the construction of two new patient care facilities: a mixed-use care complex and a rehab hospital. As patient workshops were conducted on the layout of the inpatient room, the technology feedback was quite different than that received previously, which had been asked in a general way to include both inpatient and outpatient. “In listening to the patient concerns about being in the hospital,” reflects Julia Beynon, director of Imagine Perfect Care and nursing operations, “they were not as much concerned about technology as they were in being safe and comfortable in their environment.” In fact, the more feedback the team heard, they realized that the patients’ needs in the hospital were mirroring Maslow’s hierarchy of needs, with one of the most basic needs being sleep. “To me, perfect care is being able to sleep in the ICU,” says Julia, who as a long-time ICU nurse knows how noisy the patients’ room can be. “The alarms are important, but the patients can’t do anything about them, what can we do to create a more therapeutic and healing environment for our patients?”

Margaret Pearce, chief nursing officer, also had the opportunity to listen to patients weigh in on new high-tech products and services being demonstrated for hospital rooms. “Our patients are sick and trying to heal,” says Margaret. “Most of them just want a nap, not an app.” Julia adds, “I think the diversity in feedback that we have gathered illustrates that perfect care is personal and means something different for each person.” Margaret agrees. “Perfect care starts with us connecting with each patient and understanding their unique needs. And when it comes to seeing care through the eyes of patients, the Imagine Perfect Care framework really is a perfect fit for nurses, who are on the front lines with patients every day.”

Perceptions of Perfect Care

- **#1** For Staff  Patient Empowerment
- **#1** For Patients  Technology
Innovation sandbox

To support staff as they engaged in Imagine Perfect Care, a small but vibrant Resource Center was created where groups can gather to explore, collaborate, and receive support for their innovative patient-care-centered ideas. One of the primary features of the Resource Center—the Room of the Future—has been especially popular with nursing staff and other clinicians as the organization prepares to build a new care complex. The room began with a low fidelity mock-up process of blue tape on the floor indicating dimensions and features of the room from the perimeter, to the bathroom, shower, sinks, windows, and even the nurse’s station. Project teams met regularly in the space as the architectural design process advanced, and stakeholders were invited to visit and weigh in on design decisions—both verbally and through “constructive graffiti,” writing on the whiteboard walls of the Resource Center.

As the design process progressed, light-weight foam board walls, sinks, cabinets, and swinging doors replaced the tape on the floor. Though only made of foam, these additions proved to be critical to the design decisions. The tangible layout, along with the ability to test drive proposed furniture, enabled nurses to influence the design of new inpatient rooms and determine how the layout will impact nursing work flow. “Our nurses provided perhaps some of the most valuable feedback on the proposed designs for the new inpatient rooms,” says Laura Adams, senior nursing director for acute care nursing services and psychiatric nursing services, who led the nurse feedback process. “Having their perspective early in the planning process not only ensured spaces were safe and efficient, but we also helped save the project hundreds of thousands of dollars by collaborating on layout and design.”

Julia agrees on the value of nursing input in the design phase. “At one point, it felt like there was not enough room between the foot of the bed and the wall,” says Julia. “Once the foam board wall went up, and we had the full picture of the room, the design made sense in a way that it didn’t before.”

“A little boost for great ideas

To help spur innovation and give projects a boost, the Resource Center offers seed grants to support creative ideas large and small. In the first round of funding, nurses participated in many of the teams and led several of the inaugural projects, including Julia’s and Dr. Joseph Tonna’s project to quiet alarms in the ICUs, a physician-nurse collaborative to assess patient preferences for end of life care, and newborn ICU providers and nurses seeking to increase breast milk donor sites. Outside of nursing, patient-centered projects included a community garden for staff and patients, specialty physical therapy devices for dancer athletes, and tooth technology to monitor specific health biomarkers. As the initial projects wrap up, Julia and Teri, who also work together to lead the Imagine Perfect Care initiative, look forward to another round of funding and are eager to see what the nursing staff will propose.

“Perfect doesn’t happen overnight, and certainly does not come without a lot of focus and hard work,” says Margaret. “But we know that if we look at care through the eyes of our patients and set our sights high, we will improve along the way, basically creating a path to perfect.” When perfection is attained, as in the CLABSI rate of the burn unit, the pride in accomplishment serves as further inspiration in other areas. “Now, whenever we look at urinary tract infections, or other quality measures, we reference the success of our CLABSIs and know that perfect really is possible.”

“To me, perfect care is being able to sleep in the ICU.”
The belief that infections are bound to happen seems reasonable and common in a burn intensive care unit. After all, the patient’s best protection—their skin—has been severely compromised, exposing their system to even the slightest bacterial threat. Add to that a lengthy stay in the hospital and the chance for a patient to acquire a central line associated blood stream infection (CLABSI) increases each day. But the members of the burn team at University of Utah Health are not average: they are remarkable, as is their 4-year stretch with zero central line infections.
Raising the bar

In 2013, U of U Health leadership began a hospital-wide goal to reduce the number of central line infections in ICU patients. The staff on the Burn Trauma Intensive Care Unit (BTICU) were a bit skeptical at first because burn patients are at such high risk for CLABSi. As all nurses know, a central line infection is a serious complication and can lead to prolonged hospitalization, so combine a CLABSI with burn injuries and the patient experience quickly deteriorates regardless of how compassionate or skilled the staff are. At the time BTICU had one of the highest rates of central line infections in the hospital so the BTICU leadership team knew something needed to be done, and knew their skilled staff could be the ones to do it.

For the BTICU leaders, the goal, at first, was to simply reduce the incidence of CLABSI. “With any project, the goal has to be measurable and attainable” says Lois Remington, clinical nurse coordinator in the BTICU. “We decided what we really could accomplish and set those goals together,” which started with an interdisciplinary approach and a mindset shift around central lines. “At the time we had no idea that 4 years later we still would not have a single CLABSI,” says Lois. To be CLABSI-free for 4 years is unheard of, especially in a burn ICU—some might say it’s impossible. So, exactly how did they do it?

