

PROFESSIONAL NURSING PRACTICE
UC DAVIS HEALTH SYSTEM
2011 ANNUAL REPORT



2011 ANNUAL REPORT CONTENTS

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Letter from the Chief Patient Care Services Officer



Dear Colleagues,

In 2007 I wrote that we should never become complacent about the work that we perform within UC Davis Health System. It is now 2012 and we are anything but complacent. We are creating a culture of excellence that demonstrates good patient outcomes and extraordinary compassion in care delivery. We recognize that every employee in our health system contributes to the care provided to our patients in the outpatient and inpatient settings and we embrace collegiality and teamwork.

Our first goal in UC Davis Health System's 2011-2016 Strategic Plan is Person- and family-centered care: improve health by placing the persons and families we serve at the center of care. We are committed to meet this goal by strengthening the relationship-based care model of primary nursing, empowering all staff through unit-based practice councils to improve their practice, and by celebrating the accomplishments of our extraordinary staff.

This edition of Year in Review captures the many collaborative accomplishments and highlights the extraordinary relationships that we believe set us apart and demonstrate our readiness for the Magnet Designation.

With warmest regards,

A handwritten signature in black ink that reads "Carol Robinson RN". The signature is written in a cursive, flowing style.

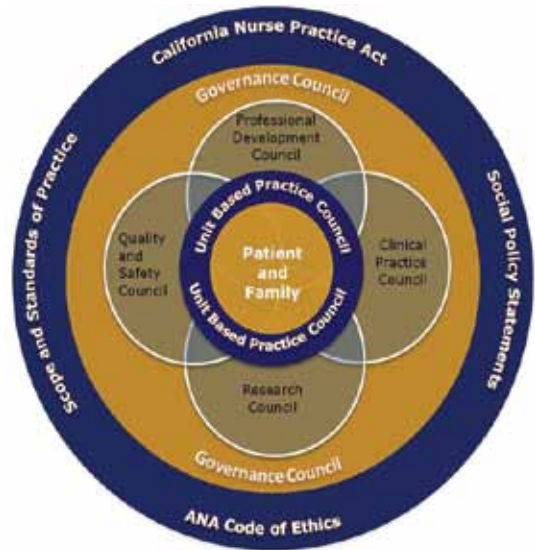
Carol A. Robinson, RN, MPA, NEA-BC, FAAN
Chief Patient Care Services Officer

PROFESSIONAL GOVERNANCE

Professional Governance is the organizational structure that was designed and implemented this past year. This structure has empowered professional direct-care nurses to contribute collaboratively as decision makers regarding their nursing practice and their nursing work environment. This includes focusing on elements such as standards of practice, policies and procedures, resource utilization, stewardship, evidence-based practice, research, and quality and performance improvement.

Participation in Professional Governance at the unit and system level has encouraged nurses to be problem solvers and leaders with a common goal; providing quality patient care.

Since its inception in 2011, many new and exciting councils have been implemented. There are currently 41 unit-based practice councils throughout the organization. These councils have identified “quick wins” and are currently implementing clinical practice initiatives such as, standardizing unit education, improving documentation for risk assessments, standardized equipment storage, preparing for specialty certification and Interdepartmental teamwork.



The Professional Governance transformation has strengthened communication and is a valuable means by which direct care nurses develop innovative ideas, take ownership and help implement solutions.

GOVERNANCE COUNCIL

Carol Robinson, RN, MPA, NEA-BC, FAAN, Chief Patient Care Services Officer (chair)
Brittney Andrews, RN, BSN, Quality and Safety Champion, D6, D12, E6, E4, and T8 (co-chair)

Nancy Badaracco, RN, MSN, Manager, Ambulatory Nursing Practice

Shelly Bergum, RN, FNP, Trauma and Emergency Surgical Services

Tina DiPierro, RN, MSN, NE-BC, Davis 14 Nurse Manager

Dorine Fowler, RN, MS, ONC, D14

Revena Gantuangco, RN, MSN, MICU

Stacy Hevener, RN, MSN, CCRN, MSICU

Toby Marsh, RN, MSA, MSN, NEA-BC, Director, Hospital and Clinics, PCS

Miguel Medina, RN, BSN, Quality and Safety Champion, CTICU

Johannon Olson, RN, BSN, Operating Room Nurse Manager

Barb Rickabaugh, RN, MSN, NE-BC, Center for Nursing Research

Jackie Stocking, RN, MSN, MBA, Program Director, Quality and Safety, PCS

Carrie Swan, RNC, NICU

Kelly Tobar, RN, MS, EdD., Center for Professional Practice of Nursing Nurse Manager

Deb Trainor, RN, MSN, Emergency Department Nurse Manager

Amy Zauch, RN, MSN, Emergency Department



Left to right, seated; Nancy Badaracco, Revena Gantuangco, Shelly Bergum
Left to right, middle row; Amy Zauch, Carol Robinson, Barbara Rickabaugh, Miguel Medina
Left to right, back row; Carrie Swan, Toby Marsh, Brittney Andrews, Alicia Loftin, Dorine Fowler, Stacy Hevener, Jackie Stocking, Elizabeth Winward (guest)

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 Marlissa Fua, RN, BSN, CNOR, Same Day Surgery Center
 Ellen Kissinger, RN-BC, MSN, NE-BC, Magnet Program Coordinator
 Toby Marsh, RN, MSN, MSA, NEA-BC, Director, Hospital and Clinics, PCS
 Bonnie McCracken, RN, MSN, NEA-BC, NP-C, NP Manager
 Karen Mondino, RN, MSN, CTICU and SICU Nurse Manager
 Stephanie Newman, RN, MSN, FNP-BC, Heart and Vascular Center
 Eleanor Salvatin, RN, BSN, CCRN, Patient Care Resources
 Josh Spangler, RN, MSICU
 Vicki Stark, RN, Labor and Delivery
 Karen Stepp, RN-C, BSN, Women's Pavilion
 Stephanie Stewart, RN, Patient Care Resources
 Katherine Suggett, RN, BSN, CHF Clinic
 Jill Taylor, RN, BSN, Radiology
 Carolyn Turner, RN, BSN, CPAN, CCRN, Same Day Surgery Center
 Jeremy Veldstra, RN, BSN, Emergency Department
 Bridget Wilson, RN, MSN, FNP-BC, CNRN, Neurological Surgery



*Left to right, seated; Jill Taylor, Stephanie Stewart, Bonnie McCracken, Katy Suggett, Dorine Fowler, Ellen Kissinger
 Left to right, middle row; Marlissa Fua, Eleanor Salvatin, Cheryl Patzer, Heidi Dahlke, Vickie Stark
 Left to right, back row; Jeremy Veldstra, Toby Marsh, Carolyn Turner, Bridget Wilson, Stacy Hevner, Josh Spangler, Stephanie Newman, Karen Stepp*

PROFESSIONAL DEVELOPMENT COUNCIL



Left to right, front row; Marianne Ciaverella, Kelly Tobar, Karen Kouretas, Casey Ingram, Judie Boehmer. Left to right, back row; Julie Khashabi, Tish Campbell, Lynn Loftis, Brittny Andrews, Alicia Loftin, Peggy Hodge, William Hammontree

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 Brittny Andrews, RN, BSN, Quality and Safety Champion, D6, D12, E6, E4, and T8
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 Tish Campbell, RN, BSN, Center for Professional Practice of Nursing
 Rebecca Case, RN-C, BSN, PICU
 Marianne Ciaverella, RN, BSN, MPH, CCRN, Home Health
 Pamela Gant, RN, CICU
 Peggy Hodge, RN, MSN, EdD., Center for Nursing Research
 Casey Ingram, RN, MSN, E4 Nurse Manager
 Julie Khashabi, RN, Same Day Surgery Center
 Karen Kouretas, RN, MSN, Davis 11 Nurse Manager
 Alicia Loftin, RN, Davis 11
 Lynn Loftis, RN, MSN, CCRN, NE-BC, GI Lab Nurse Manager
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 Bonnie McCracken, RN, MSN, NE-BC, NP-C, NP Manager
 William Hammontree, RN, Emergency Department

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 Brittny Andrews, RN, BSN, Quality and Safety Champion, D6, D12, E6, E4, and T8
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 Elvie Balinsat, RN, BSN, CRNI, Women's Pavilion
 Jerry Bambao, RN, BSN, T4
 Deb Bamber, RN, MSN, PICU, PCICU, and CCCT Nurse Manager

Mag Browne-McManus, RN, BSN, Radiology Nurse Manager
 Deborah Buchanan, RN, MSN, E4
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 Shirley DaRosa, RN, BSN, Same Day Surgery Center
 Amy Doroy, RN, BSN, MICU Nurse Manager
 Anne Fitch, RN, Same Day Surgery Center
 Debbie Glaesar, RN, BSN, MSHCA, NSICU, E5 Neuro, and E5 Rehab Nurse Manager



Left to right, seated; Elizabeth Radsliff, Betty Clark, Deborah Buchanan, Shirley DaRosa, Steve Robinson, Alice Zeboski, Christine Edwards

Left to right, middle row; Nicola Smith, Pam Mooney, Christine Williams, Joan Mallum, Maile Mauer, Linda Cooke, Cathy Adamson, Cindy Vasquez, Elvie Balinsat, Jared Quinton

Left to right, back row; Denette Valencia, Joleen Lonigan, Jackie Stocking, Jerry Bambao, Miguel Medina, Marilea Higdon, Debbie Glaeser, Alicia Loftin, Karen Kouretas

Marilea Higdon, RN, CCRN, Quality and Safety Champion, MICU
 Marci Hoze, RN, BSN, MPA, Pulmonary Lab, Apheresis, PICC, and AIM Nurse Manager
 Charles Johnston, RN, BSN, Quality and Safety Champion, Burn Unit
 Holly Kirkland Walsh, RN, FNPC, GNPC, Wound Care NP
 Karen Kouretas, RN, MSN, Davis 11 Nurse Manager
 Rose Lamberth, RN-C, BSN, T4
 Alicia Loftin, RN, D11

