Dear Colleagues,

Eight years ago, we published our first-ever annual nursing report 10 creative nursing ideas. Our goal was to share our own nursing innovations, outcomes, and tools, and in turn we invited you to share your ideas with us. Nurses are extremely innovative, and we were excited to spark a larger community of learning across our profession. Over the past few years, our health system has continued to see dramatic growth, and in a few short months we will be opening a new rehabilitation hospital, ambulatory care center, and another health center in our community. And you will see that many of the projects we are sharing this year are built on, or inspired by, earlier initiatives. Both in our physical spaces and our nursing practice, we are truly Building Momentum.

I am so delighted to share our 2019–2020 nursing innovation report, and as always, we welcome your feedback and ideas to advance the care of our patients. Please connect with us at NursingInnovation@hsc.utah.edu, or view our report extras and previous reports online at NursingInnovation.uofuhealth.org.

Margaret Pearce, RN, PhD
Chief Nursing Officer

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Preparing informal leaders for management positions

The Nursing Leadership Principles program includes fun and engaging team-building exercises. Photo by Derek Larsen.
Most nurses chose the nursing profession to learn the art and science of compassionate patient care. They imagined themselves working with patients and other caregivers to heal and comfort. Few nursing students would have pictured themselves on the frontline of a highly regulated business, mediating staff conflicts, managing multi-million dollar operating budgets, or carefully navigating labor laws. But successful nurses are often tapped for leadership roles, like nurse manager, which is one of the most challenging positions in a hospital today: addressing top-down requests from executives and physician leaders, managing bottom-up operations and staffing, and meeting patient and family needs. It’s no wonder nurse managers experience stress, burnout, and turnover at rates higher than other positions in the clinical environment. With expanding responsibilities and roles, retention for nurse leaders has become a priority for healthcare systems.

With a robust management training program already well underway for new managers and others holding an official management title, Michael Danielson felt there was still a gap in nursing. Michael, a consultant on the Organizational Development (OD) team assigned to the nursing department, saw a disconnect in the growth and development of informal nursing leaders. The scale of complexity of the nurse manager role requires more and better support from informal unit leaders. By developing these informal leaders, the organization also ensures a pipeline of qualified candidates for nurse manager vacancies. “Often times people promoted are the best nurses on the floor, which isn’t a guarantee that you’ll be the best manager,” said Michael. “The skillset is completely different, and if you don’t manage that transition smoothly, maybe we don’t have a successful manager, but on top of that we lose a great nurse.”

After bringing his observations to chief nursing officer Margaret Pearce, Michael partnered with senior nursing director Juan Hernandez to create the Nursing Leadership Principles program (NLP) that would not only build a candidate pool for future nurse manager openings, but would also benefit informal nurse leaders and their units in their current roles immediately.

**An evidence-based foundation**

Anecdotal information is powerful, especially when combined with traditional research methods. With ample subjective stories and observations in hand, Michael and the NLP team started pouring over the research. They reviewed nursing publications and business journals, and sought input from current frontline leaders as part of a gap analysis. Stacy Parker, an OD training and e-learning specialist, joined the team to co-create the learning experience, ensuring both a nursing-focused leadership curriculum and a modern training approach. Internal and external quantitative and qualitative data led to a curriculum with a strong emphasis on online learning and “practice and apply” workshops. Because of the large scale of the initial program, clinical operations director Mike Sanchez was also brought on board to...
help. “To ensure an effective roll-out, we created a robust communication and tracking program for managers and participants,” explains Mike. “We outline the logistics and also describe the roles and expectations of the both the manager and learner.” As an added support element, managers receive training guides, so they can discuss and reinforce program elements that their staff are learning in the real-life context of unit operations.

Like roles in nursing, the leadership program needed to be dynamic and adaptable, and was designed to be fluid enough to incorporate elements identified by the staff themselves. After initial pilot groups completed the program, Michael, Stacy and the rest of the NLP team reviewed the learner evaluations to identify what worked and what didn’t, and adjusted the curriculum based on feedback. Under the “what worked” category, the nurses did find that the overall paced time frame to complete the course was optimal for learning and applying concepts in their daily work.

The learning journey
Seven distinct course elements are taken in order, paced over a 6-month time period, in a carefully prescribed learning journey. The first step is a 6-hour in-person kickoff event, where cohorts of nurses from across nursing engage in fun, interactive activities, including an exploration of each individual’s StrengthsFinder® themes. The StrengthsFinder® assessment is not only a powerful self-awareness tool, it also helps knit the nurses together as they learn about how their natural strengths complement and align with each other. “StrengthsFinder® is my favorite part of the Kickoff Day experience, as it allows participants to reflect on what they do best, understand their weaknesses to work on them, and plan on how to use their identified strengths in the best possible way going forward,” says Stacy.

After the kickoff day, the remaining six components of the class are delivered online, providing flexibility for participants to complete the modules. While each module addresses a primary topic, the prescribed journey ensures that each subsequent module builds upon what has already been learned in the program. This threading of principles provides a bridge between concepts, helps to reinforce what has already been learned, and enhances the learner’s attention to the current lesson. The 6-month pacing allows adequate time for the learner to actively practice the new skills from one lesson before bringing them into the next section.

A management mindset
When a nurse manager position opens up, recruiters and senior nurse leaders often look to informal unit leaders such as nurse educators and charge nurses—positions especially targeted for the leadership training. With hundreds of informal leaders in the program, not all will go on to a nurse manager position, and those who do may not transition for several years. And that’s OK! Nursing will benefit from better-trained leaders at all levels.

“One manager, no matter how talented or experienced, needs skilled informal leaders to help share the burden and challenges of leadership.”

“The modern nursing unit requires a cohesive team of leaders, led by the nurse manager, who have shared responsibilities around strong communication, quick and fair resolution of conflict, and an ability to effectively manage and drive change,” says Michael. Speaking from years of experience, Juan heartily agrees. “One manager, no matter how talented or experienced,” explains Juan, “needs skilled informal leaders to help share the burden and challenges of leadership.” In practicing leadership skills to support their manager, these informal leaders are able to develop the manager mindset so they are well-prepared should they choose to advance into a formal management role.
Thrive with the NLP

One of the goals for the Nursing Leadership Principles Program was that it would not be an isolated initiative, but rather would have a meaningful connection to other major nursing initiatives that were already part of the culture. It turns out that NLP is a perfect fit with the existing Thrive@theBedside retention program. Under the Thrive program, nurses can advance through a clinical ladder, starting with the new graduate. In order to achieve and maintain the highest level of the ladder, nurses are expected to serve as a charge nurse or preceptor, and acquire an advanced national certification. Through NLP, nurses acquire skills critical to both the charge nurse and preceptor roles, and they are able to earn continuing education credits needed to maintain national certifications. Each NLP course is approved by ANCC through the Clinical Staff Education department, and a total of 23 hours can be earned onsite, saving time and considerable amounts of money that would otherwise be spent sending hundreds of nurses to offsite conferences or training.

Homework that works at home

As mentioned previously, early feedback from pilot participants helped provide the optimum program, keeping the content fluid and the best match for the needs of the participants. For example, “motivation” was a topic removed from the program after the pilot; nurses felt like they were motivated, but they recognized that the coaching skill was under-practiced. Now coaching is one of the most frequently referenced skill sets as reported by participants.

One nurse approached a trainer to share how the skills learned in NLP have started to blend in with her personal life as well. “In the beginning, I wasn’t sure this program would benefit me at all. However, by about the third class, I started to realize that this is really helping me, both in my job and in my personal life! I am so grateful for this program, for being invested in, and I can’t wait for my other team members to go through this program! I have learned so much and it’s really making a difference.” This sentiment is echoed by many of the nurses who have enthusiastically shared that they are using the skills they’ve developed at home just as much as in the workplace!