Culture shift

The BTICU leadership team at U of U Health guided their seasoned staff through a cultural shift about what’s possible, what’s important, and what perfect care could mean for burn trauma patients. The old culture in the BTICU was rooted in idea that “every ICU patient needs a central line—and that infections just happen in ICU patients,” says Julia Beynon, director over Imagine Perfect Care and operations director over critical care, AirMed, and emergency department. With guidance and great leadership, the new mindset about central lines eventually became ‘not everyone in an ICU needs a central line,’ but getting there took time.

The BTICU leadership team engaged their staff in Evidence Based Practices, mentoring, education, and accountability. “Lois really drove the accountability portion with the new central line bundle” says Brad Wiggins, BTICU nurse manager. A bundle comprised of four components paved the path to their perfect record: (1) a daily patient assessment to determine whether or not a central line was actually needed, (2) implementation of a central line insertion checklist, (3) a standardized dressing change process and (4) daily auditing of bundle components for compliance. “We also changed our catheter care so it is not done during wound care but as a separate process to prevent cross contamination,” says Lois.

The bundle gave nurses hands-on interaction and in-person communication about the goal with their leaders. “The goal wasn’t communicated through an email or a poster. The work was really done at the bedside with the nurse and the team, talking about the goal, and how to achieve it together” says Colby Carper, clinical nurse coordinator in the BTICU. While overwhelming for the staff at first, “the leadership from this group kept saying ‘yes we can’. They have been unwavering in their belief that the team can do it,” says Colleen Connelly, nursing director over critical care, AirMed, and emergency department.
Healthcare teams want to do the right thing for patients and will often embrace change when they come to understand, value, and recognize the change their leaders believe is important. This leadership team and the physician champions have been incredibly instrumental in changing the culture around central lines.

**Collaboration and trickle-down leadership**

From executives to unit managers and team leaders, interdisciplinary involvement with nursing, pharmacy, physical therapy, wound care, and physicians Stephen Morris, Amalia Cochran, and Giavonni Lewis were critical to transform CLABSI culture in the BTICU. “They believed it was the right thing to do for burn unit patients” says Brad. Everyone is invested in the goal and have been willing to do whatever is best for the patients, even if it requires changing old habits and taking more time to do things. “The whole interdisciplinary team was, and still is, involved every day during our multidisciplinary rounds where we address the catheter and whether or not it can be removed,” says Lois. “If it can’t be removed we discuss the indications for its continuation.”

Soon, the only infections in the BTICU were infectious motivation and leadership. “We created a quality task force where some of our senior nurses got together and worked on quality projects—one of which was to go out and mentor the staff,” says Lois. The teamwork continues to be critical to maintain the zero-CLABSI initiative, especially during a mass hiring period where 40 new staff members joined the BTICU. “Now, from the moment someone is hired, the message about central lines is clear and delivered from the beginning: it’s posted in the unit, people talk about it. New hires are immediately aware this is a big deal for this unit,” says Brad.

**Celebrating success...daily**

The leadership team recognized what could be done but also felt the need to recognize those who made it possible, fostering a spirit of success among the nurses and staff. “The longer we went with success, the more self-propelling it became” says Lois. The collaborative efforts merited collaborative milestone celebrations. “That first year Dr. Cochran (the physician champion for the project) bought lunch at every month mark. I think that type of recognition plays a big part in solving issues,” says Lois. Colleen and Julia bought dinner at the one year mark, and even gave out the “Golden Central Line” award: a gold-painted expired central line placed in a shadow box to be displayed on any unit who makes it to the 1-year mark of being CLABSI-free.

The BTICU didn’t necessarily set an end goal but rather a continuous goal. “I feel nursing really owned it at the 1-year mark,” says Colby. “The talk of, ‘Can we make it a year?’ started at about seven months. And then after the one year mark the teams really looked to yearly milestones and said, ‘Yes we can!’” After that 1-year mark the unit continues to celebrate every subsequent year, “but now this team has set an expectation of high-quality care,” says Brad.
Sharing the path to perfect

The BTICU is changing more than the process around central lines—they are changing the care dynamics in burn units. The cultural and procedural shifts have been so transformative that the leadership team has been compelled to share their success. The burn team’s work was published in an online JAMA Research Letter in 2015 and Lois presented at a conference in Boston for the American Burn Association (ABA), which is one of the accrediting organizations for the BTICU. The ABA judges were so impressed they asked Lois for the checklist—and of course, in the spirit of improving patient care, the list was immediately shared.

As the BTICU continues to share their journey of success, Brad lends some advice to other ICU teams looking to make the shift. “Have a plan. Get approachable physicians. Have a team you can sit down with and discuss what the problem is, and how to fix it.” Great results rarely come without hard work—it requires great leadership and a collaborative and competent staff. “This project went from something we had to work on, to something we’re proud of accomplishing: 4 years of being CLABSI-free. Now, when you think of excellence in care and central line care, you think of the burn unit—how cool is that?” says Julia.

A To-do List for Leaders Looking to Solve CLABSI

+ Identify a problem
+ Start a committee with scheduled meetings
+ Set a measurable and attainable goal
+ Start the project
+ Provide education to staff
+ Continually talk about the goal to increase “buy-in”
+ Perform audits to ensure compliance
+ Collect data
+ Celebrate
+ Share your success with others
2 years ago when the nursing executive team at University of Utah Health reviewed turnover data, they uncovered an interesting trend—nurses were leaving the U at right around the 3-year mark. Higher-than-average turnover is not uncommon at academic medical centers, with nurses and their partners pursuing advanced degrees in nursing, medicine, pharmacy, health, and dentistry. And when these professional goals are achieved, the employee’s exit from the general nursing workforce is not only expected, it’s celebrated. But with more growth for the organization well underway—a mixed-use care complex and rehab hospital—attracting and retaining nurses is especially critical.