Joleen Lonigan, RN, MSN, NE-BC, Patient Care Resources Nurse Manager
 Joan Mallum, RN, MICU
 Maile Mauer, RN, BSN, Quality and Safety Champion, CICU
 Christopher McKinly, RN, BSN, Quality and Safety Champion, D8, D11, D14, E5, E8, and T4
 Karen Mondino, RN, MSN, CTICU and SICU Nurse Manager
 Eric Moore, RN, BSN, MBA, NEA-BC, E8 Nurse Manager
 Pam Mooney, RN, MSN, CNS Pediatrics
 Jamie Myers, RN, MSN, Quality and Safety Champion, ED
 Marsha Nelson, RN, Manager CQI
 Cheryl Patzer, RN, MSN, T8
 Christine Pineda, RN, MSN, T8 Nurse Manager
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 Beverly Smiley, RN, BSN, CPHQ, Clinical Quality Improvement and Patient Safety
 Nicola Smith, RN, BSN, Patient Care Services
 Pam Soares, RN, Same Day Surgery Center
 Oleg Teleten, RN, BSN, WCC, Patient Care Resources
 Emily Torres, RN, BSN, Quality and Safety Champion, NSICU
 Cynthia Vasquez, RN, E4
 Denette Valencia, RN, MPA, CCRN, CICU Nurse Manager
 Holly Vierra, RN, BSN, COS, Home Health Services
 Christine Williams, RN, MS, Emergency Department CQI
 Cheryl Wraa, RN, MSN, Manager Trauma Program
 Alice Zeboski, RN, HIM
 Ad Hoc Members: Jared Quinton, Program Director, Lean Six Sigma
 Linda Moore, RN, MSN, PCS Analyst
 Pat Brown, RT, Manager Respiratory Care
 Theresa Arciniega, LCSW, Social Services

RESEARCH COUNCIL

Barbara Rickabaugh, RN, MSN, NE-BC, Center for Nursing Research (chair)
 Amy Zausch, RN, MSN, Emergency Department (co-chair)
 Eunice Carlson, RN, BSN, E6 and D6 Nurse Manager
 Helen Chester, RN, BSN, Patient Care Resources
 Kelly Colburn, RN, BSN, E6
 Gail Easter, RN, MSN, Director, Hospital and Clinics, PCS
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 Revena Gantuangco, RN, MSN, MICU
 Kathleen Guiney, RN, MN, Nurse Educator
 Jeanette Hess, RN, BSN, Pulmonary Services Lab
 Jennifer Malana, RN, BSN, Women's Pavilion
 Sanaz Martin, RN, MS, E6
 Monica Miller, RN, BSN, CCRN, MICU
 Eric Moore, RN, BSN, MBA, NEA-BC, E8 Nurse Manager
 Patti Palmer, RN, MS, AONCNS
 Carolyn Parrish, RN, MSN, Perioperative Services
 Sherri Reese, RN, BSN, CIC, Infection Prevention
 Ann Siever, RN, MA, CORLN, CNS
 Len Sterling, RN, BSN, MBA, Burn Unit Nurse Manager



Left to right, front row; Len Sterling, Sanaz Martin, Kelly Colburn, Patricia Palmer, Jennifer Malana, Revena Gantuangco

Left to right, second row; Eric Moore, Helen Chester, Monica Miller, Jeanette Hess, Barbara Rickabaugh, Amy Zausch, Gail Easter

Left to right, back row; Christine Fonseca, Sherri Reese

Knights Landing Community Engagement Project (KLCEP)

The Knights Landing Community Engagement Project (KLCEP) represents the combined interests of a University of California, Davis (UC Davis) Assistant Professor of Chicano Studies, UC Davis medical students, and UC Davis undergraduate students to use a community-centered approach to serve as advocates of the underserved farm working community within Knights Landing, California. The rural community of Knights Landing has suffered a significant loss of resources in the recent years that adversely affected its health in multiple ways.

In response, a group of predominantly monolingual, Spanish-speaking, farm worker housewives and mothers in Knights Landing surfaced as leaders, urgently expressing the need for accessible health care in their community. In an attempt to address the women's voiced priority, the KLCEP partnered with the Rural-Program in Medical Education (Rural-PRIME) of the UC Davis School of Medicine, the Yolo Family Resource Center (Yolo FRC), and the California Rural Legal Assistance Foundation (CRLA Foundation). Together they successfully persuaded Clínica Tepati, a UC Davis School of Medicine non-profit, student-run clinic, to allow the KLCEP to plan and establish a student-run clinic, Clínica Tepati's first satellite clinic, in Knights Landing.

UC Davis nurses Tina Dipierro, RN, MSN, NE-BC and Marci Hoze RN, BSN, MPA, joined efforts to see how nurse volunteers could also assist the Knight's Landing Community. Initial strategies for nursing will be to perform triage, phlebotomy and education. In planning, it was essential to remember that the clinic is influenced by the community and was established because of the advocacy of the self-formed Knights Landing women's group. The clinic serves the community based on their needs rather than perception of needs. Sundays were chosen as the day to operate the clinic by the women's group because of the men's field work hours being Monday-Saturday. The clinic will open its door in the beginning of 2012 and offer local health care to this underserved community.

Community Prevention

Christy Adams, RN, BSN, MPH / Trauma Prevention Coordinator

Motor vehicle collisions are a leading cause of injury and fatalities among adolescents. Teen drivers also account for three times as many fatal crashes as all other drivers. In an effort to reduce the number of young driver fatalities that occur every year, the Governor's Highway Safety Association (GHSA) is developing a new publication that takes a case study approach to teen driving. Intended to serve as a "best practice" manual, the publication will guide states in the development of successful teen driving safety programs. This project will utilize the expertise of traffic safety, law enforcement, and public health and health care professionals from states that have shown promising advances in teen driving safety initiatives.

In 2011, the GHSA Teen Safe Driving project invited Christy Adams, RN, BSN, MPH, Trauma Prevention Coordinator, to join the 12 member expert panel formed to oversee the development of the publication. The panel convened via teleconference for the first time in September of 2011 and is expected to contribute an additional 15-20 hours to the project during 2012. As the only registered nurse and health care professional on the panel, Christy is able to provide expertise on motor vehicle collision trauma and adolescent development. Additionally, her master's degree in public health has allowed her to contribute a public health perspective on prevention to the project.

Christy believes she was invited to participate because of her health care background combined with her recent work in traffic safety in the State of California. Trauma Prevention Programs at UC Davis Medical Center have partnered closely with the California Office of Traffic Safety (OTS) over the last decade and we have received over \$4 million in grant funding for traffic safety projects during that time. The most recent grants, for which Christy was project manager, were the Adolescent Screening and Brief Intervention study (2008-10) and the Building Community Based Injury Prevention Programs initiative (2009-10). Christy has also coordinated and participated in a number of teen driving specific initiatives including the Every 15 Minutes programs, Impact Teen Drivers, the California Teen Safe Driving Coalition, and the Strategic Highway Safety Plan, challenge area 6 (Reduce Youth Driver Fatalities).

Trauma Outreach and Prevention Program

The Trauma Outreach and Prevention Program is dedicated to reducing trauma related death and injuries in the greater Sacramento area. Most unintentional injuries and deaths, such as those that result from reckless driving or improper use of a child safety seat, are preventable. The goal of this program is to facilitate evidence based environmental and behavioral changes that promote safety and reduce the risk of injury in both pediatric and adult populations.

Trauma Outreach and Prevention Program staff partner with schools, community centers, private organizations and government agencies to create community based injury prevention projects that are relevant to the local residents. In 2011, the trauma prevention program reached over 18,500 parents and children in the Sacramento region through safety education and distribution of resources. With a program staff of one registered nurse, a child passenger safety instructor and a health educator this level of community outreach would not be possible without the support of the hospital nurses who volunteered their time to join in outreach activities. The program provides a wide variety of outreach opportunities for UC Davis Health System nurses, ranging from the Every 15 Minutes program to child safety seat inspection events. Much of the work supporting the outreach efforts is provided by the community itself through essential partnerships with numerous Family Resource Centers in the area such as Birth & Beyond, and The Effort clinics.

Although preventing injuries from occurring is a priority, the mission of the trauma prevention program extends beyond the immediate safety needs of residents in the greater Sacramento area. Centered on a public health framework for prevention, the outreach program incorporates injury prevention awareness and education for both current and future health care professionals. The

2011 Child Passenger Safety Outreach through December 31

OUTREACH	NUMBER OF EVENTS	PEOPLE IMPACTED	CAR SEATS DISTRIBUTED
Health System Car Seat Classes	18	186	189
Hospital Car Seat Distribution			200
Community Car Seat Classes	108	1,117	1,207
Hospital Car Seat Inspection Station		115 (121 seats inspected)	0
Community Car Seat Inspection Events		115 (170 seats inspected)	97
Car seat safety 36 hr certification course	2	37	0
Car seat safety class for UCD RNs	2	29	0
Car seat safety skills lab for UCD L&D RNs	1	105	0
Car seat overview for pediatric residents	1	30	0
TOTAL	132	1,734	1,693

prevention program partners with the California State University, Sacramento (CSUS) nursing program to provide community health clinical rotation hours which include comprehensive didactic on the public health issues surrounding trauma related injury and death. Last year the Trauma Outreach and Prevention Program established a partnership with the UC Davis School of Medicine to provide community health focused injury prevention education to first year pediatric residents through the school's Community & Health Professionals Together (CHPT) program.

The success of these programs in reducing injuries is contingent on more than safety education focusing on behavioral changes. Many families experience financial barriers to obtain much needed safety equipment such as child safety seats and bicycle helmets. Through generous donations from Kohl's Cares®, the program has been able to provide a significant number of no-cost car seats, helmets and life jackets to low-income families through the Kohl's Buckle Up to Grow Up Program. More than just an equipment distribution program, Kohl's Buckle Up to Grow Up focuses on providing one-on-one safety education and fitting with each car seat or bicycle helmet distributed.

Nurses who generously donated their time back to our community:

Elizabeth Dacpano, RN, NICU, Geraldine Pickett, RN, NICU, Shirley Shingara, RN-C, BSN D7, Angie Luper, RN, BSN, D7, Cindy Steele, RN-BC, BSN, D7, Kriston Reneau, RN,BSN, D7, Kimberly Wilcox, RN, D7, Melissa Bradford, RN,BSN, D7, Stacy McCarthy, RN, ED, Marni Far, RN, ED, Yvonne Hansen, RN, ED, Andrea Szontagh, RN, BSN, ED, Maggie Johnston, RN, ED, Connie Zasa RN, Action team, Maria Romero, RN, Trauma NP, Bonnie McCracken, RN,MSN, NP-C, NEA-BC,PA Trauma, Michelle Linenberger, RN, PICU/PCICU

Listed below is a 2011 summary of Trauma Outreach and Prevention Program events.