Responsible achieveers

Over the last year, 529 nurses representing over 60 units have completed the 6-month program, and based on their feedback, plans are underway for a booster program, a team strengths program, a research component, and a pass to the organization’s formal manager training program, which previously was open only to those with a manager title. Based on the results and feedback so far, it’s not a surprise that the top Strength Finders® attributes for the NLP groups are Responsibility and Achiever, followed by Relator, Harmony, and Learner.

Most importantly, the program outcomes are best represented by the participants themselves: “I came to the coaching course and thought, ‘yeah, this isn’t going to work.’ Then I ended up needing to have a difficult conversation with someone and I figured I’d at least give what I learned a try. And it went pretty badly. I walked away thinking it just didn’t work. However, the next day, the person I had the conversation with came up to me and thanked me. They said that I was the first person to ever coach them about this and they were really grateful for that. I realized that what we’re learning really does work!”

A Glance at Nursing

Responsibility, Achiever, Relator, Harmony, Learner were the Top StrengthsFinders® strengths at NLP.

529 nurses attended the 2018 Fall and 2019 Spring cohort kickoffs, representing 60 different nursing units.

Nursing departments at U Health encompass 39% of all employees.
Show staff their numbers

Improving labor efficiency through staff awareness

Everyday interaction with the timeclock can have a big impact on labor costs.
Nurse staffing is always driven by patient care needs, and leaders often ask their staff to come in early, stay late, and even work through lunch if needed to care for patients. Depending on unit coverage, nurses will also work extra shifts, incurring overtime expenses to provide the safest care possible for patients. But what about those times when the unit is fully staffed and running at a comfortable pace? Do the extra labor costs slow down as well?

Last year, while looking for ways to improve the hospital’s bottom line, centralized nursing payroll manager Karen Nye suggested that we consider the big impact that seemingly small but unnecessary work behaviors were having on labor expenses. “An individual clinical staff member might think that voluntarily skipping lunch and working an extra 30 minutes a few times a week is no big deal,” says Karen. “But when you multiply 30 minutes for each event by 50 weeks, and then again by 3,200 employees, you are looking at millions of dollars of unplanned and potentially unnecessary labor costs.”

As a former bedside nurse and ICU nurse manager, Karen is always quick to point out that patient care needs come first. At the same time, Karen and her team process over 3,200 timecards, and are able to identify hotspots where employees are not adhering to nursing expectations—like taking a 30-minute lunch break. “Some units are very cognizant about trying to give each clinical staff member a lunch break, and the staff members are expected to clock out for lunch, or as we say: punch for lunch,” says Karen. “With the increasing focus on staff resilience, lunch breaks provide a necessary mental and physical break for all of the nursing staff.” On some units, however, there may be a culture of optional lunch breaks, or even taking a short paid break instead of lunch. In other instances, staff may be clocking in earlier than needed for their shift, or staying late to wrap up their shift after patient handoff.

With thousands of employees and unit-specific patient care staffing needs that change daily, the question was: where do we start?

**Expertise, energy, transparency**

Having had an interest in workforce operations and other human resource functions for several years, Karen recently finished her masters degree in HR, and is a certified HR professional through the National Society for Human Resource Management. “Human capital management is one of the most significant expenses with any organization, and we knew that providing actual metrics and transparency was the first step to analyze and tackle those labor costs associated with employee behavior.” Fortunately, Karen is also a self-described ‘payroll nerd’ and brought a lot of personal energy to the project. “Karen approaches problems very logically, and since she understands unit operations first hand, she puts the problems into the proper context,” says chief nursing officer Margaret Pearce. “Also, she loves our nurses and nurse managers, and advocates for them in everything she does.”

To get started, Karen and her team used the prior year’s payroll data to identify baseline numbers and organize the project into manageable pieces. They picked four daily behaviors/metrics that had the most significant impact on labor costs and were the most straight-forward for managers to address: unapproved early in, late out, no lunch, and missed punch. Approved early arrivals were not monitored, as approval is typically given by the charge nurse for patient care circumstances, like a patient transfer into the unit or a complex patient or family situation. Lunch breaks were tracked, again with the caveat that patient care could have prevented the break, but managers could at least start seeing the data and analyze it in the context of their unit. Missed punches happen when an employee forgets to clock in or out, and instead ‘self reports’ to the payroll specialist the time they arrived or left the unit, which may or may not be accurate—not reporting a late arrival, for example. The missed punches also add work for the payroll specialists, who have to manually adjust the time card.

Along with the metrics on how frequently each of the four behaviors occurred, Karen and her team then used their
payroll data to quantify the cumulative financial impact of each metric. “It was a little painstaking to create our first scorecard,” says Angie Milloy, centralized nursing payroll supervisor who, along with four others in the department, designed the scorecard. Indeed, the process is mostly manual with data manipulation being done in an Excel spreadsheet using data pulled from the Kronos time and attendance system. Angie took the scorecard a step further and created an executive dashboard that shows the ongoing financial impact. “After we got started and figured out the best way to extract and present the data, it went more smoothly, and now we are really proud of our work and how we are able to provide such valuable and timely information to the managers.”

Making it personal

With the first scorecard ready, the team launched the project: Karen and Angie educated unit managers about the four metrics, shared historical data, and offered assistance from the payroll specialists. The intention was for managers to first see the data, then identify the necessary vs. unnecessary labor costs, and finally work with their staff to fix errant behaviors. Managers were excited—if not shocked—to see their first unit report, especially in areas where the culture may have drifted away from standard time and attendance expectations. But all of the managers were supportive, and over the next few months, the metrics steadily, if only slightly, improved.

“We realized that while we had illustrated the general problem,” said Margaret, “the data was aggregated at a unit level and not an individual employee level, so it was hard for the managers to address behaviors with any one staff member.” Karen and Angie agreed, and after reviewing more detailed data, they witnessed the classic 80/20 rule in action: 80 percent or more of the unnecessary expenses were being caused by the same, small group of employees. In fact, the payroll specialists themselves were able to quickly identify specific outliers to traditional time and attendance practices. “Our payroll specialists never want to overstep their role and judge what is or isn’t appropriate for a specific unit,” says Angie, “but the managers were asking for details, and we were able to identify consistent outliers, which really helped the managers know who might benefit from coaching around the time and attendance policy.”

So, in order to further support the managers in this culture shift, the next version of the scorecard contained specific employee data, and also included a heat map so that problem areas could quickly be spotted. The response to the new and improved scorecard was overwhelmingly positive. Instead of a blanket statement to everyone, whether they needed to hear the message or not, managers could now just visit one-on-one with those employees who needed help.

The new transparency also highlighted the fact that the organization’s time and attendance policy was outdated and not being enforced. “The policy was written years before data was readily available to track time and attendance compliance,” explains Karen. “And even with limited data, the standards were not being applied consistently from unit to unit.” With feedback from the payroll team, nursing leaders, and the HR team, the time and attendance policy is being updated to provide realistic expectations, as well as ones that could be applied consistently throughout nursing and backed up by actual, timely data.

$450,000 saved in the first 10 months

Promising results

Just under a year into the project, the payroll process itself is receiving positive attention. Angie and the payroll specialists have been able to bring on more departments because of efficiencies gained through improved metrics like missed punches, which required significant hand-processing. In nursing, savings for the first 8 months totaled $335,000, and managers have set labor savings goals for the next fiscal year. Karen will also be sharing the team’s work at a national conference this fall.