Don’t Just Survive, Thrive
“...it was clear that there was still a disconnect between their feedback and our actions, and we knew that we could do better.”

“We had already started to ramp up our retention efforts,” says chief nursing officer Margaret Pearce, referring to off-cycle salary increases and the implementation of a nursing exit survey, “but after several small and large group meetings with our front-line nurses, it was clear that there was still a disconnect between their feedback and our actions, and we knew that we could do better.” With the charge from Margaret to further assess retention, Colleen Connelly, senior nursing director for critical care, emergency, and AirMed, and Melissa Banner, nurse manager for inpatient oncology, spent several months conducting additional data analysis and research about the retention issue. When the results were shared, the entire senior nursing team agreed that even though they did not have a complete plan in place, it was time to take action.

Thrive is the U of U Health’s new nurse reward and recognition program: a retention platform which is designed to help nurses thrive in all stages of their careers. A special component of the program, Thrive@theBedside, focuses specifically on those nurses who provide direct patient care. While the initial program launch has been extremely successful, implementation has really just begun. “Right now, Thrive is in its infancy,” says Margaret. “It was a much bigger project than we originally planned for it to be, with a lot of detail. But now that we’ve got it going, I think it’ll be easier to work out those details.”

Growth for every career phase

Thrive offers a range of opportunities for nurses to grow their career both professionally and academically. “Professional growth is critically important,” says Margaret. “You need to be continuously improving your skillset and your knowledge base, because the more of an expert you are, the better your patient outcomes will be.” For new associate degree nurses, Thrive provides instructor funding to the U’s College of Nursing so they can expand class sizes and ensure enough spots for U of U Health nurses looking to obtain a BSN in both traditional and online programs. As nurses gain a few years of experience and start finding their passion for a specialty area, costs for most national certifications (and recertifications) are covered by the program and nursing units. Even the Continuing Education Unit (CEU) requirements are helped along by the Thrive program, which brings national experts to campus via the Thrive Conference Speaker Series. These local conferences provide professional development opportunities for hundreds of nurses and end up being a fraction of the cost of sending the same number of nurses to national events. Thrive offers a mix of conference options including hosting and paying for the whole conference, or partnering with other groups and sharing costs with the unit. “We received a lot of positive feedback about our inaugural Thrive conference,” says Colleen. “Nurses really want these local conferences and gave us suggestions about other programs they’d like to see, which helps.”

U of U Health’s new Nursing Professional Practice Model, developed by the nurse-led practice council
See the full model at: Healthcare.utah.edu/nursinginnovation
Show and tell

With the belief that it’s critical to thoughtfully recognize nurses’ achievements and dedication to patients, one of the anchors of the Thrive program is reward and recognition. “Recognition is a matter of acknowledgment and respect for nurses,” says Margaret. “You hope nurses know how much you appreciate them, but formally telling them they are appreciated, and specifically why, is always the right thing to do.” And under Thrive, recognition comes from many sources, including the nurses themselves. A link on the organization’s intranet home page streamlines kudos and expressions of gratitude from peers, which are posted immediately for all employees to see. During Nurses Week, there were over 160 peer nominations online. “It was fantastic to see how much our nurses appreciate each other as colleagues and depend on each other to help provide excellent care to our patients,” says Colleen.

Another source of recognition comes from patients and providers, who nominate nurses who have gone above and beyond their regular duties in caring for a patient. Nominees and winners are recognized twice a year with the Thrive program’s Patient Promise award. The title and intent of the award are aligned with U of U Health nursing’s new Professional Practice Model, The Caring Promise of Nursing.

Thrive@theBedside

Perhaps the most notable recognition opportunity in the new reward and recognition program is reserved for direct patient care nurses in the program component called Thrive@theBedside. This special recognition honors nurses who stay at the bedside—and stretch side—because they are at the heart of patient care. Bedside nurses are the front lines of patient care and patient outcomes. “The bedside is the ‘hub,’ where all the patient care and action takes place,” says Margaret. “So if you’re not taking care of patients directly, you need to be taking care of someone who is.”

During Nurses Week, one of the first Thrive components launched was the Thrive@theBedside service pins recognizing hours worked at the bedside. The University of Utah celebrates the years of service for all employees by way of their hire date. The Thrive@theBedside pins celebrate actual hours worked, bestowing a bronze, silver, and gold Thrive pin to recognize milestones of 6,000+ hours (about 3 years), 10,000+ hours (about 5 years) 20,000+ hours (about 10 years) worked at the bedside, specifically at U of U Health. These pins can be worn on scrubs or name badges to reflect years of service and assure patients that they are in experienced hands.

During the first-ever Thrive Honors Banquet, nurses with over 20,000 hours spent, and currently in, a direct patient care role were honored by their managers, colleagues, nursing directors, and system executives. The banquet featured a pinning ceremony, video tributes to a few of the longest-term nurses who chose to stay at the bedside, and presentations from leaders highlighting nursing practices from the decades. “It was so fun going down memory lane through the 70’s, 80’s, 90’s and 2000’s. You truly made me feel special as a nurse,” says banquet honoree nurse Debbie Peterson, who has worked about 28,000 hours at the bedside. “It was so fun to meet and see colleagues I have worked with in the past. Thank you for a tribute to nursing.”