2011 Helmet Safety Outreach through December 31

OUTREACH	NUMBER OF EVENTS	PEOPLE IMPACTED	HELMETS DISTRIBUTED
Classroom presentations	130	4,669	3,651
Health and safety fairs	9	8,700	0
OUTREACH	NUMBER OF EVENTS	PEOPLE IMPACTED	HELMETS DISTRIBUTED
Helmet Fitting Events	5	2,985	670
Bicycle rodeo	2	350	96
Helmet training for educators	8	18	446
Helmet fitting stations established	3		
TOTAL	157	16,722	4,863

2011 Life Jacket Safety Outreach through December 31

OUTREACH	NUMBER OF EVENTS	PEOPLE IMPACTED	JACKETS DISTRIBUTED
Life Jacket Trade In event	1	200-300	810
Life Jacket fitting stations established	1	20	20
TOTAL	2	300	830

The gentleman was not a stranger. Every Sunday I would see him come into 24 Hour Fitness in Carmichael using a walker and being assisted by a woman and another gentleman, it was obvious that he had some physical limitations. Despite these limitations he faithfully exercised on the stationary bike. It's funny, as a nurse you are always observant and watchful of people in different situations that may need your assistance.

This Sunday was no different, he came into the gym with his walker, and was assisted onto the bike. I was on an elliptical machine exercising with my friend Molly Nelson, who is also an RN at UC Davis Medical Center. Shortly after getting on the bike, Molly noticed that the gentleman was slumped over the handlebars. As she was saying "I hope everything is OK", another gym member who was near the man, moved him quickly from the bike to the floor. Simultaneously Molly said "Lori they need a nurse over there" I jumped off my machine and ran to help, the 24 hour fitness staff grabbed the Automated External Defibrillator (AED) and emergency equipment and brought it to us. I am not sure who actually called 911 but as everyone around inquired I heard someone say "yes 911 has been called". As it turns out this gentleman was very fortunate as the other gym member was a physician and he started chest compressions as I started rescue breathing. As soon as the 24 hour fitness staff brought the AED to us, we quickly placed it on him.

Upon reflection, I never thought twice about where I was but rather that this gentleman needed help and I am trained to provide it, as I am a nurse. I remember feeling a rush of adrenaline kick in at the realization that this man wasn't breathing and was in full cardiac arrest.

I am still not sure how much time we spent performing CPR and using the AED, in reality it was probably 12 to 15 minutes but it seemed like an hour to me. Once we calmed down and assessed the patient and the situation my feelings changed from that adrenaline rush to calm and clinical. Immediately my clinical skills took over, it was surreal, almost like I was reviewing the CPR video that I have watched for years. I had never met the gentleman who was doing chest compressions but there was a sense of teamwork between the two of us. We had an immediate bond and immediate trust in one another. As a team, he trusted me with proper airway management and assessment of the gentleman and me trusting him, that he was delivering adequate chest compressions. It was at this point that this gentleman became my patient.

I have been at UC Davis Medical Center for 23 years and a nurse for 31 years. Currently I am a Clinical Documentation Specialist, but at that moment I felt as if I had never left bedside nursing. I felt comfortable with my clinical assessment skills and necessary teamwork to care for this gentleman in this uncontrolled situation. In retrospect, I have thought of all the things that could have gone wrong such as: being alone to do CPR, unable to find or use the AED properly, unable to control the actions of by-standers during resuscitation and how different the outcome may have been if we were both not readily available. I cannot think of anything that I would have done differently.

My response was automatic because of all those years of CPR and ACLS training. I spent many years working as an ICU nurse and because of my years of training and education I knew exactly what to do. I can remember my first words were "I am a nurse, I know CPR". How many times have we said that during CPR training? As we continued

My Patient

by Lori Bergemann, RN

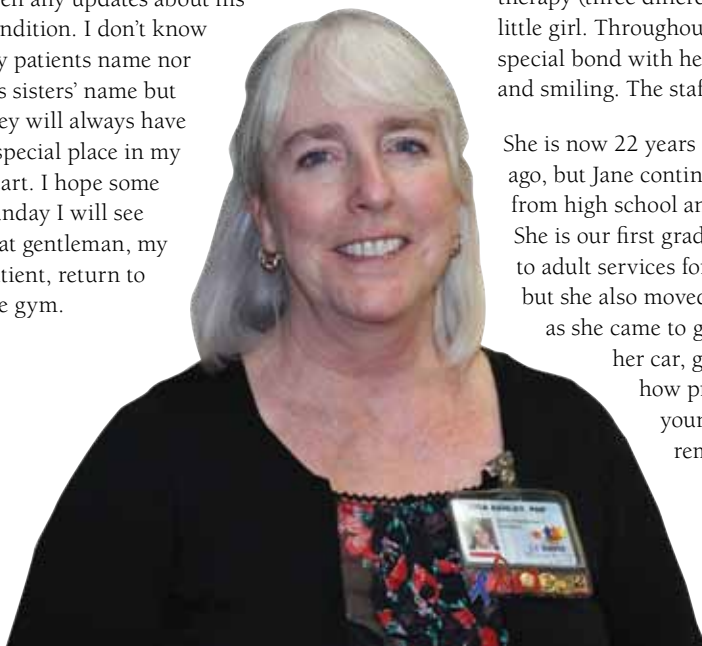


performing CPR, the AED fired a total of three times. After each shock I would re-assess the patient for a pulse and breathing, and each time announced no pulse and no respirations. I felt all eyes on me as I felt for a carotid pulse and re-positioned the airway. Each time we re-initiated CPR.

When the Fire Department and paramedics arrived we had performed CPR for about 12-15 minutes and delivered three shocks per the AED. I felt happy and relieved to see them. One of the paramedics immediately took over chest compressions and another connected our patient to a cardiac monitoring system and defibrillator. I remember asking the third paramedic "Do you want me to move", he directed me to stay and continue airway management while he prepared to intubate the gentleman.

When I was relieved of my nursing duties and had a moment to reflect on what had just happened, I found myself shivering and shaking with a feeling of disbelief at what had just taken place. I couldn't stop thinking about my patient. I felt comfort in knowing that a heartbeat had been established prior to being transported to a local hospital. I also felt comfort in knowing that other gym members acted with kindness in transporting the woman (who is his sister) to the hospital.

Every day I think about my patient and wonder how he is doing. When I go to the gym I often ask if there have been any updates about his condition. I don't know my patients name nor his sisters' name but they will always have a special place in my heart. I hope some Sunday I will see that gentleman, my patient, return to the gym.



Pediatric and Young Adult HIV Services

By Lisa M. Ashley, RN, MSN, PNP

I have been a Pediatric Nurse Practitioner with the Pediatric HIV/AIDS clinic for 16 years and so I have witnessed firsthand the tremendous change in the disease and the treatment modalities. Sixteen years ago our patients went from having no medications available and succumbing to frequent deaths to currently having multiple medications available and rare occurrences of deaths. In fact, I have only seen two deaths in the past 16 years and both were a result of young adults who decided their fate by choosing to be non-compliant with their treatment.

Due to the great support in our community for people living with HIV/AIDS, the clinic has also been involved with the Ryan White Program, which is a federally funded program to provide additional services to our patients. Our grant was just renewed for another three years and our patients and their families will continue to be provided with medical case management services, a pharmacist to assist with medication adherence, and transportation to medical appointments if needed. In the past year we have also been involved with fund raising events such as the AIDS walk and Bingo Night. Last year we raised over \$9,000! These funds go directly to our patients and families to help provide food, clothing, school supplies and gas to help get to appointments.

That being said, I am proud and delighted with several HIV/AIDS patients that have been able to graduate from our pediatric service. We have found that the transition to adult services can be difficult for our patients and their families. Two years ago I was instrumental in helping to create HIV Young Adult Clinic that assists young people, ages 18 – 24 years, in not only transitioning to an adult medical service, but to encourage and support them with their life challenges (college, work, moving out to apartment etc).

There is one young lady whom I have known since she was 6 years old. Her mother contracted the disease through her partner and Jane (not her real name) was born with HIV. At that time we only had single therapy AZT available and it was a miracle she survived infancy. By the time she was six years old, we entered the world of triple therapy (three different drugs to attack the virus) and she became a thriving beautiful little girl. Throughout the years she continued to thrive and develop and had a very special bond with her mother. She came regularly to clinic and was always cheerful and smiling. The staff including myself just admired and loved them both dearly.

She is now 22 years old and unfortunately her mother passed away several years ago, but Jane continues to fight the disease and continues to thrive; graduating from high school and now attending college and plays drums in her church choir. She is our first graduate of the young adult clinic, and has transferred completely to adult services for her medical care. Not only did Jane graduate to adult services but she also moved into her first apartment! I had a very special moment with her as she came to get a microwave that I was donating. I placed it in the trunk of her car, gave her a big hug and told her how proud that I was of her and how proud I knew her mother would be to see her turn into a terrific young person. As she drove away in her car, I smiled to myself and remembered that is why I am in nursing.

Maureen Craig, RN, MSN, CNN



Maureen Craig, MSN, CNN
*Clinical Nurse Specialist,
Nephrology*

Maureen Craig, RN, MSN, CNN has just completed seven years volunteering as a commissioner on the Nephrology Nursing Certification Commission (NNCC). During her time she served as Treasurer, Website Chair, President Elect and President.

During her years as President, Maureen worked hard to increase governmental and public recognition of “certification” as the means to improve the opportunity that patients with kidney disease

will receive safe and effective care. The NNCC and their testing partner, Center for Nursing Education and Testing (C-NET) put forth an enormous and successful effort to support the Center for Medicare and Medicaid Services (CMS) End Stage Renal Disease (ESRD) Conditions for Coverage (V tag 695) regulating that all Patient Care Technicians working in hemodialysis must be certified. Technicians choosing to certify with NNCC as Certified Clinical Hemodialysis Technicians (CCHT) increased from just over 3,000 in the prior eight years to nearly 26,000 certificants by the end of Craig’s term.