While the inner workings of payroll are certainly not for everyone, Margaret and the team see Karen as the ideal bridge between nursing practice and basic HR functions. “I am passionate about the impact and influence I can have for both our organization and our clinical staff, who are out there every day providing exceptional patient care,” says Karen. “It’s a privilege to be a meaningful link between the two.”
Jeni Colarusso provides long-distance weekly training sessions for ICU staff at affiliate hospitals.
At 25-bed Caribou Memorial Hospital in the rural community of Soda Springs, Idaho, many complex patients have the option to receive specialized care close to home thanks to a collaborative effort between physicians and nurses at Caribou and University of Utah Health. In situations where a critical patient’s condition changes suddenly, a local attending is out sick, or the hospital’s ICU resources are stretched, Caribou’s local team can consult—24x7—critical care providers and nurses at U Health through the TeleICU program.

“Many patients who may have been transferred to the U or other tertiary center have been able to stay in their community hospital near family and support systems,” says Nate Gladwell, a nurse and senior operations director for the U’s TeleHealth department. “In addition to the patient being able to heal amongst friends and family, the money spent on their hospital stay provides revenue for their local hospital and supports the local economy.”

Founded on the premise of a consultative approach between providers, the TeleICU program first focused on physician-to-physician collaboration. But physicians are only part of the care team: in an inpatient setting, the hour-by-hour, 24x7 care and monitoring comes from nursing staff. To complete the care team, ICU nurse Jeni Colarusso joined the TeleICU team to focus specifically on nursing’s role in treating clinically complex patients in their home communities.

**Nurse-driven protocols**

Jeni and (recently retired) nurse educator Betsy Bradley started by first learning the unique culture of each of the rural hospitals. A common thread that emerged was the opportunity to share and assist in developing critical care protocols or standard care plans for the nurses.

“We learned that many of the hospital cultures were very physician-driven, to the point that nurses would be waiting on physicians when there were tasks they could initiate on their own if a nursing protocol was in place,” said Jeni. But the protocols themselves presented a challenge, as they are very labor intensive to keep up-to-date with current medical literature and practice.

“At the U, we are fortunate to have teams of pharmacists, educators, and other ICU-specific staff working to keep our protocols as efficient and effective as possible. It made sense for us to share active protocols with our TeleICU partners to adapt to their system and flow of care.”

At Caribou Memorial Hospital, one of the first nursing protocols developed was designed to extend the expertise of a highly experienced respiratory therapist who practiced two and a half days a week. The hospital’s nursing leadership wanted to take her decision-making process and incorporate some necessary nursing steps—including calling TeleICU prior to any patient intubation—and turn it into a protocol for the nursing staff. This new protocol would allow staff to practice autonomously, with a plan outlining when to involve providers for reassessment.

“Protocols and scenarios provide the extra confidence that nurses need to be able to go from basically being on standby waiting for the next list of instructions, to managing the patient and having critical assessments ready for the physician when they arrive,” noted Betsy.

**Multi-mode learning**

The nursing team uses a mixture of online, virtual, and in-person strategies to provide an individualized path for each nurse depending on their clinical area of focus and expertise level. For example, a popular topic for affiliates and the U’s own staff is on transitioning from acute nursing to critical care nursing. Virtual training sessions are offered four times a month: three of the sessions are typically focused on nursing skills, such as fluids vs. pressers, CV assessments, ventilator use, etc. The fourth session is geared toward the providers, though both groups are welcome to join any topic. Sessions are all archived for ongoing reference, and most offer continuing education credits.

In-person training is highly encouraged, and to prepare for their on-site visit, participants complete eight self-study core modules to provide exposure for the types of experiences they are likely to experience once in the U’s critical care units. Nurses are then matched with the ICU where they are most likely to use the skills they are
targeting, for example, surgical or medical ICU. Once at the U, affiliate nurses work side by side with U nurses and learn during 12-hour shifts in the ICUs. By working together, personal relationships between the affiliate nurses and U Health nurses are formed. “We offer a nurse-to-nurse hotline where they can call our ICU charge nurses 24x7 with any question,” explains Betsy, “and we have seen that the time spent onsite here at the U has made our affiliate partner nurses more comfortable picking up the phone when they have a question.” Jeni agrees, adding, “Having another RN to bounce ideas off of can be the difference between keeping a patient, and transferring them to a higher level of care.”

Unexpected, welcome outcomes

Akin to the formal, robust protocols, a recent development of the TeleICU program is a new classification tool created by Jeni and Ted Kimball, emergency physician and medical director for the U’s outreach teams and TeleHealth program. Like the national Trauma System Verification index (Trauma 1, Trauma 2, etc.), the Critical Care Capacity Index, or 3CI, was created as a way to identify a hospital’s current ICU clinical capacity, areas for ICU quality improvement, and appropriate timing of patient transfers. The index, which has been verified by expert consensus, helps both the rural hospital and large urban medical centers by accurately assessing acuity matching of patients to facilities and improved decision making for transfers.

With the program running smoothly on all fronts, Ted and Nate were surprised to receive a concerned call from the CEO and CMO (chief medical officer) at one of the TeleICU partner hospitals. “We quickly travelled to the hospital to hear the concerns in person,” said Ted, who with Nate felt anxious about the meeting since they were unaware of any problems. But the worry quickly passed. “They basically thought that the program had fallen off the radar because they hadn’t heard about any problems from the physicians,” joked Ted. “I was happy to reassure them that the program was going strong in large part because the nurses were working so well together and keeping everything running smoothly.”

Jeni credits strong communication for program success and growth. “Frequent communication is key to the success of any program,” says Jeni. “In talking with our sites regularly, we have grown from simply a provider-to-provider structure to include the nurse hot line, weekly and special educational offerings, and clinical hands-on training. This has all developed due to open communication and collaboration.” Nate agreed, adding that the doctors will communicate with each other as needed, which could be a few times a month, but the nurses are talking to each other multiple times a week. “Nurses naturally band together,” said Nate, “and this is what has kept the TeleICU program going strong. Our nurses banding together with our affiliate nurses on the other end of the ‘tele’.”

Connecting with Caribou

Caribou Memorial Hospital and U Health nurses are continuing their collaboration, with a focus on nurse education. Existing offerings are improved through feedback from nurses after hands-on training at the U: It’s always interesting to learn the new things as well as verify that your facility is doing many of the same protocols... For me, two days was great to learn the routine and be able to participate in patient care... I was mentally exhausted trying to learn so much, so I felt the timeframe was perfect. Senior Caribou leader Brenda Bergholm, who is the chief clinical officer and chief nursing officer, requested the initial respiratory therapy protocol, and has now asked lead RN ICU Hunter Goodenough to lead the nursing education program. Caribou is using archived TeleICU videos to teach and reinforce ICU skills, and will be enhancing their program with three respiratory modules. If a training topic is not in the existing TeleICU repository, Hunter and Jeni will collaborate to leverage existing resources, or create new modules as needed.
Each new nursing assistant receives a welcome kit from the Caring Core program.

Dear Health Care Assistants,

Happy National Certified Nursing Assistants Week! Across the country, this week is dedicated to honor you for all that you do for our patients! As part of our celebration this year, we are very excited to officially roll out the Caring Core program, which is designed to recognize and honor your great work all year round, as well as support you with professional development.

The first key clinical skills that bedside care requires are:

- Patient assessment
- Communication skills
- Critical thinking
- Teamwork and collaboration
- Documentation

The Caring Core program aims to provide nurses with the resources they need to excel in their roles and improve patient outcomes. We hope you will find the Caring Core program valuable and supportive.

Thank you for your dedication and commitment to our patients. We cannot do it without you.

Sincerely,

[Signature]
There literally is no cost to say “Thank You,” yet the benefits can be immeasurable. Employees crave a supportive working environment; they want to be acknowledged for their hard work, competent contributions, and dedication. In our 2017 Nursing Report, we shared our fledgling Thrive@theBedside program, which, for U Health, is appreciation in action. Each of the Thrive components demonstrate the organization’s gratitude to our nurses through career growth, financial strength, and regular, meaningful recognition.