Money matters

Though the focus of a nurse’s workday is rightfully on clinical patient care, the financial stability of the organization provides the tools and infrastructure to support nursing, so it’s important for nurses to under-
stand their role in the business of healthcare. “Nursing documentation is just one example of the critical role of nursing on our bottom line,” explained Andrew Wood, nursing finance director. “Accurately capturing the services provided to patients is a key step in the financial process, yet many nurses may not understand the connection or how important they are.” Nursing finance director Eric Allen agrees, and adds, “We want nurses to understand how to be good stewards of the unit’s money, because it is an investment into providing optimal care to our patients.” Andrew and Eric will be joining Melissa in creating online courses to help nurses understand what makes U of U Health financially viable and how to approach nursing with a financial outlook to contribute to the business.

A more in-depth understanding of the money flow is also necessary as nurses look to advance into management positions. “It’s about helping nurses understand the components of managing a large budget,” says Margaret. “We want them to understand that yes, we are a not-for-profit organization, but it’s not that we don’t make a profit, it’s just that money we make goes back into the hospital and patient care,” which includes everything from new equipment, to nursing salaries. “If we were for profit, the money would go to investors.”

An organization’s financial health has personal benefits for individual nurses, too. A perfect example of this mutually beneficial relationship was the ability to overhaul nursing compensation as part of the Thrive program. In addition to U of U Health’s human resources department review of market salaries, Margaret engaged a national firm to review local, regional, and national academic medical center nursing salaries. The analysis, paired with implementation of a new clinical ladder for bedside nurses, resulted in salary adjustments for the entire nursing workforce. “As long as we are good stewards of our money, we can continue to respond to changing market factors and support the various reward and recognition aspects of the Thrive program,” says Margaret.

By nurses, for nurses

Thrive is constantly evolving, and continually seeking feedback from nurses to become a meaningful retention program. “I’ve gotten emails from staff, just thanking us for all that we’re doing,” says Margaret. “But we do want feedback about what nurses want, and suggestions for what Thrive could be.” As to the rapid rollout and current state of the program? “We thought, rather than wait until it’s perfect, we launched what he had. And we can grow it as we need to” says Margaret. “There are large volumes of patients we need to take care of, so we need to take care of our nurses, too.”

“If you’re not taking care of patients directly, you need to be taking care of someone who is.”
Nurses Recognized for Reaching Thrive Milestone

- 360 Nurses have reached the 5 year milestone
- 315 Nurses have reached the 3 year milestone
- 270 Nurses have reached the 10 year milestone

Average years of experience: 10.3
Average years at the U: 6.5

Nursing Demographics

- RNs system-wide: 2,681
- RN FTEs: 2,101
- Number of nurses with bachelor’s degree: 56
- Number of recognized certifications: 65%
As an academic medical center, U of U Health attracts nurses who want to practice in a high-acuity environment, and who want to teach and mentor the next generation of nurses. Our nursing units support clinical and capstone placements for students from local and national nursing programs, many of whom are represented below for placements from Summer 2016 through Summer 2017.
On any typical day, the bed census at University of Utah Health is at capacity, and hundreds of nurses are busy tending to their patients, mentoring new colleagues, teaching students, and participating in a number of unit quality projects. At the same time, the chief nursing officer is juggling a full calendar of meetings, most of which require her attendance to represent the needs and professional practice of the nursing workforce, or to advocate for patients. So how exactly do nurses and their leaders find time and effective ways to communicate with each other? There simply aren’t enough hours in the day! Yet, over the last year, chief nursing officer Margaret Pearce has drastically improved nursing department communication. She has been able to get to know her nurses personally, listen to their concerns, identify how she can help them, and even resolve big issues like broken equipment—and salaries. But getting to this point wasn’t easy, and was in fact a long series of trial and error.
“It’s not a speech—I eat with them, we joke, I tell them stories.”

“For many months I would schedule rounds on all the units,” says Margaret. “I would wander around throughout the day and try and talk to the nurses.” But what she found was that the nurses were not really available. “They were just too busy, or they would be in a patient’s room and not even know I was there.” Similar problems came up when Margaret scheduled night shift rounds once every quarter. “I could talk to a few people, but I could never get to everybody.”

So then, to try and get the most people in one room at a time without interrupting patient care, Margaret started to attend staff meetings. “But that was hard to manage. There were so many staff meetings,” says Margaret. Dozens a week, if you include the various shifts. “And then there was always a full agenda, so when I came, it kind of threw things off.” After attending staff meetings for several months, Margaret resigned to the fact that “this just isn’t working.”

Let’s Ask Margaret

As Margaret considered new ways to communicate with her large nursing workforce, she decided to focus on being available to nurses on their timelines, and on simply answering questions they might have for her. With the help of Lizz Corrigan, communications specialist for nursing, Margaret created an “Ask Margaret” email address which was supplemented by an intranet blog page where any question or suggestion could be submitted directly to the chief nursing officer. “Some people were surprised to learn that Margaret personally reads and answers questions coming into Ask Margaret,” says Lizz, “but she is very engaged with the communication, double-checks to make sure she hasn’t missed any messages, and always gives nurses the most thorough answers possible.” Nurses know they can always get in touch with Margaret if they have a concern, question, or just want to say hello or thank her for something—which many nurses have done—and they will get a timely and detailed response. Some nurses ask tough questions that require a bit of investigating, others pose general questions that can be posted on the blog, and some messages are more personal. In all cases, Margaret always responds.

Everybody eats, right?

It has been said about nursing that if you want information to get noticed, there are 2 places to post it: bathrooms and break rooms. For Margaret’s next channel of communication, she decided to bring food and a listening ear to unit break rooms at 2 convenient times of the day: breakfast for staff coming off the night shift, and lunch for the dayshift. “I wanted it to be casual so they can not only grab a bite to eat, but to also see that I’m a real person,” says Margaret. “It’s not a speech—I eat with them, we joke, I tell them stories. They don’t have to come, I just want to be there for our nurses if they need me,” she says. The breakfasts and lunches are scheduled in advance, so it’s possible that when the day comes, the unit might be crazy busy. “Nurses need to eat anyway, so they’re welcome to just grab some food and go, and at least they know I’m there and that I care about them.”