Maureen oversaw all four certification exams (Certified Nephrology Nurse, Certified Dialysis Nurse, Certified Nephrology Nurse – Nurse Practitioner and Certified Clinical Hemodialysis Technician) offered by the NNCC being converted from paper and pencil to the Computer Based Testing format.

Ms. Craig was able to secure \$5,000 annual funding for the Barbara Prowant Nursing Research Scholarship offered through the American Nephrology Nurses Association (ANNA). These funds are available to a nurse researcher in the field of Nephrology Nursing.

During Maureen’s time on the NNCC, the two nursing certifications, CNN and CDN received national accreditation by the Accreditation Board for Specialty Nursing Certification (ABSNC). To achieve this accreditation, NNCC had to provide extensive documentation demonstrating that its certifications met the ABSNC’s 18 standards of quality. This accreditation demonstrates that the CDN and CNN credentials are founded on valid and reliable exams and that the NNCC meets or exceeds the industry standards as a certification organization.

LARYNGEAL TRANSPLANT

Participating in the world’s second documented laryngeal transplant was the highlight of many this past year and also probably in the entire career of many of the nurses who care for otolaryngology patients. This momentous effort by a team of Otorhinolaryngology Attending Physicians, residents, fellows, countless numbers of nurses, speech pathologists, dietitians, and support staff was unprecedented at UC Davis Medical Center. The opportunity for nurses to participate in world level care was extraordinary.

The care of such a complex patient was challenging and beyond rewarding. The UC Davis nursing and speech pathology team presented this unique case at the UC Davis Nursing Grand Rounds, the Society of Otolaryngology Head and Neck Nurses national meeting in San Francisco in September 2011 and will present again at the California Speech and Hearing Convention in April 2012. The care review was published in Otorhinolaryngology (ORL)-Head and Neck Nursing Fall 2011, Volume 29, No 4. The opportunity to present this case to peers is indeed an honor.

Left to right, front row: Carol Hobbs, Brenda Jensen, Ann Sievers,
Left to right, middle row: Ann Virinten, Shannon Whitney, Ann
Madden-Rice, Kim Olson, Kim Schuckert, Carolyn Mofidi,
Left to right, back row: Kathy Adamson, Bev Lorins, Kathy Speegle-
Clark, Janet Peterson, Jerry Bambao





Pediatric Diabetes

Sultanna Iden, RN, BSN, CDE

Sultanna Iden, RN, BSN, CDE, nurse with the Pediatric Diabetes Clinic believes in giving children with diabetes power and control over their disease. She is a strong proponent of “Diabetes Self-Management”, where children and their families accept their diagnosis and learn how to cope with and treat their disease. To this end, she teaches children and their families not only how to medically manage their disease; but more importantly, how to COPE with their disease.

To help families with the coping process, Ms. Iden hosted events throughout the year where families can come together for support. This past year she hosted two events, the “Pediatric Diabetes Survivor Day” and a meet and greet with a “Team Type 1” cyclist. The Pediatric Diabetes Survivor Day was held in August in conjunction with the Rancho Cordova Parks and Recreation department. It was held at the Rancho Cordova Senior Center and was open to the greater Sacramento community. The theme was “how to survive diabetes”. Children had to work together with teams to solve puzzles and games, much like the popular Survivor television show. The lesson learned was, diabetes can be tough, but if you work as a TEAM, it can be done. The day included an address from keynote speaker Joe Solowiejczyk, RN, MSW, CDE. Joe is a family therapist who himself has had Type 1 diabetes for 50

years and specializes in helping children and families cope with diabetes. A healthy lunch was served and the day concluded with nurse Sultanna, dietitian Dayna Green-Burgeson and therapist Joe getting in a dunk tank so the kids could take out their frustrations on them.

The meet and greet with Team Type 1 was held in the fall on site. This was an opportunity for children with diabetes to meet a successful athlete who himself has Type I diabetes. The mission of Team Type 1 is to instill hope and inspiration for people around the world affected by diabetes. The Team Type 1 athlete who spoke to the group was Jerry Willis, member of Team Type 1’s 2010 winning Race Across America Team. Jerry provided an inspirational speech to the group and answered many questions. The evening concluded with some fun games which reviewed how to manage your diabetes while exercising.

It is Ms. Iden’s hope that by hosting these types of events for children with diabetes and their families, that they can interact and socialize with others, who share the same disease. It is her inspiration that they will learn to feel more comfortable, learn to accept and cope with the diabetes lifestyle. Ms. Iden has been a diabetes nurse for 12 years, a nurse for 22 years and a Type 1 diabetic for 32 years. Her mantra is “Just Do It!”

Left to right: Claire Basco, Susan Edwards, Debbie Glaesar, Delia Christian



UC Davis Medical Center Receives “Best Emergency Department”, “Best Intensive Care Unit–Pediatric” “Best Intensive Care Unit–Adult Neurosurgical” Awards



Left to right: Jacqueline Arrietta, Linda Hovath, Debbie Glaesar, Karen Mondino, Varita Patel, Susan Edwards, Deb Bamber, Donal Grohosky, Vicki Velasquez, Dawn Love, Jeremy Veldstra, Jerry Kerekes, Gypsy Tippet

Fourteen Shining Stars from UC Davis Medical Center walked the Rock Star Hall of Fame at the 2011 hospital awards party hosted by Golden State Donor Services and Sierra Eye & Tissue Donor Services: Jerry Kerekes, RN, Dawn Love, RN, CCRN, Susan Edwards, RN, Christian Sebat, MD, Joyce Colobong, RN, MS, ACNP-BC, Gail Easter, RN, MSN, Vicky Velasquez, LCSW, Jeremy Veldstra, RN, BSN, Susan Murin, MD, Lori Shuker, RN, CNOR, Cheryl Wraa, RN, MSN, Sheryl Ruth, RN-C, MS, Joh Olson, RN, BSN, and Lorenzo Rossaro, MD. These Rock Stars for Life accepted the “Best Emergency Department, Best Intensive Care Unit - Pediatric, Best Intensive Care Unit – Adult Neurosurgical” awards on behalf of the entire hospital. UC Davis Medical Center was recognized for creating a culture where a strong partnership and teamwork are a priority to ensure successful outcomes for organ and tissue donation.

The event was a rockin’ night of fun, where individual Shining Stars who illuminate the way for their teams to support life-saving donation, were celebrated. Golden State Donor Services and Sierra Eye & Tissue Donor Services consider each team member at UC Davis Medical Center absolutely central to their mission and feel it is because of our passion for saving lives that countless others continue to live on – with renewed health and energy. UC Davis Medical Center staff are available any hour of the day or night to do what is necessary to honor the compassionate generosity of donors and their families.

UC Davis Medical Center also contributes to the national goal of a 75 percent conversion rate for donations (actual versus potential donors) by ensuring that every potential donor is referred. As a result of our efforts to identify ways to bridge the gap between loss of life and the gift of life, we received the Health Resources and Services Administration Medal of Honor for the fourth year running!

There are 100 million registered organ, eye and tissue donors, as reported through state donor registries in the United States - that is roughly 42 percent of the adult population in the country. California, with more than 8.6 million registered organ and tissue donors, has more registered donors than any other state. As we celebrate this achievement, the need for transplants continues to grow. More than 112,000 men, women and children nationwide are awaiting a lifesaving organ transplant today. Of those waiting on the national transplant list, more than 21,000 (nearly 21 percent) are Californians.

Due to the fact that donation is possible only in the rarest circumstances, hospital teams from various departments play an integral role in making sure a patient’s authorization to extend the gift of life is honored. Our staff encourage and support families in their darkest moments to shine a light on hope and reach out to someone else in need.



Home Care

Home Care (Home Health and Hospice) provided home visits by an interdisciplinary team to over 1,000 patients and their families last year.

Home Care with the help of Ambulatory Care supported the certification of a wound nurse for each program due to the increasing and complex needs of wound care patients. In addition, the department has nurses certified in the following: IV and infusion therapy, Urology, Medical Surgical, Pediatrics, Chemotherapy, OASIS - home health assessment, Hospice and Palliative Care.

In collaboration with Interventional Radiology, Home Care supported the collaborative research, competency development and implementation of a procedure that allows nurses to drain pleural and peritoneal fluid from implanted ports and external catheters for a select group of patients. The addition of this clinical service has not only improved patient care and satisfaction but has also improved the patient's quality of life.

Hospice hosted 114 medical students, two MD's, one RN from Taiwan and four pharmacy interns for a day to visit patients with a clinician. In addition, 10 fourth year medical students elected a two week rotation and one MSW was selected for a nine month internship.

Home health hosted approximately 40 nursing students who spent a day visiting patients in their homes with a home health RN.

HOSPICE

Although a small department, 100 percent of the RN and physician staff are certified in hospice and palliative care. Additionally, all hospice staff participate in educating the health system and community about end of life care. Hospice staff are participating both with didactic and hands on learning in a new school of medicine initiative; Hospice Experience for the First Year Medical Students.

This past year hospice has continued to flourish in their philanthropic efforts. The third annual hospice "Celebrate Life" wine tasting in June raised \$7,000. In addition, the fourth annual hospice "Night of Giving" was hosted at the home of Dr. Bommer and Marla Bommer, Hospice Volunteer and was another huge success raising over \$8,000, both events to support the hospice program.

2011 continued to be a year of giving back to the community. Thanksgiving was a pleasurable day for 46 hospice patients and their families thanks to the generous work of the hospice volunteers. For the past 15 years, hospice has provided Thanksgiving dinners to patients and their families averaging 40 dinners per year.

The year ended with an annual toy drive sponsored by Contractors Caring for Kids. Michele Zumwalt, spearheaded this event and is now in its 16th year, providing new toys for children of all ages in both hospice and home health. The hospice volunteer elves work very hard to meet the Christmas wish list of all the children served by home care whether a patient or a family of a patient.

HOME HEALTH

Home health has collaborated with the Congestive Heart Failure (CHF) clinic providing education to the CHF staff on home-based care, the admission criteria and regulatory requirements. In addition, the CHF providers provided education to the home care staff on CHF management strategies.

Home Evaluation Assessment Program (HEAP) was developed as a pilot project with a select group of physicians based on regular requests to do a home safety evaluation. It was determined that an assessment of the environment and resources needed to remain independent would be appropriate. The criteria established included caregiver concerns, safety at home, frequent ER visits and transportation challenges. The goals of providing the service included reducing ER visits, increasing appropriate referrals to both home health and hospice, facilitating physician clinic visits for those patients with transportation challenges and increasing referral and patient satisfaction.