Now entering its fourth year, Thrive continues to be a highly visible, successful program for our nurses. When it comes to genuine recognition, we have found that you really can’t get too much of a good thing. “It never gets old,” said Janet Zidon, Thrive program administrator. “Every day when a nurse picks up a prize for their co-worker, they are so excited and can’t wait to give the prize to their co-worker.” Jake Ekker, Thrive communication specialist agrees. “One of my favorite tasks of the day is to review the peer nominations, and see how our nurses are thanking each other.”

With Thrive established and running smoothly for our nurses, our attention turned to another key member of the nursing team: Certified Nursing Assistant (CNA), whose job title at U Health is Health Care Assistant (HCA). Though they occupy the same clinical role as a CNA, we view our HCAs as vital support for the units as a whole, rather than support staff specifically for nurses. With new clinical buildings once again on the verge of opening, HCA recruitment and retention was a top concern, and nursing leadership was anxious to solidify a Thrive-like program for the HCAs.

Know your audience

Like many hospitals, our HCAs represented two primary career paths: seasoned “career” HCAs known for longevity and stability on the unit, and HCAs in nursing school or training for other healthcare roles, who are also strong contributors, but are in career transition. For both groups, we wanted to support and honor this very challenging and important role on the care team. Recognizing that the first core clinical skills that all nurses develop are those of a CNA/HCA, the Caring Core program was created to support and honor those skills performed by our HCAs on a daily basis.

Although we started with the successful Thrive program as a model, we also recognized that our RNs and HCAs have different needs, goals, and expectations, and we wanted to create something special and unique for the HCAs. We also did not want the HCAs to feel like they were getting a “junior” program or “leftovers.” To confirm what we knew anecdotally, we analyzed basic employee data for the HCA employee group. “We looked at the total number of Health Care Assistants, the FTE level, length of employment at the U, education level, and applicable years of experience (AYE),” said Maiko Taguchi, manager for executive projects and the Thrive program. “Though not perfect, we could make some general assumptions about career paths, which, combined with anecdotal information from our nurse managers and HCAs themselves, gave us a pretty good idea of the group attributes.”

The data, which has been consistent over time, shows that two-thirds (67%) of the HCAs have a tenure of 0-3 years, and another 16% of 3-4 years—the time it typically takes new or associate degree nurses to finish nursing school. At the 5-year mark, numbers drop significantly, with 10% being at the U for 5-10 years, and just 7% staying over 10 years. With a clearer picture of the size and tenure of our HCAs, the Caring Core focuses on three key objectives:

- Develop and support new and short-term HCAs (e.g., new employees and nursing students)
- Provide professional development and growth opportunities for long-term “career” HCAs
- Recognize and reward all HCAs
Lead-out with life skills

To kick off the personal development component of the Caring Core, the team started with topics relevant to any staff member, but especially useful to new HCAs. Seats were reserved in a popular Restore and Balance retreat, and a collaboration with a national vendor brought a new twist on resiliency training onsite. As the resiliency workshops rolled out, the staff (and managers) were delighted to learn that attendance was paid as work time, sponsored by the Caring Core. “It’s not just the money that matters,” said Maiko, “but they feel truly valued, and as a result are willing to take time out of their days off to invest in their own development.” And like other recent training topics, staff are expressing gratitude for tools that they can incorporate at home with family members. “We learned how to apply resilience in our everyday lives at work and our personal lives.”

In addition to the workshops, StrengthsFinder assessments are underway for all HCAs. In partnership with the Organizational Development team, the assessments will be administered and results shared in team retreats or workshops throughout the coming year. “It was so fun to watch my HCAs discover their natural strengths and how to use them in their patient care role,” said nurse manager Andrea Idudhe. “It’s incredible that we now have the resources to do more for our front line nursing assistants.”

Learning pathways and partners

Not all HCAs are on a path to nursing school, but for those who express an interest or are on the path but have been unsuccessful in the admissions process, the Caring Core mobilizes resources to answer questions and connect with experts. In partnership with the U’s College of Nursing, HCAs can speak with a counselor one-on-one, and with the revival of our Future University of Utah Nurses (FUUN) monthly support group, they can hear from other regional school representatives as well as our own nurses on how to increase their chances for a successful college admission.
To help navigate the growing number of for-profit education options, our “Know Before You Go” tutorial describes the difference between regional and national accreditation, so those who may want to continue their education at the U won’t be surprised with credits that aren’t transferrable.

Learning also happens every day on the unit, as knowledge is transferred from experienced employee to new staff member. Seasoned HCAs especially are called on to orient new employees, a role that to-date had been informal and without additional compensation. For nurses, being a charge nurse or preceptor is one of the criteria for their clinical ladder, and precepting required completion of a formal preceptor course. Recognizing the valuable role of HCA preceptors on the unit, nursing leadership extended the existing precepting classes to HCAs and added a differential, which was overwhelmingly celebrated by the HCAs. “The differential isn’t huge, but it’s just another way to show our HCAs that they are a valuable member of our team, and to thank them for investing in themselves and our new staff,” said Andrea.

The enduring power of “Thank You”

While management recognition of staff is important, we have learned through Thrive@theBedside that peer recognition is crucial. It’s the glue that holds teams together, inspiring a culture of gratitude and appreciation. Some employees revel in public praise during events or meetings, while others prefer a more private or individual exchange. Either way, these personal elements improve working relationships and create a sense of belonging.

The Caring Core recognition encompasses a variety of ways to give meaningful praise to our employees. Similar to Thrive, HCAs can nominate each other for daily acts of kindness and support, with weekly drawings from the nominees for $50 gift cards. The gift cards are then delivered to the staff member by their nominator—not management—adding to the value of the peer relationship. Nurses can also nominate their HCAs, and the sentiments from all are simple but heartfelt.

“Thank you so much for helping with my burn dressing change today.”

“She is always on task and will go the extra mile to make sure that things are done properly without cutting corners.”

“She encourages other staff to put in their best effort and stay on task as well.”

Future elements of the Caring Core include a biannual award for HCAs nominated by patients, nurses, or providers for extraordinary care of their patients, an annual honors banquet with years of service milestone recognition, and a potential clinical ladder to further advance the career HCA role.

“We love our nurses and have been so honored to roll out the Thrive Program,” said Janet. “And now we are thrilled to be able to do the same for our HCAs!” “Visits to our office from nurses to pick up peer recognition are always transactions of smiles,” said Jake, adding that more often than not, the nurses then ask when the HCAs will be included in peer recognition. “This year during National CNA week, we were ecstatic to announce that we were finally ready—The Caring Core is live!” •
Give discharged patients a room for waiting

Smoothing the census with a discharge hospitality suite
With the implementation of real-time demand capacity management over five years ago, nursing teams at University of Utah Health have been steadily—and successfully—improving patient flow through the health system. But increasing patient volumes from the local market and from affiliate referrals across the mountain west have kept pressure on the team to continue to look for additional ways to open beds at the busy main hospital.

“It’s rides. Family rides,” says Spencer Steinbach, the director of the capacity management team. “Based on our data, one of our biggest barriers to a timely discharge is family arrival time,” which is understandable given the long distances that many of our patients travel to receive care at U Health. Local patients also have challenges with rides, as their family members or loved ones are often tied up at work until late in the day. As a result, the patient may be at the hospital, in their room, for several hours longer than needed just waiting for their ride.

Right owners, real data

Spencer was confident that this barrier was worth tackling and proposed a discharge lounge where patients could safely and comfortably wait for their rides. But the proposal didn’t initially excite senior nursing director Tracey Nixon. “Discharge lounges are wildly controversial,” says Tracey. “Fifty percent think it’s great, and fifty percent think it’s a bad idea.” And the U itself had some history to overcome; an unsuccessful attempt many years earlier to create a discharge lounge had other nursing leaders hesitant to make the investment. So what would be different this time? “Before, it was a nurse and physician-owned process, and nurses are naturally resistant to having their patients leave,” notes Tracey, referring to tasks and workload that come with each new patient. Under the new capacity management structure, discharge is a Case Management-owned process, that nurses and physicians support—not drive.