While the “Meals with Margaret” have been a great way to get to know one another, it has turned out to be another direct platform for nurses to ask questions, make suggestions, or raise concerns while Margaret listens. “Really, it’s direct communication with me,” says Margaret. She’s been able to tackle issues from parking lot shuttle bus times to slow computers and obtaining special supplies. One nurse mentioned a broken printer in the patient rooms, and after Margaret inquired with other units about printers, she discovered this was an organization-wide issue, so all the printers were quickly replaced.

Solving tough issues

Some issues, like broken printers, needed a little funding and a bit of authority to solve quickly. However, some issues are more complicated and require follow ups with other leaders or departments, like human resources, to get an answer. And the first and most prevalent complicated issue? Compensation! “The most dramatic thing I learned from the breakfasts and lunches were the issues with salaries,” says Margaret. “It came from meeting with the nurses and letting
“I just listened and then tried to get something done as soon as possible.”

them express their frustrations.” Margaret worked with the HR department and reviewed the market position of nursing compensation, and on paper it all appeared as it should. However, based on direct nurse feedback, “I felt like we were missing something,” says Margaret. She went back to the nurses, asked for specific examples, and also hired a national external consultant to closely examine local, regional, and national data. Based on the wider scope of data and detailed review, the salary anomalies were resolved, and nurses could not have been more appreciative. “I just listened and then tried to get something done as soon as possible. It took some time, but I was able to intervene,” says Margaret. The compensation challenge and successful outcome prompted the leadership team to include the annual external review in the new Thrive nurse retention program, ensuring that nursing salaries would also remain top of mind for the organization.

Big fixes, like the compensation changes, are announced in yet another avenue of communication: the more traditional Town Hall, which was added to the mix to reach as many nurses as possible. “With Town Halls, we can get a lot of people together at once to relay information, answer questions, and listen to concerns.” In both the town halls and Meals with Margaret, detailed notes are taken by Lizz so that all of the questions and suggestions are captured for follow up.

So, is the new approach to communication working? Well, about halfway through visiting each unit for breakfast and lunch, the employee satisfaction survey was repeated for nursing to gauge progress on key questions. “We did a re-evaluation survey for employee satisfaction, and the results were much improved,” says Margaret. “I read all the comments, and they were very helpful. A lot of the comments came from areas I hadn’t yet visited, but I feel like it proved that the breakfasts and lunches were very effective.”

While all of the “Ask Margaret” tactics have been successful in strengthening nursing communication, Margaret was able to learn a lot about our nurses personally, and what they want and need from leadership teams. This nursing feedback was used to shape the Thrive program, which illustrates the vital importance of the voice of nurses in the nursing practice. “Being able to directly hear the concerns of our nurses and respond to it has been the biggest win for our nurses, and for me.”

Meals with Margaret in action. Day and night shift nurses chatting with Margaret (right) and enjoying breakfast before they start their shift, or head home.
A few years ago, we shared the beginnings of our journey to improve communication through Bedside Report—the process of giving shift-change report at the bedside with patients and their loved ones. We learned from our data that when nurses always do Bedside Report, our patient satisfaction results were positive. But, like many of you, we have struggled getting to “always,” which is why we are eager to share our latest efforts.

– Margaret Pearce

Truly Connect with Patients
Reporting for takeoff

In 2013, nurses at U of U Health began to change the culture of communication between nurses and their patients by implementing Bedside Report. At the time, Bedside Report was primarily a new philosophy, process, and expectation for all nurses. However, there wasn’t a tool in the electronic medical record (EMR) to specifically support this new process, and it became clear that this was impacting the success of Bedside Report.

The first bedside report charting tool tried to be a one size fits all template, but “it just didn’t work that way” says Desiree Dougherty, nurse manager for surgical ICU. Without incorporating unique workflows, nurses in many units found it difficult to use the charting tool in combination with the bedside report process. “While nurses supported the bedside report concept, our challenge was how to improve the charting tool so that it wasn’t a barrier to success,” says Desiree.

Fortunately, an upgrade to the EMR around the same time as the initial Bedside Report launch gave the information technology department the ability to create a customized Bedside Report charting tool. “We worked with application analyst David Stringham and informatics nurse Pam Poss to build a charting tool that aggregates the necessary information for nurses to document Bedside Report on one unique page within the EMR,” says Trell Inzunza, clinical operations director for nursing support. Prior to the consolidated screen, nurses would spend time looking in several places in the patient’s chart to find information needed during the shift-change report. And the hunt for information was different from unit to unit based on the workflows. “Understanding how nurses would interact with the charting tool while delivering Bedside Report is an important part of safety and efficiency,” says Trell, “so we made sure to meet with each of the nursing units to get their feedback. The unique workflows were vital to the success of this version of the BSR.”

A multi-pronged approach

By the fall of 2016, the team had created a new charting tool that balanced standard process while honoring a culture that values individual patient experiences, and nursing decided to re-launch the entire Bedside Report initiative with Desiree and Trell leading the charge. “The updates we rolled out included changes to the steps in the communication process, the ability to build and extract data from the charting tool, and greater emphasis on accountability for nurses to conduct—and complete—Bedside Report,” says Trell. “Now we can generate stats showing a nursing compliance rate for each nurse, and we are currently at about a 93% compliance rate.”

In addition to the improved bedside report charting tool, the successful re-launch also required another cultural shift from the nursing staff: from viewing the process as merely the patient portion and the computer portion, to a fluid exchange of information between nurses, patients, and the family members. “There were skill sets that needed to be developed about how to manage information on the computer, while also being able to listen and talk to patients, families, and the nurse receiving the report—all at the same time,” says Trell. When nurses learn those core skills, they can go anywhere in the hospital and deliver a standardized Bedside Report, which means more standardized care for the patient.