In summary, 90 percent of home health nurses are certified in a specialty supporting the clinical expertise needed in home care. Home health continues to maintain outstanding outcomes in both patient satisfaction and clinical care. The home health team received a 5 Star Award for being in the 100 percentile for overall quality of care. Additionally, home health has an average re-hospitalization rate of 17 percent, compared to 23 percent state average and 27 percent national average.



Photo on the Left: (Left to right) Beverly Perrin, Marianne Ciavarella

Photo on the Right: (Left to right, seated) Aissata Morton, Holly Vieira, Karen Merick, Stacey Magee, Colleen Hogan

(Left to right, standing) Denise Barton, aAnne Jones, Sue Kirkpatrick, Audra Flynn, Debby Switters, Beverly Perrin, Wendi Johns, Bertha Scherrer, Patti Michel-Evleth, Gina Geoffrion

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PRESENTATIONS

PRESENTER	DEPARTMENT	TITLE AND AUTHORS	CONFERENCE	CONFERENCE LOCATION
Hilda Curry, RN, Holly Kirkland-Walsh, RN, FNP-c, GNP-c Larrisa Kuzmenko, RN Bo Vang Yang, RN	Wound Program	Posters: (1) Implementing Systems Change in Policy, Procedure, and Documentation in 10 Days or Less (2) Best Practices Pathway for Chronic Pressure Ulcers in Acute Care H. Curry, H. Kirkland-Walsh, L. Kuzmenko, B. Vang Yang.	February 2011 National Pressure Ulcer Advisory Panel Conference	Las Vegas, NV
Barbara Rickabaugh, RN, MSN, NE-BC	Center for Nrsng Research	Podium: A Multidisciplinary Approach to a Comprehensive Pediatric Bereavement Program. B. Rickabaugh & J. Boehmer.	March 2011 National Associations of Children's Hospitals and Related Institutions (NACHRI); Creating Connections Conference	Baltimore, MD
Holly Kirkland-Walsh, RN, FNP-c, GNP-c	Wound Program	Poster: Best Practices Pathway for Chronic Pressure Ulcers in Acute Care, H. Curry, H. Kirkland-Walsh, L. Kuzmenko, B. Vang Yang.	April 2011 Wound Care Conference	Dallas, TX
Patricia Palmer, RN, MS, AOCNS	CNS	Poster: Sickle Cell Pain Management: A Survey of Clinicians' Perceived Barriers, Knowledge and Satisfaction. P. Palmer, H. Rice, N. Mahr, M. Crandall, T. Wun. MD	April 2011 36th Annual Oncology Conference	Boston, MA
Catherine Payne, RN, MSN, CCRN, CEN	Emergency Dept	Podium: Nurses' Perceptions on the Use and Effectiveness of Capnography in the Emergency Department. C. Payne.	April 2011 Communicating Research Nursing Conf	Las Vegas, NV
Mary Tegen, RN, BSN, OCN	Davis 8	Poster: Innovative Inservice Education Plan for an Inpatient Oncology/Bone Marrow Transplant Unit. M. Tegen, B. Hedrick, W. Yen, P. Palmer.	April 2011 36th Annual Oncology Conference	Boston, MA
Cynthia Steele, RN-BC, BSN	Davis 7	Poster: This Won't Hurt, Diabetes Education Made Easy. C. Steele.	June 2011 Pediatric Nursing Annual Conference	Lake Buena Vista, FL
Holly Kirkland-Walsh, RN, FNP-c, GNP-c	Wound Program	Podium: An Acute Care Multidisciplinary Approach to Wound Care. H. Kirkland-Walsh.	July 2011 Sigma Theta Tau 22nd International Nursing Research Congress	Cancun, Mexico
Patricia Palmer, RN, MS, AOCNS	CNS	Podium: Organization of Lung Cancer Nurses in the United States. P. Palmer.	July 2011 World Conference on Lung Cancer	Amsterdam, Netherlands
Melinda Breight, RN-C, BSN Mary Lee-Fong, RN-C, MSN	Davis 12	Poster: Multidisciplinary Approach to the Care of the Bariatric Surgery Patient - Building and Maintaining Relationship is Key. M. Breight, M. Lee-Fong	September 2011 NABN Annual Conference	Nashville, TN
Sarah Hernandez, RN, BSN Sarah Doucette, RN, BSN	Davis 12	Poster: A Multidisciplinary Approach to Mobilizing the Bariatric Patient - A Case Study by New Graduate Nurses. S. Hernandez, S. Doucette.	September 2011 NABN Annual Conference	Nashville, TN

PRESENTER	DEPARTMENT	TITLE AND AUTHORS	CONFERENCE	CONFERENCE LOCATION
Mary Lee-Fong, RN-C, MSN Shirley Thomas, RN, BSN, MPA	Davis 12	Poster: Maintaining Dignity of Patients with Morbid Obesity in the Hospital Setting. M. Lee-Fong, S. Thomas.	September 2011 University Hospital Consortium Annual Conference	Chicago, IL
Christine Weiss, RN, BSN	Davis 12	Poster: What New Graduate Nurses Need to Know about Caring for Bariatric patients. C. Weiss.	September 2011 NABN Annual Conference	Nashville, TN
Sarah Doucette, RN, BSN Justin Massaro, RN, BSN	Davis 12	Poster: New Graduate Nurses Explore the Process of Completing a Research Study Focuses on Bariatric Patients. S. Doucette, J. Massaro.	September 2011 NABN Annual Conference	Nashville, TN
Eric Moore, RN, BSN, MBA , NEA-BC	East 8	Podium: Palliative Care: A Cost Effective Approach. E. Moore.	September 2011 University Hospital Consortium Annual Conference	Chicago, IL
Betty Clark, RN, MPA, NEA-BC	PCS Admin	Podium: Culture Change Coverting to CPMRC Content	September 2011 Epic 2011 Nursing Advisory Meeting	Madison, WI
Ann Sievers, RN, MA, CORLN Kim Olson, RN, BSN, CORLN Janet Peterson, RN, BSN, CORLN	Tower 4, OR and CNS	Podium: Nursing Care of the Laryngeal Transplant Patient. A. Sievers, K. Olson, J. Peterson, J. Pryor.	September 2011 SOHN Congress and Symposium	San Francisco, CA
Barbara Rickabaugh, RN, MSN, NE-BC	Center for Nrsng Research	Poster: Improving Communication: A BLOG for Non-emergent organizational change. B. Rickabaugh, G. Easter & B. Underwood.	September 2011 University Health Care Consortium (UHC) Annual Conference	Chicago, IL
Shirley Thomas, RN, BSN, MPA	Davis 12	Poster: Keeping Bariatric Patients Safe: A Partnership with Industry for Quality Improvement. S. Thomas.	September 2011 NABN Annual Conference	Nashville, TN
Katelyn Nystrom , RN, BSN	Davis 12	Poster: Primary Nursing: Improving Bariatric Patients Outcomes Through Therapeutic Relationships. K. Nystrom.	September 2011 NABN Annual Conference	Nashville, TN
Kristi Cargill, RN, BSN, MSN, CAPA	Same Day Surgery Center	Poster Presentation: Accuracy of Post-Operative Temperatures with a Goal of Normothermia on Arrival to the Recovery Room in the Same Day Surgery Center at UC Davis Medical Center	October 2011 International Conference for PeriAnesthesia Nurses (ICPAN)	Toronto, Canada
Ron Ordon, RN, MSN	Patient Care Resources	Poster: The Biometric Monitoring System: A Pilot Study at Care Home by RNs (Problem Areas: Fall and Prevention and Continuous Monitoring/Population: Elderly Long-Term Care Residents in a Community Setting). R. Ordon.	October 2011 National Gerontological Association (NGNA)	Louisville, KY
Barbara Rickabaugh, RN, MSN, NE-BC	Center for Nrsng Research	Poster: Improving Communication: A BLOG for Non-emergent organizational change. B. Rickabaugh, G. Easter & B. Underwood.	October 2011 Sigma Theta Tau	Dallas, TX
Roxann Moritz, RN	CCRC	Poster: C.R.E.A.T.E., Creation of an Acuity and Recharge System for Clinical Research Use. R. Moritz, L. Wilson.	November 2011 IACRN Annual Conference	Washington, DC

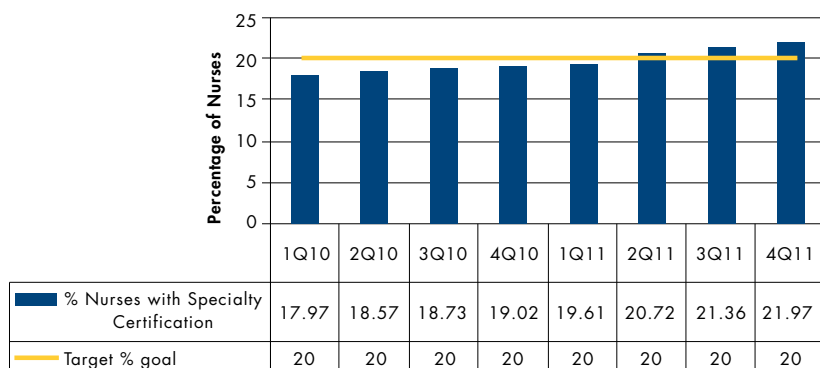
NURSE SPECIALTY CERTIFICATIONS

Nurses validate their mastery of experience, skills, knowledge and clinical judgment through obtaining specialty certification and meet ongoing education and practice requirements through recertification. Nursing specialty certification and the continuing education required to maintain certification contribute to an environment of professionalism.

As health care has become more complex, patients and families expect knowledgeable nurses to provide care to them. Specialty certification offers reassurance that nurses are qualified and experienced and have met rigorous requirements to achieve the additional credential of a specialty certification. It is vital to assure our patients and families that the nursing care they are receiving is competent.

UC Davis Health System encourages nurses to pursue obtaining specialty certification by offering assistance through Training and Development education reimbursement program for exam fees and rewards and recognizes nurses monthly with certification pay.