The other glaring difference in this attempt at a discharge lounge is the hard set of data that had been collected to support the decision. “You intuitively feel that the ride home is a barrier, but until you have data, you don’t really KNOW it’s a barrier,” said Tracey, “and you don’t make huge investments off a gut feeling.” Monitoring the data daily over the past year had convinced Spencer that it was the right thing to do. “From June of last year to May of this year, we had 632 patients who stayed in their rooms, just waiting for a ride. That’s 632 new patients we couldn’t admit when we needed to.” Spencer’s team carefully tracks patients who are scheduled to be discharged by 1100 or 1400 each day. If they don’t leave by their target time, the reason is captured in the Teletracking system used by capacity management.

Race for space

One of the key decisions that the team made was that the discharge space be beautiful, comfortable, centrally located, and easy to access—a Discharge Hospitality Suite. The amenities would include recliners and footstools, storage cubbies for personal belongings, laptop tables and charging stations, individual TVs, dimmable lights, warm blankets, and complimentary food and drink. Who wouldn’t want to leave their room and wait in the hospitality suite!

Discharged patients waiting for their ride home can rest comfortably in a private hospitality suite.
Even the patients are educated upon admissions about the discharge hospitality suite. “We sell it like a high-end airline lounge,” said Tracey, “and it’s close to the front door so easier for family to find you.” But it’s not presented as an option—simply as what will happen when the patient is ready to go home.

If at first you don’t succeed...

On opening day of the discharge hospitality suite, the response from patients was overwhelmingly positive. “Our very first patient had to wait 5 hours for his wife to get off work,” said Spencer, “and he loved the suite!” The patient told Spencer that he posted a picture of his surroundings on facebook, telling all of his followers how great it was. He has even planned on making sure his nurse gets him to the suite on his follow-up hospital stay. Other patients have consistently echoed the same sentiments, to Spencer’s delight: “Nice! This is going to work!”

Word of the hospitality suite has even spread outside of inpatient nursing, with requests to send patients from same day surgery, outpatient clinics, and even admissions. Tracey and Spencer joke that instead of a barrier to discharge, the new requests have created a barrier to getting to the discharge suite, all because it is so useful and accommodating. “Patients LOVE the lounge,” said Tracey. “It’s the right space and the right services.”

And it’s helping tremendously with patient flow. “Today we had 10 boarders in the ED by the time we had morning bed huddle at 9:15,” said Spencer. “But we had a handful of discharges before 1100 and a few more that could go to the lounge, and that made all the difference. By 1300, no boarders in the ED, and available beds for the OR.”

As to the risk of trying again with a discharge space, Tracey explains, “Just because you tried it once and failed, doesn’t mean it wouldn’t work. The failure allowed us to see what NOT to do, and it informed our current approach. It never hurts to try.”

Creating buy-in

Consistent with most other clinical initiatives, communication and education were the most important and most challenging aspect of the project. Spencer and his team tailored information and delivered the message individually to each of the primary stakeholder groups: case managers, nursing, and physicians. The chief medical officer Thomas Miller also joined the project, communicating 1-1 with the physicians, helping them get orders written to the discharge suite. Candidates are discussed daily in bed huddle, and charge nurses identify the 2-3 patients in their unit who are candidates for the discharge suite. Leadership is present throughout the process in a way that is supportive, but also ensures accountability to the process.

To help determine the amount of space needed, the team examined their “family ride” data and outlined clinical criteria that must be met in order for a patient to be able to use the hospitality suite. Currently, only those patients who are discharged, fully independent, and not on oxygen can be sent to the suite, which is staffed by a nursing or medical assistant who provides concierge-level services to the patients. Spencer’s team has set an initial target of at least one patient per unit per day to use the new discharge suite.

With a clear vision of the hospitality suite and its potential occupants, the team started on what would be an on-again, off-again process of securing the actual space. “Space is always a challenge,” says chief nursing officer Margaret Pearce, “and even more so at the U where we continue to rapidly outgrow our space, despite new construction.” Margaret is accustomed to the space challenge and has been uniquely successful in seeing hidden potential in the nooks and corners of the hospital. After 18 long months, including three separate approved/unapproved decisions, the space was secured, and construction underway.
Patient Eligibility Criteria:

- Signed discharge order
- Discharge tasks complete
- Independent with ADLs
- Cognitively intact
- Pick-up time confirmed and documented by Case Management
- Able to administer and monitor medications independently
- Able to sit comfortably and interact appropriately
- No severe pain, no active nausea, vomiting, or diarrhea

Patient Exclusions:

- No patients on supplemental oxygen. Patients who have used an O2 concentrator before are ok.
- No patients admitted for behavioral health diagnosis
- No IP precautions (active or rule-out)
- No durable medical equipment still requiring nursing intervention

Cards are given to patients who are ready for discharge, explaining the discharge suite and the services it provides.
Safeguard your staff

Deploying de-escalation for aggressive patients

From left to right: Olivia Del Campo reviews the morning patient list with Mitch Howard and Scott Christensen.
Keeping employees safe in the workplace is a priority, and can be especially challenging in healthcare, where aggression from patients and visitors is on the rise across the globe. Over the past few years, University of Utah Health has intensified their focus on keeping staff safe, and after a couple of particularly worrisome events, chief nursing officer Margaret Pearce and Thomas Miller, chief medical officer, asked two key leaders to create a formal program to deal with workplace aggression.

One of those asked to lead the effort is senior nursing director Laura Adams. "It's not physician-to-nurse, or nurse-to-therapist, or nurse-to-nurse aggression," states Laura. "Where these tensions may have existed in the past, clinical teams have really come together to support each other in the face of increased aggression from patients and visitors." Joining Laura in the effort was Dustin Banks, director of support services, which includes hospital security services. Together, Laura and Dustin engaged the nursing and security teams to create a program of non-violent de-escalation.

BERT alert

“When we were asked by Laura and Dustin to work on this program, we knew that within our organization, we were already doing great things,” said Scott Christensen, an acute care nursing director. “Patient aggression has been seen commonly in psychiatric care settings, and our psychiatric hospital already had a program for de-escalation called Code White,” said Scott. “In addition, our Emergency Department used crisis prevention training, so we called in those experts to join our efforts so we could incorporate that knowledge.”

Scott and team members visited Boston Massachusetts General and Piedmont Athens Regional to observe how de-escalation programs worked in other large facilities. One of their key findings was around the culture. “When it comes to patient violence, you need to create a zero-tolerance culture,” said Scott, “because a lot of nurses are good-natured, and they accept that a patient might hit them, or kick them, or say mean things to them. We realized that we needed to change this mindset.” Newly hired security manager and team member Glenn Smith agreed. “What your nurses consider as normal behavior from a patient really surprised me,” said Glenn, bringing an important outside, objective perspective to the process.

Through the site visits and other research, the team learned about BERT—Behavioral Emergency Response Team—a general term and concept that was being adopted by a number of healthcare facilities across the country as they worked to de-escalate patient situations. BERT typically involves groups like nursing, security, behavioral health, social work, and administration, with a goal of preventing violence using de-escalation or other preventive measures. Scott and the team decided to adopt the BERT terminology and went to work developing U-specific processes and procedures.

Resetting a key relationship

As an academic medical center, many hospital services at U Health are either shared with, or provided by the academic campus. Security is one of these “purchased services.” While the relationship between nursing and security was functional, it was largely disconnected. Security staff generally visited the units when called to intervene in a severe patient escalation event, and then would often express apprehension about being in a clinical space. At the same time, calls for help to security were minimal, because nursing considered patient and family outbursts as routine and within their scope of practice.