To help ensure that the nurses’ new skills endured, the re-launch also included a greater emphasis on manager education and engagement. “We had to let managers know that complete, documented Bedside Reports were an expectation of their staff, but more importantly, we were excited to share with them the value of the tool and the safety that it can provide for our patients,” says Desiree. “If something is important to managers, it becomes important to the staff.”

Trell agrees, adding that the education was also an opportunity for managers to mentor and help nurses balance the flexibility of the new charting tool with a consistent, standardized process. “Time is always
number one on a nurse’s mind,” says Trell, so the new charting tool was artfully designed to be more efficient and consistent in its delivery, while better considering the different work flows on each unit. “We’ve assembled the most pertinent pieces of data on one screen so nurses can quickly access, view, and process information—because if they can’t, and they have to spend time sorting through pages of information, it’s not going to be useful, and it’s not going to entice nurses to do Bedside Report.”

Not just a number

Bedside Report sets the expectations of what patients can, and should expect from nursing: great communication and a safe healing environment. Bedside Report helps nursing achieve both of these through a standardized communication process. “Patients might assume that the oncoming nurse is going to come in with no knowledge of what the previous nurse knew, and ask the same questions over and over,” says Desiree. “But those issues can be alleviated with Bedside Report. We ensure that the patient is informed and has a say in the care they receive from us. And most often it is the little things that make patients feel safe and cared for.”

Critical parts of the Bedside Report are patient education, goal setting, and providing opportunities for the patient and their loved ones to ask questions. While nurses are always available to answer questions, the Bedside Report dedicates time and a safe space for patients to open up. “Most patients are here for the first time, or this is their first experience with illness, trauma, or tragedy. They don’t know what to expect from us and may know nothing about the healthcare system, so they just take what we give them,” says Desiree. “Bedside Report allows us to give them coping skills, resources, and the ability to know it’s OK to feel afraid and ask questions.” Bedside Report is also a time for both off-going and on-coming nurses to pause and recognize when a patient might not understand something, but may be too afraid to ask. “Nurses bridge the gap and notice things,” says Trell. “We get to know our patients, talk to them, and can encourage them to speak up so we can make our patients more comfortable and help them understand the care we provide. Those are our skills, and that’s the art of nursing.”

Are we there yet?

While the new iteration of the Bedside Report process and bedside report charting tool are making positive impacts on patient care, it’s still not perfect and both will continue to evolve with input from the nursing staff, leadership, and the new Bedside Report Committee, which is comprised of nurses from all inpatient units. “Nurses are the ones actually giving Bedside Report, so it’s important for them to be the ones to identify and make necessary changes,” says Trell. This formal and comprehensive committee focuses on all things Bedside Report: the charting tool, the art of the report, mentoring, accountability, and rewards and recognition for successful outcomes. “We’re just trying to streamline the process, overcome barriers, and make people aware of any issues that come up,” says Desiree. “With new upgrades coming for our charting tool, we’ll continue to get more functionality and better work flows.” Trell adds, that even though standardization is important, “Bedside Report is not about being identical, it’s about being consistent.” And, as Margaret would say, it’s about “always.”
A Special Connection

For Kate and Brad McKeen, baby Luke’s debut came unexpectedly in September 2016 after Kate’s water broke 3 months too early. From the moment Brad and Kate arrived at the hospital, they were welcomed with helping hands—first by a hospital security guard who quickly bundled up Kate in a wheelchair and whisked her to the emergency OB services department. “Everyone was great right from the beginning,” says Kate, who went on for emergency surgery to deliver Luke, who spent the next 125 days in the intensive care unit. “The nurses in the newborn ICU gave just the right amount of advice and parenting tips without being negative or bossy,” says Kate. She and Brad were grateful for how much support they received from the nurses—from the first time they got to hold Luke, to the frequent check-ins, even when the nurses were especially busy. “They cared for him every 3 hours for 4 months—that’s a lot of care,” says Kate. “And they were willing to make little exceptions for us, like having a third person at the bedside to take photos the first time we got to hold Luke. Those things meant a lot to us.”

In addition to support, Kate and Brad are touched with how invested the nurses became in Luke. “It was really all of the nurses. Every single one of them.” says Kate. One of those memorable nurses was Linda Hoyt who wanted to be Luke’s primary nurse, and who Luke always fed well with. “It’s really special that Linda asked to be our baby’s primary. It seemed like so many nurses genuinely liked and wanted to spend time with him,” says Brad. “It was this awesome blend of ‘yeah, this is serious,’ while also knowing, with their help, this was just becoming our everyday life, and that Luke was going to be ok.” Even on the bad days, they were assured that good days were ahead.

Kate and Brad were so grateful and profoundly impacted by the care their family received that they wrote the name of each nurse and doctor who took care of Luke on a paper mache leaf for each day he spent in the newborn ICU. Those leaves are strung together into a baby mobile, which is now hanging above Luke’s crib. Kate also wrote a poem dedicated to the nurses. “I wanted to let them know they were still on my mind, and that I credit them for all the great outcomes we received,” says Kate. “They do all the hard work but don’t often get the reward. This poem was a way to address everyone I knew who made a difference.”

Newborn ICU nurse manager, Carol Henderson, is proud of the care her nurses provided to the McKeens and each family who comes through the newborn ICU. “A baby in the newborn ICU means the parent’s vision of a perfect healthy, chubby, bouncing baby isn’t their reality, so we try to make up for that with perfect patient care,” says Carol. “Perfect care in the newborn ICU means our nurses meet the physical, psych-social, and spiritual needs of the family and infant during a time of hope, uncertainty, joy, and at times heartbreaking sadness.” As with baby Luke, Carol and her nurses give parents as many opportunities as possible to parent their child. “We listen to them, we allow them to share, and we validate their experiences—to the families, that’s perfect care. And at the end of the day, we have more happy stories than sad ones, just like Luke.”