NURSES WITH SPECIALTY CERTIFICATION



The eight most common nursing specialty certifications obtained at UC Davis Health System are:

- Critical Care CCRN
- Oncology Nurse OCN
- Perioperative Nurse CNOR
- Advanced Trauma Nurse ATCN
- Medical-Surgical Nurse CMSRN
- Neonatal Intensive Care Nurse RNC-NIC
- Inpatient Obstetric Nurse RNC-NIC
- Pediatric Nurse CPN

Falls Program

A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object. Falls can be categorized as unwitnessed, accidental, unanticipated, anticipated or assisted. Goal 9 of the Joint Commission 2011 National Patient Safety Goals is to reduce the risk of patient harm resulting from falls.

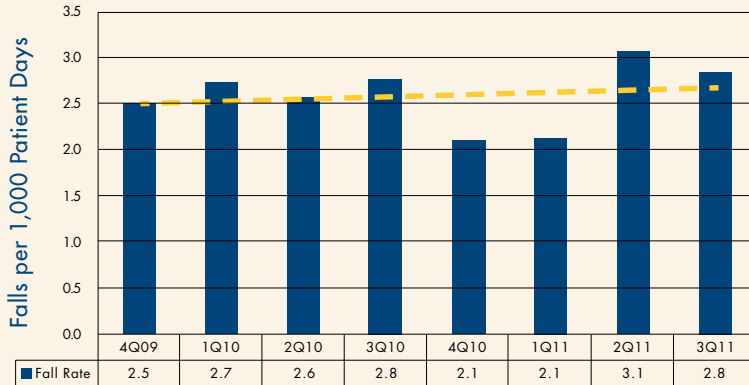
The Patient Care Services Falls Program has the goal to reduce the number and severity of inpatient falls. Committee members which include: RN's, nurse managers, pharmacists, performance improvement manager, PT/OT manager, staffing manager, and assistant director of nursing, monitor the number of falls, fall rates and interventions.

The Falls Program includes the RN assessing and documenting the fall risk score every shift. This score indicates the patient's likelihood of falling using the Morse Scale. A variety of interventions can be initiated by the RN. Some possible interventions include using a bed alarm or use of the Evolution Bed, educating patients on the side effects of pain medications, providing patients the falls brochure and ensuring review of the falls video, rounding hourly, putting the bed in low position, encouraging the use of the call light to call for assistance when getting out of bed, and maintaining a hazard free environment.

An Incident Report is completed if a patient falls and is reviewed by several individuals including the falls champion and unit manager. A quarterly report is sent to the managers to share with staff which includes monthly inpatient falls, inpatients fall rate by quarter, inpatient falls by Morse score, inpatient falls with harm, falls by nursing unit and new actions/interventions. The information regarding the unit rate compared to national benchmarks is available on the dashboards and should be used by unit-based practice councils to track data and develop unit action plans to help outperform the national benchmark.

HOSPITAL ACQUIRED PRESSURE ULCERS

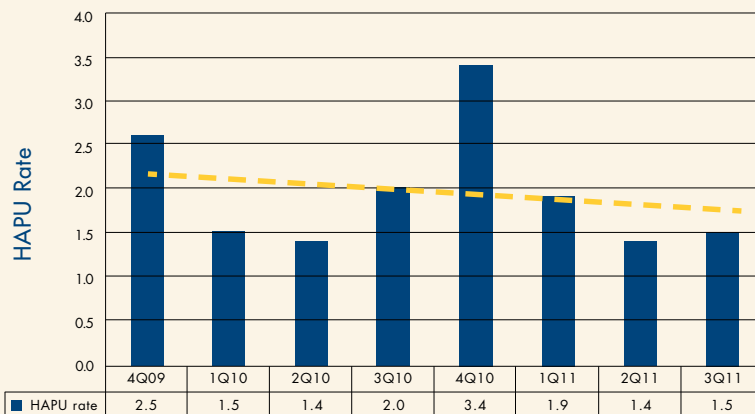
FALL RATE Adult Inpatient Units



The Skin Wound Assessment-Treatment (SWA-T) team has had a productive year in decreasing the incidence of hospital acquired pressure ulcers (HAPU). Through a Children's Miracle Network (CMN) Grant, improved supplies were purchased which helped with the prevention of pressure ulcers in acutely ill neonates. In 2009, there were eight neonatal hospital acquired occipital pressure ulcers. Since the implementation of new practices there have been no hospital acquired occipital pressure ulcers in neonates for over 18 months.

The CMN funds also allowed the purchase of a pressure mapping machine. The SWA-T team has pressure mapped every surface in the hospital, including all specialty beds, gurneys, operating room (OR) and interventional radiology (IR) tables. This allows for pressure redistribution surface evaluation for specific patient use in the prevention of pressure ulcers. This data will be published in the near future.

HAPU RATE



The SWA-T team has led the National Database of Nursing Quality Indicators (NDNQI) data collection quarterly which can be used for benchmarking and goal setting. UC Davis Medical Center will be the first to gather the documentation data through electronic medical record (EMR) for the NDNQI which will save hours of EMR visual review and will be available in real time. We welcome nurses from all units to join us quarterly, to act as a data collectors and as pressure ulcer staging champions for your unit.

The SWA-T team is currently working on prevention and early identification of suspected deep tissue injuries (sDTI). There are two new nurses on the team who will be championing prevention of pressure ulcers; Maritza Menendez, RN, perioperative areas and Giselle Walters, RN, BSN, emergency department.

CAUTI

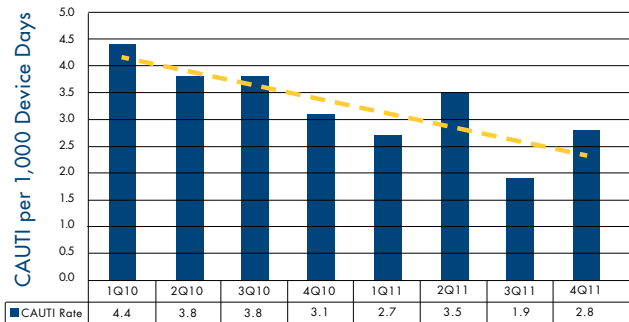
In 2008, Patient Care Services (PCS) created a quality improvement initiative to evaluate the appropriate use of urinary catheters to reduce the risk of catheter acquired urinary tract infections (CAUTI). Using Lean Six Sigma processes the CAUTI committee was formed with the interdisciplinary collaboration of nursing, infection prevention department, physician champion, emergency department, and information technology (IT) department.

The CAUTI committee implemented a policy to reduce CAUTI by 10 percent through critiquing evidence-based research and instituting a change in practice through education. The CAUTI campaign ran on the premise that foley catheters are widespread, inappropriate, forgotten, or invisible. The CAUTI committee also used the UC-infection prevention bundle suggestions to guide our practice.

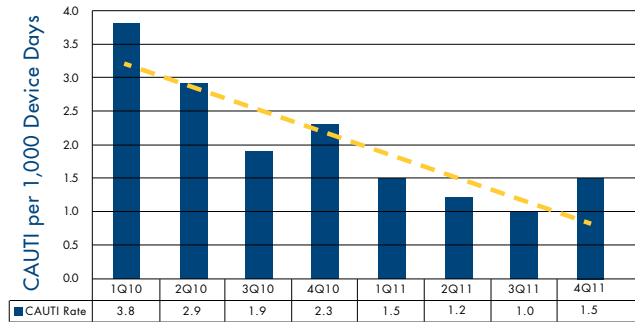
Data mining and reporting from the EMR includes: a device days report, device utilization rate, and a daily/monthly/yearly CAUTI report. An infection prevention RN mines EMR data for real time infection incidence and prevalence recording. The infection prevention RN reports to National Health and Safety Network (NHSN) including present on admission (POA) CAUTI. The PCS quality and safety data dashboard is used for staff education and awareness.

The initial goal of the CAUTI committee in 2008-2009 was to reduce CAUTI by 10 percent. We have surpassed that goal with a reduction of 69 percent. Zero CAUTI's is ideal and we continue to work towards that goal.

CAUTI Adult Critical Care Units

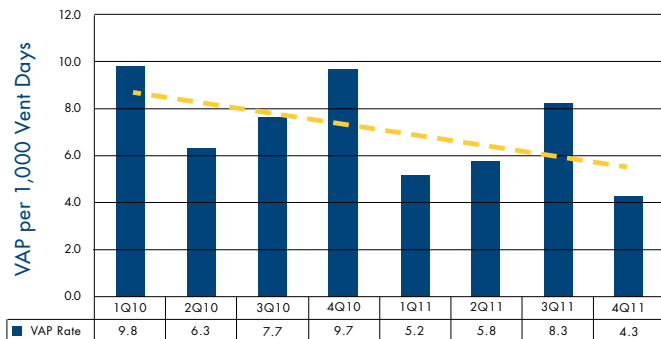


CAUTI Adult Acute Care Units



THE VAP PREVENTION INITIATIVE

VAP Adult Critical Care Units



The Ventilator Associated Pneumonia (VAP) Prevention Initiative, funded by a generous grant from The Gordon and Betty Moore Foundation, officially began in September 2010. VAP refers to pneumonia that develops in a patient who was intubated and ventilated according to the National Health and Safety Network (NHSN). VAP prevention nurse champions were hired for each adult ICU and together with a multidisciplinary group developed a VAP project charter, education implementation calendar and a learning module for physicians and nurses.

UC Davis Medical Center has adopted five bundle elements that when implemented together for all patients on mechanical ventilation has resulted in dramatic reductions in VAP:

- HOB elevation at 30 degrees
- Daily sedation interruption
- Daily assessment of readiness to extubate
- Daily oral care with chlorhexidine
- Stress ulcer prophylaxis & deep vein thrombosis prophylaxis

The education of all the adult ICU staff was accomplished over several months starting in December, 2010 with the focus on head of the bed elevation. After achieving 100 percent compliance within the month, daily sedation interruption and assessment of readiness to wean was introduced the following month. In February, the third bundle element oral care with chlorhexidine was implemented. The last two elements; stress ulcer and DVT prophylaxis were completed in March. All seven adult ICU's achieved bundle compliance goals by the deadline of March 31, 2011. This education involved collaboration between nurses, respiratory therapists and physicians and has developed a new sense of teamwork and camaraderie in all the ICUs.

What has been accomplished in this first year?