In his new role as manager of the security team, Glenn evaluated the security team members and reviewed how they were currently interfacing with the various clinical departments. He learned that this academic campus-based team did not see proactive rounds with nurses as part of the workflow; at the same time, he learned from nurses that such interactions would be welcome.

To build a solid team that would reflect the values needed to improve the safety of patients and caregivers, Glenn recruited retired police officers with decades of experience to serve as leaders. These experienced officers had two core skillsets that were sorely needed in the new training
or just needing permission to lead out in a clinical environment. “After the training, it was so lovely to see a security officer start moving objects around the room and away from the patient, or stepping in-between the nurse and the patient, to protect the nurse.”

After the simulation, the team comes together to debrief, which cements the skills as well as the relationships among the team members. Susan Clark, a nurse manager in neuro acute care, received overwhelmingly positive feedback on the training from her staff. “Realism was frequently mentioned in feedback, so this was clearly sticking with participants.” And when they see each other during an actual event, they instantly know they’ve got the support they need. Shegi Thomas, an acute care nurse manager, applauds the impact on her team. “The trainings they did together and the time they spent together was very meaningful. It decreased the gap that existed before. Now nursing knows who is in security, and what their vision is, what their mission is, and how they can help us.”

**Team training that sticks**

With the help of the highly acclaimed simulation program at the U’s College of Nursing, training was created for a patient violence scenario that helps clinical teams to experience the range of emotions that surface during an event. Luckily, the project could not have come at a better time for Maddie Lassche, executive director for the simulation center, who was in the final stages of her doctorate program. “Sometimes, collaboration between academic and operational units is tricky, as the needs for each group can be very different,” explained Maddie. “In this case, I was ready to start my DNP project, and the hospital needed a customized training program--our needs were a perfect match!”

Mirroring an actual BERT code, the simulation involves a charge nurse, security officer, house supervisor, and a social worker. In the simulation, these diverse roles learn from one another and experience the same emotions together. Maddie noted that before the training, the security officers seemed hesitant to take command of the patient room, whether out of deference to the nurse or just needing permission to lead out in a clinical environment. “After the training, it was so lovely to see a security officer start moving objects around the room and away from the patient, or stepping in-between the nurse and the patient, to protect the nurse.”

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**Formalizing improvement**

In conjunction with the creation of BERT at U Health, Scott and Laura took this opportunity to conduct a formal quality improvement (QI) initiative. The QI project would yield data gathered through pre- and post- surveys that identified those project elements with the most impact on success. Their overall goal for the formal research process was to provide evidence-based outcomes that other
healthcare providers in worldwide institutions could use to create their own programs.

QI project outcomes show that with the BERT training and implementation, nurse ability to effectively manage patient conflict improved significantly, as did their ability to talk with security, and their confidence in caring for aggressive patients. The strongest findings were nurses recognizing the warning signs of escalation and ability to use de-escalating techniques. “Put simply, we learned that nursing and security need to work together, we need to change our culture so nurses are comfortable asking for help, and that aggression is NOT OK,” said Scott. The QI project will soon be submitted for publication and will hopefully be published early 2020. Meanwhile, the U’s BERT project has already gained national and international interest as a result of conference presentations.

A stronger bond

Relationships are always an important part of a successful workplace, and working together, Glenn and Laura ensured a strong bond was created with nursing staff and security team members. Through daily rounds, security checks in with the charge nurses, whom they now know personally. “Security staff has gotten more comfortable working in clinical areas,” says senior director Laura Adams. “They know they’re not coming in to take over, but rather to offer themselves as part of a team to formulate a good outcome.”

Nurses surveyed about the effectiveness of BERT now count security as part of the care team. “I feel like our security staff are empowered with the new training program, and they have gotten better and more comfortable deescalating a patient” said Eric Sawyer, a charge nurse in the neuro acute care unit. “They show up as security, know how to act with patients, and they do better than they used to.” In addition to enhanced teamwork, nurses have personally gained valuable skills in handling difficult patient situations. “Now nursing knows the signs of classic escalation,” said Laura. And a promising trend is emerging: “Teams are able to recognize and diffuse potential aggression before it starts.” The BERT process helps to move an escalating situation away from the other patients, which is always a priority on the units as nurses work to care for all of their patients. “It’s important to recognize the importance of maintaining a clinical environment as one of rest and healing for everyone.”

### The BERT Process

<table>
<thead>
<tr>
<th>Why individuals experience escalation:</th>
<th>BERT alerts the response team:</th>
<th>When to call a BERT Alert:</th>
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<tbody>
<tr>
<td>• Stress</td>
<td>• House Supervisor</td>
<td>• Patient exhibiting indicators of potential violence</td>
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<tr>
<td>• Loss of control</td>
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<td>• Medical complications</td>
<td>• Attending Physician</td>
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#### BERT Goals:

• Empower staff with a step-by-step model of how to assess, control, resolve, and report incidents of disruptive workplace encounters.
• Enhance safety of patients, staff, and visitors by focusing on de-escalating behaviors that threaten environmental safety.
Making mindfulness practical for busy caregivers

Polly Dacus cleans her hands and clears her mind between patients in the busy emergency department. Photo by Derek Larsen.
In a fast-paced unit like the Emergency Department, you wouldn’t expect to see employees slowing down their workflow or taking a time-out to squeeze in a meditation session, even though such breaks in the work day can reduce stress and burnout. In fact, even the word “mindfulness” can spark skeptical, sarcastic, or even dismissive comments. Clinicians simply do not have enough time to slow down and add one more thing to their process. But staff do have—and make—time to sanitize their hands before, during, and after interactions with patients, understanding the evidence and clinical outcomes associated with hand hygiene.

With employees sanitizing their hands dozens of times a day, could those clinical moments be transformed into mindful moments?

When ED nurse Polly Dacus accepted the assignment to lead the unit’s patient experience team, she first felt overwhelmed with the plethora of data, tactics, and tools provided by patient satisfaction experts. With all of the initiatives that could be adopted, she felt that there was still a disconnect. “It’s hard for me to see a direct correlation between the ED patient satisfaction scores and my own personal practice,” says Polly. “That is, I can do the exact same things from day to day, with the same mindset, yet the unit’s scores will fluctuate widely.” As Polly reviewed the options, she realized that instead of focusing on the scores, perhaps a better place to start improving the patient experience would be to prepare the staff themselves. “I felt like we could start by making ourselves the best we can be for every patient encounter.”

The ED patient experience team agreed, and began their journey to help the clinicians with their own resiliency and focus. Fortunately, they had a budding expert at the table in teammate Michael Mangum, a transport health care assistant who had been researching mindfulness in medicine as part of a campus work group for pre-med students. “There’s a stigma associated with the touchy-feely-spiritualness of mindful practice,” said Michael. “Our goal is to use the findings of western neuroscience research surrounding mindfulness practice to help remove this stigma and make mindful practice more appealing to providers.” Michael and Polly both point to research where a provider who is more present and focused with the patient is perceived by the patient as spending more time in the exam, even though the actual length of time spent has not increased. “When staff can practice awareness and be more fully present in their own lives, the care of patients will improve,” says Polly. “Patients will notice their providers are more engaged, not distracted, and truly listening, so the quality of their experience will increase without providers increasing time spent with the patient.”