Read Kate’s poem to the nurses at: Healthcare.utah.edu/nursinginnovation

From the first time Kate got to hold Luke, to now.
Scan the wristband, scan the drug, scan the IV pump. The result? The right patient, the right drug, the right dosage.

In other words, safer patients. In the fall of 2016, an interdisciplinary team of nurses, information technology professionals, pharmacists, and other support staff at University of Utah Health worked together to integrate over 1,000 IV pumps into the electronic medical record (EMR). This monumental project, with high risk factors for patient safety, has already produced remarkable outcomes, including hundreds of reduced pump override alerts and reduced reprogrammed infusions each month.

Remove Opportunities for Error
“Pump integration is still fairly new,” says Lori Larsen, senior director of nursing support services. “There are more and more hospitals starting to integrate, but it’s not yet a common practice.” While U of U Health is not the first to leverage this critical technology, they remain a healthcare technology leader, as indicated in their recent designation as one of the country’s “Most Wired Hospitals,” an honor given by the American Hospital Association’s Health Forum. “There are a lot of associated costs and infrastructure required,” says Josh Kooyman, project administrator for nursing support services. “But fortunately, the U is great about prioritizing projects that benefit our patients. If it’s right for the patients, it’s right for the hospital.”

One less chance for error

“Before the pump integration, nurses were required to manually program the IV pumps based on the order in the chart,” says Lori. “Now, the pump and the EMR talk to each other so that the order from the EMR flows directly over to the pump to ensure we are dosing correctly.” Given the complexity of patients seen at an academic medical center, a nurse can be managing a large number of medications for each patient, and, of course, managing multiple patients at a time. “The reality is, when you’re manually programming, there’s always the possibility of mis-punching a button,” says Magnet coordinator, Shay Taylor. With integration, there are fewer keystrokes a nurse has to enter, so the likelihood of error decreases immediately. “Suddenly nurses went from a large number of manual entries, to just a few steps, which increased accuracy from the medication order in the EMR to the IV drips, ultimately keeping our patients safer,” says nursing support services manager, Julianne Fleming.

“I don’t want to say it takes less time, because if I have to walk from the pump over to the computer and back, maybe it’s taking the same amount of time,” adds Shay. “But what’s important is that there are fewer steps in the process, and therefore fewer opportunities for error.” And reducing error is the most important part of this project.

“Front-line buy-in

The IV pump integration project provided an opportunity for the nursing department to create a standardized process of pump interaction and programming, from continuous to intermittent medications. With dozens of inpatient units, arriving at a standardized process took quite a bit of work. “Because it was such a big technological shift, for such a big group, it required buy-in from all levels of nursing,” says Lori. That buy-in was facilitated by a nursing committee comprised of representatives from each area of the hospital, from acute care units, to the ICUs, to the women’s and children’s service line. The committee met monthly and gathered feedback from the nurses in their respective areas. “Nurses were involved and had a lot of input, which created more buy-in regarding the project outcome. Everyone was able to go back and take the pulse of their unit, and bring valuable feedback about what nurses really wanted,” says Josh. Along the way, the team was able to conduct demonstrations for the nursing groups, and in the end, the entire feedback process proved extremely successful. “At the start, we had some nurses saying I’ve been doing it this way for 20 years, so why do I need a computer to do it for me?,” says Josh, “but in the end, those same nurses were 100% on board!”

Practice makes perfect

Given their strict timeline to roll-out the new pumps on time, the team had only 10 days to locate, update, barcode, and return 2,866 pieces of pump equipment from across the entire organization before constructing the meds library and diving into training for 1,500 nurses. Fortunately, the nursing informatics team has had a lot of experience rolling out new technology to a large workforce, and they started the process by creating a robust communication and education plan. “Prior to formal training, we communicated broadly to nursing to let them know what we were doing, and why we were doing it,” says Shay. “And of course, the reason is patient safety.” With a basic understanding
Of the project, nurses then were required to attend formal, classroom training. “The training included a computer and a pump, and nurses had to work through the lesson plans and pump simulations with different examples using different work flows,” says Lori.

The team’s goal was to train 90% of the target nursing group (inpatient nurses who use the pump) in the span of just 4 weeks. Not surprisingly, the team exceeded their goal, training 98% in the allotted 4 weeks. “To me, it shows how dedicated our nurses are to their patients—to jump so quickly on board for the training,” says Shay.

But going forward, training for new nurses will still include the manual programming process. “We are not totally phasing out manual programming, because while a nurse should be using the pump integration, they should also know how to program the pump should there be a downtime, even though the likelihood of that is low,” says Julianne.

### Shared decisions, shared success

When all was said and done, the transition went smoothly. From kick off to go-live, it took just 8 months to integrate something that truly keeps patients safer—all of the preparation, training, and hard work paid off.

“We have had a lot of successful system upgrades over the past several years, but this one was especially meaningful because of its huge and direct impact on patient safety,” says Lori. “It was a monumental effort,” adds informatics nurse, Julie O’Neill. “We had to do a lot of testing, including the testing of every administrable drug. The efforts and success were all in conjunction with information technology, clinical staff education, pharmacy, biomed, central supply, and of course our nurses. We couldn’t have done it without them.”