In 2011, overall adult ICU VAP bundle compliance has increased from 89.75 percent to 99.96 percent and overall VAP rates are trending down. The CICU has had one year with zero VAP's and in the month of May, all seven adult ICU's had zero VAP's. This is significant progress toward our goal. These changes are encouraging but show that we still have work to do to reach our goal of "The Zero Zone".

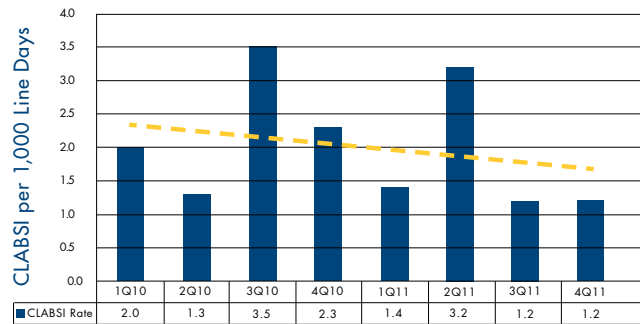
CLABSI

The Central Line Associated Bloodstream Infection (CLABSI) Prevention Program has been in place for several years. The original group joined together with the IV resource committee two years ago. In the past year the CLABSI Prevention Program has reviewed and revised line management therapy policies, utilizing Swabcaps® on all IV ports (with the exception of the pediatrics area), assessing the need for central lines on a daily basis and encouraging the removal of unnecessary central line catheters.

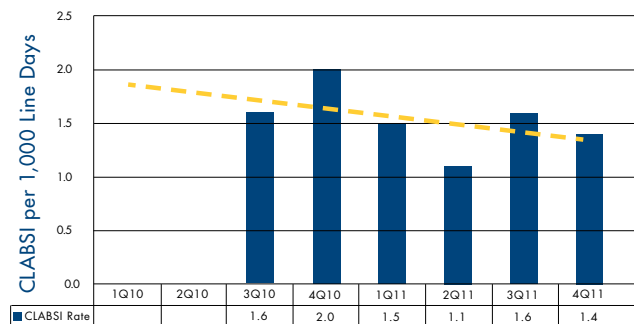
An in house education campaign was done this past year on the correct procedure for obtaining blood cultures. Our education was successful as we have been able to decrease our contamination rates from 12 percent to 3.5 percent.

A Lean Six Sigma group was also organized this past year and will implement Hand Hygiene as their first initiative to help decrease infection rates. The CLABSI Prevention Program has an ongoing collaborative project with the Center for Virtual Care in proctoring residents who place central lines in the ICUs, to ensure the utilization of a checklist.

CLABSI Adult Critical Care Units



CLABSI Adult Acute Care Units



SEPSIS MORTALITY IMPROVEMENT

The Sepsis Mortality Improvement Initiative was launched in July 2011. This go-live was preceded by 12 months of research, planning, design, build, testing, and education. The goal of the initiative is to reduce hospital-wide sepsis mortality in adults, 15 percent by December 2012.

The UC Davis Medical Center mortality rate for all patients diagnosed with sepsis in 2009 was 20 percent. For patients with severe sepsis, the mortality rate was 36 percent, and for septic shock, the most severe form of the disease, the mortality rate was 42 percent. At hospitals nationwide, the mortality rate for patients with the most severe form of sepsis ranges from 30 to 50 percent.

YEAR	PATIENT POPULATION	NUMERATOR	DENOMINATOR	UC DAVIS MORTALITY RATE	RATE OF PATIENT POPULATION INCREASE (FROM BASELINE)	EXPECTED DEATHS	OBSERVED/ EXPECTED RATIO	POTENTIAL LIVES SAVED
2009	Septic Shock	112	257	43.6%	-	-	-	-
	Severe Sepsis	67	235	28.5%	-	-	-	-
	Combined	179	492	36.4%	-	-	-	-
2010	Septic Shock	121	310	39.0%	20.6%	135	0.90	14
	Severe Sepsis	73	330	22.1%	40.4%	94	0.78	21
	Combined	194	640	30.3%	30.1%	233	0.83	39
2011	Septic Shock	113	321	35.2%	24.9%	140	0.81	27
	Severe Sepsis	63	311	20.3%	32.3%	89	0.71	26
	Combined	176	632	27.8%	28.5%	230	0.77	54

Program Improvements

Clinical Quality Improvement and Patient Safety Department

The Sepsis Mortality Improvement Initiative is based on national standards published by the Institute for Healthcare Improvement with input from an interdisciplinary group of our physicians and nurses (representing the emergency department, intensive care units, acute care areas and quality improvement), infection prevention staff, pharmacists, laboratory specialists, finance and information technology experts. The UC Davis campaign is unique in that it capitalizes on the sophisticated capabilities of the medical center's electronic medical record (EMR). The EMR was enhanced to include an aggressive monitoring and alerting system to detect sepsis early and tools to support definitive care delivery within one hour of patient identification.

Data dashboards will be posted on the Sepsis Website, created for this process, in 2012. Early indicators suggest we are well on our way to meeting our goal and that we are saving lives!

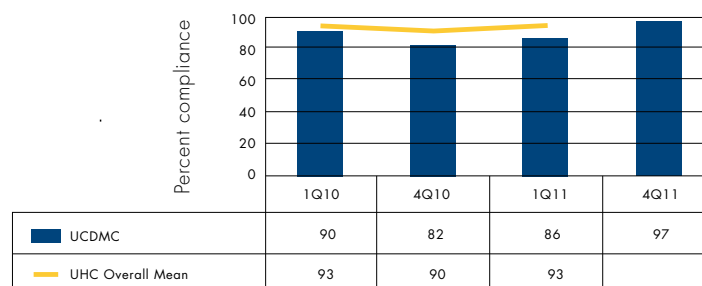
Influenza and Pneumococcal vaccinations are indicated for patients because they are highly effective in preventing influenza-related pneumonia, hospitalization, and death. Vaccine coverage in the United States is suboptimal. Hospitalization is an underutilized opportunity to provide vaccinations to adults. The Clinical Quality Improvement and Patient Safety Department worked collaboratively with multiple departments to make significant improvements in Pneumococcal and Influenza vaccination administration rates for our patients.

Physician and nursing staff education was conducted; a standardized procedure for nursing assessment of vaccination status and administration of immunizations was developed and put into use, a "Best Practice Alert" in the EMR to remind physicians and nurses to screen patients

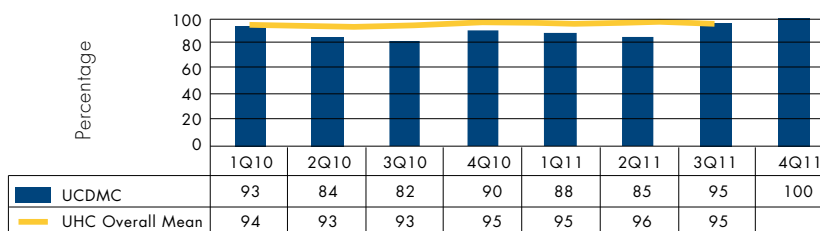
was developed and implemented. Inpatient nurse managers and ordering physicians are notified when it is noted that a vaccination was ordered but not received before discharge so that education can be provided to the individuals involved. "Real time" review of patients currently in the hospital and their immunizations status' are being conducted.

These collaborative efforts have helped the hospital achieve rates of 100 percent for Pneumococcal vaccination and 96 percent for Influenza vaccinations for Pneumonia Core Measure patients in 2011. In 2010 our Pneumococcal vaccination rate was 82 percent and our Influenza rate was 58 percent. The goal for 2012 is to continue this framework and work towards the goal of 100 percent in each of these areas for all inpatients.

Influenza Vaccination Screening and/or Administration Pneumonia Patients Only



Pneumococcal Vaccination Screening and/or Administration Pneumonia Patients Only



Davis 8 Team Huddle

Since its launch in July, the Davis 8 Medical and Surgical Oncology and Bone Marrow Transplant Inpatient Huddle Project has improved teamwork scores in staff surveys and created increases in a wide range of important patient satisfaction metrics.

The Davis 8 Inpatient Huddle Project was one of three Honorable Mention projects honored last year by the California Association of Public Hospitals/California Health Care Safety Net Institute Quality Leaders Awards program, which recognizes and showcases innovative and creative system improvements achieved by California's public hospitals and health systems.

The inpatient huddle project was inspired by a twice-daily huddle used in Department of Family and Community Medicine primary care clinics, part of an overall "patient-centered medical home" strategy there that earned a 2011 Spirit of Excellence Award for Service from Modern Healthcare magazine. Angela Gandolfo, the Family Practice Clinic's former manager who is now a performance improvement advisor in Clinical Operations, served as an advisor for the Davis 8 project.

As it does in sports, the huddle serves as a quick way to make sure everyone on the care team "knows the plan". Davis 8 inpatient huddles average seven to twenty minutes and includes physicians, nurses, social workers, discharge planners, dietitians, pharmacists, physical therapists and others. The groups typically review patients currently on

*Left to right:
Godwin Castrance, Megan Kushner, Patti Palmer*



Chronic Disease Management Nurse Directed Initiatives 2011

Chronic Disease Management (CDM) is a nurse directed program that works collaboratively to empower patients in self-care skills to improve their health and quality of life. Bridget R. Levich, RN, MS, CDE, is the director and has been a part of the program since its inception in 2003. Over the years, CDM has been able to leverage support to grow the program to include resources on multiple chronic illnesses as well as provide support to health system primary care providers and staff in caring for patients.



Bridget R. Levich, RN, MS, CDE

In 2011 CDM received Pay for Performance funding for two unique programs: "Expanded Diabetes Care Management" and "Depression Care Management". Working in a team based manner consistent with the Patient Centered Medical Home model, CDM demonstrated significant outcomes from these projects.

Healthcare Pay for Performance (P4P) programs reward hospitals, physician practices and other providers with both financial and non-financial incentives based on performance on select measures. These performance measures cover various aspects of healthcare delivery: clinical quality and safety, efficiency, patient experience, and health information technology adoption. Sponsors of P4P programs typically include government agencies, health insurance plans (health plans), employers (purchasers), healthcare providers, and a variety of coalitions. UC Davis Ambulatory Work Group awards financial support for P4P proposals that identify potential for improvements in clinical quality measures and success in encouraging providers to adopt clinical decision systems.