As the team brainstormed ways to introduce and embed mindfulness into the ED, Michael suggested using the
time spent sanitizing your hands before you enter a room as a trigger to a mindful moment. “Why not take that 10 or 15 seconds to quiet your mind and become present for the patient?” The team sorted through various communication points, tactics, and workflow considerations to create practical steps and education tips for the unit. Learning aids include a bulletin board display, staff meeting presentations, reminder stickers on hand-sanitizer dispensers, and mini-hand sanitizers to give each clinician to reinforce the program. A mindful moment was even incorporated into each shift safety briefing so the process could be modeled and reinforced. “We pause, breathe, think about the room we are in and the sounds we hear,” says Polly. “We ask our team to quiet their mind.” For the staff gelling their hands before entering the patient room, they are asked to “think about how the gel feels on their hands, identify smells near them, hot or cold sensations, areas of tension and other thoughts or distractions occupying their brains.”

The team received a seed grant from Imagine Perfect Care (the organization’s staff innovation center) to launch the pilot program in the ED, and they are looking for three distinct outcomes: create providers who are more present and focused in the moment during their brief patient encounters, promote overall wellness and prevent burnout, and also to simply improve hand hygiene numbers. The team will also be gathering feedback to improve the program, which will hopefully be adopted by other units in the system.

“Multiple staff members have approached me with positive feedback about their workflow during the day and enjoying our staff briefing mindful moments in the morning,” says Polly. “And for some reason, our Exceptional Patient Experience scores are trending up right now!” Michael adds, “I have heard tremendously positive feedback from those in the Integrative Health sphere. They appreciate the simple and informal nature of the time spent.” As to widespread change, Michael acknowledges that “trains take a long time to get rolling, and education will be key in evoking participation and feedback to improve the program.”

Since the Emergency Department began practicing their awareness and mindful moments nine months ago, about 40% of the department have found the Sani-Moment to be beneficial and influential in their self-care as well as patient care. “Multiple staff members have approached me with positive feedback about their workflow during the day, and have enjoyed our staff briefing mindful moments in the morning,” Polly said. “There will always be a few folks who don’t find the mindfulness serves them, but if even just a few benefit, the project is worth it.”

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**Sani-Moment Steps**

- **Pause before walking into a patient room and Sani up.**
- **Key:** make sure to have INTENTION to pay ATTENTION, and here we are going to focus on the sensations in the hands with the sanitizer.
- **As you sanitize your hands, pay attention to:**
  - The positive or negative feeling you have in doing this. You might be annoyed at having to pause your workflow. That’s ok, it can be weird at first. But pay attention to HOW the feeling feels, WHERE it is found, and if the feeling is negative, does it go away or get better?
  - The slippery, cool feeling of the gel. The tickle-y feeling of the bubbles. The sting of the alcohol on a small nick or cut.
  - The feel of your hands. Are they rough? Are they smooth? Are they getting dry from constantly sanitizing?
  - **Is your mind able to KEEP attention on your hands, or does it drift into the thought stream even within 10 seconds?**
  - **If your mind at first can’t stay on whatever object of present awareness you chose to focus on, acknowledge where your mind went, notice that it left, and then simply guide it back to your hands.**
  - **Have fun with it.** See if your present awareness ability in your Sani-Moment improves over a shift, or a week. Practice, and you will see benefits come with practically no cost.
Taming hospital “bed head”

Innovation takes on a variety of forms, which for patient relation specialist Terri Berg and her team is improved hair care options for patients. Many of the patients Terri visits with during her daily rounds on the units are embarrassed to leave their room for therapeutic daily walks because of their appearance. “It’s harder to heal if you feel bad about how you look,” said Terri, who is also a licensed cosmetologist. “Patients frequently ask for help with their tangled, messy hair.” While nurses and nursing assistants brush and wash patient hair whenever possible, there is a greater need than nursing staff can provide, especially for patients with longer lengths of stay. And to be honest, a hospital stay takes the concept of “bed head hair” to a new level.

“Having hair care in the hospital would enhance patients’ well-being,” said Mary Lynne Cortez, who supervises customer service and is part of the Hair Care team who received an Imagine Perfect Care seed grant. The goal of their Hair Care project is to find a network of volunteers—whether employees at U Health or in the community—with cosmetology licenses who can help. A pilot project will start in the next few months once safety and procedural details are finalized. Services will include hair brushing, cutting and styling, beard trims as well as washing and scalp massage, all at no cost to the patient. Hair care would be available to hospital patients after their provider or the nursing staff signed off on the request.

It’s not about the hat

For now, patients who are letting a bad-hair day stop them from getting around are offered their very own University of Utah themed scrub hat to cover their hair and boost their spirits. The scrub hats are special because they are sewn by U Health employees and volunteers. “Our surgery team donated a box of scrub hats they had sewn for their staff to use while on surgical humanitarian trips,” said Teri Olsen, who leads the Imagine Perfect Care team. “We felt that this would be a great way to help the patients right away.” With the initial supply of hats quickly depleted, the Imagine Perfect Care team decided to follow in the surgical team’s footsteps, purchasing U-themed fabric and calling for volunteers to sew more scrub hats. “Could we have simply purchased generic scrub hats, or found a vendor to do this for us?” notes Teri. “Sure. But it’s not just about the hat—it’s about giving our staff, especially non-clinical staff, the opportunity do something out of the ordinary for our patients.”

Even for those who don’t know how to sew, staff can attend fabric-cutting lunches and assemble sewing kits for others to take home. Once sewn, the staff or volunteer is invited to sign their name on the inside of the scrub hat or leave an inspirational ‘get well’ note. “The feedback we have received so far is that the sewing volunteers feel really connected,” Teri said. “Beyond direct patient care, this is something they were able to do to help a patient.”
Start with a blank slate

Innovating patient care through clinician-driven design

The new Craig H. Neilsen Rehabilitation Hospital nears completion on the University of Utah Health campus. Photo by Mike Wessman.
Shortly after nurse Alissa Brown was hired as the nurse educator on the inpatient rehab unit, meeting appointments for a building planning committee started popping up on her calendar. The project: a new rehabilitation hospital, space sorely needed on the U Health campus. Led by the project architects, and attended by a host of clinical and operational staff, the primary topic of these early meetings was the conceptual design for the new Craig H. Neilsen Rehabilitation Hospital. After attending a few of the “architectural design” meetings, Alissa wondered, “Am I supposed to be here?” What she soon realized was that not only did she belong—she and her nursing coworkers were essential to the success of the project.

Unlike a traditional process, the architects had turned the design of the hospital over to the clinical team and basically gave them a blank slate. After all, who better to determine the needs for this diverse and medically complex patient population than the care team members themselves? “The architects gave us the basic shape of the building, a rough idea of how many patient rooms, and where the elevator needed to go,” said Alissa. “After that, we had free reign to think about how the building would best function.”

Such involvement and leadership from the front lines is common at University of Utah Health. “In our organizational culture, it’s the norm to have bedside nurses shaping and driving practice,” said Juan Hernandez, senior nursing director over rehabilitation and post-acute care. “Our nurses can be on a committee that determines medication administration, or on a team that designs buildings. You don’t have to be an executive to make these decisions,” notes Juan. “In fact, our executives look to the front line staff—those who are making the magic happen—to make decisions about how to best care for the patients.”

Roomier rooms

As the nurses worked through the design of the patient rooms, they infused their belief that the best care for patients includes the support that their family and loved ones offer. Because of the length of time that family members can stay, they designated one side of the room as the family space, and created a comfortable and welcoming area, even adding a nurse call light. The other side of the room was designated as the nursing care side, where all of the equipment needed to care for the patient would be placed. Alissa noted, “We were really thoughtful about making sure that every piece of equipment that each patient would need has a specific place to be stored in their room, so that equipment doesn’t end up crowding a hallway.”

To accommodate the extra space needed to care for rehab patients, the rooms in the new hospital are significantly larger than the nurses were used to. They were able to see the larger room layout on paper, and even brought a team of 20 into a foam-board model. But the large size didn’t really hit the team until they walked through a mocked-up room on the construction site. “We were like, are you
kidding me? This is how much room we have? We could hold a dance class in here!"