### Increased positive patient ID usage by

- **2%** per month

### Reduced average # of reprogrammed infusions by

- **369** per month

### Reduced average high risk overrides by

- **716** a month

### Reduced average total override alerts by

- **668** a month
"Your nurse saved my life over the phone," are not words you hear every day. But every day, hundreds of calls come into University of Utah Health community clinics, where front line triage nurses, medical assistants, and scheduling specialists quickly determine how best to care for each patient. On this day, paramedics had just left Richard Eddington’s home, telling him he didn’t need emergency attention, instructing him to make a follow-up appointment with his provider. Because the staff who took Richard’s call adhere to strict protocols to assess clinical situations, nurse Kathleen Gomez was able to evaluate Richard’s symptoms and determine he needed to go to the emergency room immediately. Within 12 hours, Richard was in the operating room, and after successful 7-bypass surgery and recovery, he was able to pick up the phone and personally thank Kathleen for saving his life.
“It is not uncommon that a patient calls the clinic with emergency symptoms, like Richard did,” says Tiffany Obray, nursing supervisor. “In some cases, we end up being 911 dispatchers. We’ve had patients pass out on the phone, so if a patient can’t call 911 themselves, we call dispatch and keep the patient on the line.” While triage nurses make critical care recommendations, they cannot diagnose patients. “So, we really try to educate patients on why it’s important to go to the emergency room,” says Shirley Denicke, clinical quality assurance analyst. “If they visit a clinic, they will end up sending them to the emergency room anyway, so we’re really trying to save them an extra trip and prevent any delay in getting the care they need.”

While Richard’s phone call is a standout, members of the call center and triage team—together known as the Care Navigation Center—make critical live-saving decisions every day, all without the luxury of a visual or hands-on assessment. Their work is all done over the phone. “Our nurses are expected to do everything other nurses do, but essentially with their eyes closed and their hands behind their back,” says Dave Chatterton, director of clinical operations for the community clinics. “They have to go back and visualize the anatomy and physiology of the patient because you can’t see them.”

A different kind of nurse

Not every nurse is cut out for telephone triage work. The success of the triage nurses is attributed to diverse clinical backgrounds, experience, a problem-solving mindset, and superior training. Each nurse is required to undergo a 6-8 week, in-depth training process at the South Jordan Health Center, where the Care Navigation Center for all of the community clinics is located. Regardless of how much clinical experience the nurse may have, providing care over the phone requires a unique set of skills. “Triage nurses must be multi-specialized and expert multi-taskers,” says Aimee Hartney, clinical trainer for the Care Navigation Center. “We train our nurses how to document and talk to the patients at the same time, how to successfully triage all types of patients, and how to keep patient information safe.” And even though the nurses deal with one patient at a time, they are managing several critical details at once. “We’re looking for nurses who are critical thinkers and problem solvers, and who can learn our process, because you never know what type of phone call you’re going to get,” says Tiffany. And the team receives a lot of calls a month—over 12,000.

“There are hundreds of scenarios that could arise when answering calls, so our processes must support safety and standardized quality care,” explains Shirley. “We train our nurses to follow a strict process specifically to enhance patient safety.”

Technology as a teammate

An important partner for triage nurses is the technology that supports the team, and in particular the triage process. “The nurse triage module in Epic is a tool equipped with hundreds of evidence-based, gold-standard protocols covering everything from Zika to jellyfish stings,” says Shirley. However, the tool must be used correctly to work.

With the help of the system, each call is screened by experienced schedulers who then forward calls to the nurses should the patient mention any red flag symptoms embedded in the screening tool. Keywords that raise a red flag include poison, fever, breathing, bleeding, abdomen, abuse, cardio, OB, and neuro.

“The answer to one question can make the difference in someone going to the emergency room and just going to a clinic appointment,” says Aimee. Using the protocols, nurses determine the patient’s most emergent symptom, assess, and steer the patient to the right level of care, whether that means the patient can stay home with their symptoms, they need to be seen that day, or they need to go to the emergency room.

“Your nurse saved my life over the phone...”
“The nurses here may not necessarily be hands-on, but they certainly touch a lot of patients.”

Technology is not the only vital collaboration for the team. The triage nurses work seamlessly with care management, case management, social work, poison control, the crisis team, pharmacy, and of course designated providers who are always on-call for emergencies. Whether the nurses are connecting patients directly with their provider, calling ahead to brief the clinical or emergency staff and providers on a situation, or coordinating oxygen delivery, collaboration is key to the team—and organization’s—success.

“We may not hear about it for weeks, months, or even years—that our intervention saved someone's life,” says Dave. “But we respect and trust the process, and find satisfaction in knowing we’re doing the right thing for the patient.” Shirley agrees. “The nurses here may not necessarily be hands-on, but they certainly touch a lot of patients.” And at the end of the day, it’s not about who provided the care. “All that matters is that we all work together to help the patient get the right care, at the right time—and at U of U Health, of course!”

The doctor shouldn’t see you right now

Although they are prepared for the worst, the triage team provides another invaluable service: they can prevent unnecessary treatment or trips to the clinic. “Our quality assurance process is part of our safety and preventative measures.” says Dave. “We monitor and review phone calls, and use them for training purposes, so that nurses can learn how to keep patients who don’t need in-person treatment out of the hospital or clinics.” For example, if a patient calls in before they are too sick, “maybe we can give them home care advice so they don’t get sick enough to even need a clinic appointment,” says Tiffany, which keeps patients who do need to be in the hospital safe from unnecessary exposure to illness.

Nurse triage can even prevent hospital readmissions among discharged patients by identifying complications and getting the patient in touch with their provider in a timely manner. “It saves money for providers and patients, and ensures the best use of time for everyone” says Dave. If patients do, however, need to return to the hospital, triage nurses can prevent delayed care. “Maybe a patient was going to stay home and do nothing,” says Aimee. “But instead, they may be getting the right care at the right time because of a triage nurse.”

The reward in saving a patient’s life as a triage nurse can be a little different than a typical inpatient nurse. Nurse Kathleen Gomez catches up with patient Richard Eddington. Triage nurse Jodie Hughes (left) trains nurse Krystina Ralph (right) how to provide quick care to patients over the phone, and how to work together to ensure patients get the right care, at the right time.
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