Every time the design team made a decision, the results were brought back to the nursing unit, with progress tracked through photos on a bulletin board. Information also flowed from the unit back to the design team, as nurses weighed in on project decisions. One particular point of feedback involved a proposal to replace the nurse’s “workstation on wheels” with an iPad, something that the leaders thought would be desirable along with the many other technology innovations in the building. But the nurses quickly—and unanimously—voted down the idea of walking around with iPad as their sole means of typing and charting. “The computers have to stay!” Juan laughs as he admits that he was the one bringing the idea of iPads to the nurses. “It just reinforces that the front line knows what’s best,” said Juan. “And also, they aren’t shy about letting us know.”

### Accessibility for all

One of the basic principles behind the design of the rehab hospital was to make “accessibility” a foregone conclusion. “Whether you are bipedal, or if you are walking in, or rolling in a wheel chair, or coming in a motorized chair, you should have full access to every corner of the hospital,” said Juan. “There should be no accessibility barriers to anyone. Even the term ‘accessibility’ shouldn’t even come up—it’s a given.”

Occupational therapist James Gardner is among the many clinicians on the interdisciplinary team who contributed to the design of the new hospital, with a focus on ensuring accessibility to anyone regardless of ability. “Elevators will have added voice access and can be called and controlled through a smart phone app. Room lighting, blinds, doors, fans, music, TV, and video games will all be accessible through voice, eye-gaze, and sip-and-puff technologies.” Innovation is the norm for James and his therapy colleagues, who have been at the forefront of using 3D printing to create custom assistive devices. Now, their fabrication lab will be embedded into the new hospital, close to the patients. “We are not the only ones excited, about the rehab hospital,” said James. “Our patients are excited to be the first to experience these state-of-the-art innovations.”

In addition to the clinical team, students are getting involved with the rehab patients, through gaming and app development. Every semester, a group of students from the U’s top-ranked Entertainment Arts and Engineering (EAE) program are selected to work in The Therapeutic Games and Apps Lab (The GApp Lab), a collaboration between EAE and two other health sciences groups: the Center for Medical Innovation and the Eccles Health Sciences Library. Students work with clinicians, researchers, and patients to create innovative, medically-focused games and apps that help patients in their recovery process. “Instead of a clinician going down to the main campus and lecturing students about gait disorders,” says Juan, “students will be able to come to the rehab hospital and meet patients to observe their altered gait and clinical limitations. They then can incorporate what they see and hear from the patient in their apps.”

### Caring for staff, too

An especially notable improvement in the patient rooms of the new hospital is equipment that supports and protects the health of the staff. “We will have overhead lifts in every room,” says Sonia Zafra, nurse manager for the unit. Patient transfers are common and especially challenging in rehab. Even with training, rehab nurses are still at risk for back injuries. “The bathrooms are gurney and wheelchair accessible, and some of the rooms will even have lifts from the bed right into the shower. Overall, the physical impact on the nurses of transferring patients will be minimized.” Juan is even more animated when describing the new bathroom design. “The nurses are giddy!” he said. “They can’t wait to try the bathrooms for the first time. They say, ‘You mean, I will have room to apply proper body techniques to help my patient in the bathroom?’”

While nursing staff are excited for moving day, Sonia is busy planning the move itself and working out the extra training that will be required of the staff to use all of the
building technology. “We have smart beds that can track when patients move in the bed, for example.” And it’s not just the room technology; the unit will be adding services like telemetry and oncology rehab, so additional clinical skills and protocols will be included in an upcoming skills day. With the unit size doubling after the move, more nurses and nursing assistants must be hired, oriented, and trained. “We are working on a strategy to get staffing and training completed before the building opens in the spring.”

A special kind of nurse

Reflecting on the design process, Alissa expressed admiration for her nursing co-workers. “Everyone was so engaged in this process. Even nurses who were retiring, and wouldn’t be here for the move, were still very engaged in creating a product that would satisfy everyone’s needs—nurses, patients, and their families.” Personally, Alissa was grateful to learn more about the patient population through the design process. Coming from an orthopedic surgery unit with short lengths of stay on common procedures, the design committee exposed her to a variety of patient conditions and care considerations, from respiratory to occupational therapy to psychological support.

Since the project started, Alissa has been promoted to a higher level of educator, and is mentoring a new rehab nurse educator. But she isn’t going anywhere! “The satisfaction you get with the cares that you do, watching your patients progress and get better, is completely different than on other units,” says Alissa. “Here, nurses have a chance to develop a relationship with their patient, and have the time to help the patient problem-solve and find what will work for them long-term.” Sonia also feels that rehab nursing is changing as far as the skills required. “Most of the nurses in rehab started as new grads, some with the idea that it would be a stepping stone to other service lines,” explained Sonia. “But those who stay have been able to expand their skills because of the changing patient population. We now care for LVAD, neuro, burn, and medically complex patients coming straight from the ICUs.”

As to the nurse-patient relationships in rehab nursing, Sonia agrees with Alissa. “There’s a lot of satisfaction of building rapport with the patient because of the longer length of stay.” Sonia describes the joy of seeing a patient progress from being completely immobile and on a ventilator, to ultimately walk independently out of the unit. “I had a patient who would come back year after year just to say ‘thank you.’ For a nurse, these experiences are very satisfying.” For Alissa, the reward is in helping patients cope with new conditions and sometimes, a new way of life. “Most of our patients won’t remember their ICU nurse or acute care nurse, but they will remember their rehab nurse, thanks to the amount of time we get to invest in the relationship.”
“Wow!” It’s a common reaction when someone new to virtual reality (VR) dons a headset and immediately finds themselves standing in a Japanese garden, riding a roller coaster, holding and playing a virtual guitar, or aiming a bow and arrow at an archery target. These are just some of the VR activities and experiences that can be used for therapeutic purposes. With some patients spending weeks or months in the hospital, these new experiences, and ‘breaks from reality’ can be both exciting and motivating for patients.

Once a niche product requiring big budgets for custom technologies, VR has now advanced to include reasonably priced, off-the-shelf consumer products. As a result, VR use in industries including education, entertainment, business, and healthcare is rapidly expanding.

What might we see in healthcare as VR programs continue to become more accessible and popular? “All kinds of exciting things,” says Dr. Rhonda Nelson of the Department of Occupational and Recreational Therapies at the University of Utah. “In addition to impressive, specialized VR applications designed to address specific health care needs, the use of commercial applications for therapeutic purposes holds enormous potential for widespread adoption.”

At the University of Utah Health Rehabilitation Center, interdisciplinary teams are currently incorporating several commercial VR systems and applications into traditional physical therapy, occupational therapy, and recreational therapy treatment with great success in meeting treatment outcomes. Furthermore, many patients find the interventions fun and motivating.

Capitalizing on this, Lauren Lee Isaacs, a PhD student in Rehabilitation Science has begun working with therapists to examine what role patients’ leisure motivation might play in their response to different VR applications. This may impact treatment outcomes and help therapists select VR interventions that can maximize treatment outcomes. Simultaneously, VR activities that align with patients’ leisure motivations may facilitate continued participation post –discharge.

The LUKE Arm

Innovation doesn’t take a break on the University of Utah’s campus, especially when the biomedical engineering team gains momentum on an idea that’s already gaining traction on social media and news outlets alike. It’s affectionately dubbed the “LUKE arm” in reference to the cybernetic hand Luke Skywalker receives after a light saber duel with Darth Vader. This revolutionary prototype allows the wearer to experience sensory feedback through peripheral nerve stimulation. Detailed in a new study published in the journal *Science Robotics*, Utah interfaced DEKA’s LUKE arm with electrode arrays implanted in residual arm nerves to evoke tactile and proprioceptive perception in the phantom limb, enabling greater precision and dexterity in handling fragile objects. This is a leap forward and a major advance from standard prosthetic devices.