Davis 8 as well as off-floor patients, discuss the day's admissions and transfers, and consider CQI announcements and complicated future patients, as well as occasional, short educational topics.

Davis 8 piloted the huddle program in June and rolled it out one clinical area at a time over the next three months. Post-huddle staff surveys have shown improvements in communication, cohesiveness and teamwork, with the vast majority of scores now at "strong-excellent" levels. Staff members have praised increases in efficiency and inclusiveness and noted reductions in pages, unnecessary calls and the time needed for new interns to assimilate.

The increased teamwork has translated into higher patient satisfaction scores. Compared

to similar units nationally, Davis 8's score for overall quality of care based on "percent excellent" ratings rose from the 24th percentile in April-June 2011 to the 64th percentile the following July-September quarter.

Scores for doctor communication with patients and family rose from the 28th percentile to the 74th percentile, and scores for doctor explanations of treatments and tests rose from the 45th percentile to reach the 80th percentile among similar units nationwide. Scores for nurses' explanation of treatments and tests rose dramatically as well.

Scores also improved for measures related to the discharge process, doctors involving patients in decisions about care, and overall teamwork among doctors, nurses and staff.



Holly Kirkland-Walsh



Franco Balitan, Stacey Babcock



Christina Gillespie



Amanda Kirby

The 2011 Depression Care Management Pilot Project

The 2011 Depression Care Management pilot project by CDM successfully improved management of depression/anxiety in the primary care setting using an interdisciplinary model of care. The goals and outcomes of the project were as follows:

- The Depression Care Management Project was embedded in two primary-care clinics as pilot sites for managed care patients
- A multidisciplinary depression treatment team was established, comprised of an LCSW, a psychiatrist, and the primary care provider, with support from CDM, an analyst, and a statistician
- Physicians participated in four one-hour case consultations and training sessions with the project psychiatrist and LCSW, which resulted in heightened provider confidence and skill in primary care management of depression
- Improved patient outcomes were demonstrated by CGI ratings, patient self-report, physician survey, and most notably, statistically significant changes in PHQ9 scores (an established depression symptom measure)
- The benefit of an LCSW driven depression program was evident in their role as liaison between patient, psychiatrist, and primary care provider
- Patient receptivity to telephonic care management was overwhelmingly positive, based on patient satisfaction survey results and direct feedback to project staff

Further Benefits:

1. EMR tools were created and enhanced, including a care management referral order and the ability to include and track patient goals within the problem list.
2. Funding was secured for an additional year of the project including expansion to a third clinic site, encompassing all of the appropriate primary care patients regardless of their insurance.
3. Patients beyond those enrolled in the Depression Care Management project benefitted from the enhanced skill and confidence acquired by their primary care physicians.

The 2011 Diabetes Care Management P4P Project

The 2011 Expanded Diabetes Care Management Program was built on the success of the previous year's P4P project. Both were led by the advanced practice nurse director of CDM and coordinated by a certified nurse case manager. The goals and outcomes were met, as follows:

- Diabetes care management in four primary-care clinic sites improved the coordination of care of patients with Type 2 diabetes and introduced the role of consulting pharmacist located within the primary-care clinic sites for improved hypertension management
- Statistically significant decreases in both Hemoglobin A1C and blood pressure
- Improved quality and continuity of care of diabetes patients: nearly 50 percent of the patients contacted completed requested follow up labs, appointment with their primary care physician or saw the pharmacist
- Increased patient awareness and utilization of diabetes education resources
- Positive impact on patient satisfaction without exception, assessed with two different survey approaches. Patients not interested can self-opt-out by simply not responding to telephone outreach

Further Benefits:

1. After two years of pilot projects, a Diabetes Care Manager is now a fully funded FTE within CDM for all of the primary care clinics.
2. New care management tools have been integrated into the EMR.
3. This program aligns with the Care Coordination activities of DSRIP, Patient Centered Medical Home, and the Strategic Plan.

Electronic Medical Record

What an exciting year it has been for our electronic medical record (EMR) and much lies ahead as we continue the journey into the technological revolution in healthcare. We achieved HIMSS Stage 6 recognition indicated that we have adopted clinician order entry, device integration into the EMR, decision support for the clinicians, and some degree of barcoding medication administration. Only 3 percent of hospitals in the United States and Canada achieve this distinction. Hospitals and Health Networks magazine, a publication of the American Hospital Association, awarded UC Davis Health System "Most Wired" status after evaluating four focus areas: infrastructure, business and administrative management, clinical quality and safety for inpatient and outpatient arenas, and care continuum for ambulatory/physician/community. Along with these awards, this year's implementations have increased efficiency, productivity and improved the quality of patient care.

Nurse representatives from throughout the health system had opportunities to join EMR workgroups and serve as EMR champions. Highlights from the past year include our EMR functionality replacing INVISION plan of care and most paper Multidisciplinary Patient Education Records for inpatient staff. Nursing flowsheets were updated with integration of the plan of care and Clinical Practice Guidelines (CPG). The content of CPG is interdisciplinary and evidenced-based with a patient focus. Clinical practice guidelines are the foundation for documentation which help guide practice and support each discipline's scope of practice. Nursing and other disciplines, including respiratory therapists, dietitians, PT/OT/ST, child life, pastoral services, and social services are all documenting in the same place.

Another exciting enhancement was the STORK go live, which provides tools to assist obstetricians, nurses, and HUSC's streamline their daily tasks and create up-to-date clinical records. Nursing admission and assessment documentation transfers from OB TraceVue to EMR documentation flowsheets utilizing a combination of Stork SmartForm documentation tools and CPM documentation flowsheets. Mother and Baby charts link together to allow information from the delivery, medical, and family history sections to update the baby's clinical record. Inpatient and outpatient providers share relevant pregnancy and delivery information via flowsheets and encounters linked by the pregnancy episode.

A pilot was initiated on Tower 7 MSICU to administer medications using barcode technology. The multidisciplinary barcode medication administration committee with staff nurses, respiratory therapy and pharmacists have written over 35 workflows for every type of medication that we give. MSICU implemented the technology which is designed to confirm the right patient, right drug, right dose, and right time. We have seen reductions in errors by the proper use of the technology. We look forward to taking this project house wide in 2012.

Left to right: Esther Vazquez, Susan Lentz, Jean Courquin, Kerri Stuart

CADD-Solis Ambulatory Pumps

Upgrading pumps is not an easy task, but this committee managed to make the transition to CADD-Solis Ambulatory Pumps a smoother transition. The CADD-Solis Ambulatory Infusion System for epidurals and peripheral nerve blocks was rolled out in May (University Birthing Suites and Women's Pavilion saw their introduction November 2010), and for PCA infusions in October. For the spring roll-out, 429 nurses and physicians were trained. For the fall roll-out, 1,233 nurses were trained, which was 79 percent of the total number of nurses assigned to the PCA training classes.

A needs assessment prior to pump selection clarified the need for better pumps to improve patient safety. Pump selection criteria included: safety features, ease of use and programming, cost, durability and reliability. A multidisciplinary group that included bedside nurses, pharmacists, and physicians reviewed pumps from different manufacturers. Their selection, the CADD-Solis Smart Pump, was trialed in the high use areas: University Birthing Suites, D14 Ortho Trauma, PACU, as well as open house evaluations for all nursing staff. In 2010, the hospital purchased 150 of these pumps.

The CADD-Solis Pump Committee guided the process of pump selection, training, implementation, policy revision, and the EMR documentation. The committee members included RN's, pharmacist's and an EMR nurse analyst. Physicians participated in revisions to order sets and in the development of drug libraries. Epidural and PCA policies were revised to match the functionality of the CADD pumps, and evidence-based practice changes. A new policy was created to cover peripheral nerve blocks.

More than 100 RN superusers assisted with the transition to the new pumps and practice changes. Most training was done through classes taught by representatives from Smiths Medical, RN superusers, and nurse educators. There were a total of 128 day and evening classes. For clinicians who missed the classes, those desiring additional review, and new hires, training is still provided through online modules in UC Learning Center. On the Go-Live days and the weeks following, Smiths Medical representatives and superusers assisted nurses with setting up and programming pumps, and initiating new order sets.

CADD-Solis pump committee members: Terry Nishizaki, Pharm.D., Ryan Cello, PharmD., Mark Holtzman, PharmD., Sean Fraser, Jim Hill, RN-BC, MSN, Tish Campbell, RN, BSN, Amanda Boyd, Eva Hall and Judie Boehmer, RN, MN, NEA-BC (chair).



GRASP

GRASP is the patient classification system that is used to determine staffing requirements on a day-to-day, shift-by-shift basis. Patients are scored by the direct care nurses prospectively each shift covering care needs for the next 24 hours with the exception of the Labor & Delivery and the Women's Pavilion.

GRASP maintenance takes place once a year. During the GRASP maintenance, the GRASP representative meets with each nursing unit to ensure that each workload instrument is current and reflective of the practice on the unit. GRASP maintenance is an opportunity for direct care nurses to meet with the GRASP representative and provide input regarding the patient classification system, and make suggestions for changes or modifications to the system. Based on the recommendations from the direct care nurses, the GRASP representative makes changes to each unit's workload instrument and indirect care.

GRASP refinement takes place several months after the nursing staff have been working with and using the changes made to the workload instruments during the GRASP maintenance process. Prior to the GRASP representative returning to the institution for the refinement process, each unit completes a 10 – 14 day test of the workload instrument. During the testing phase, each unit completes a staffing adequacy questionnaire that will be used by the GRASP representative to compare and contrast required staffing, actual staffing and the direct care nurses perception of adequacy of staffing.

The Patient Classification Oversight Committee (PCOC) is appointed annually by Carol Robinson RN, Chief Patient Care Services Officer and traditionally meets at the conclusion of the GRASP refinement process. The PCOC is made up of at least half direct care nurses from different areas in the hospital. This year's committee members were: Claire Basco, RN, BSN, CNRN, NSICU, Karyn Cross, RN, PCCN, E6, Heather Lalone, RN, BSN, PICU, Kristin Dzugan, RNC, NICU, Alicia Loftin, RN, TNU, Jeanne Ings, RNC, UBC, Gail Easter, RN, MSN, Toby Marsh, RN, MSA, MSN, NEA-BC, Eric Moore, RN, BSN, MBA, NEA-BC, and Carol Robinson, RN, MPA, NEA-BC, FAAN. The committee meets to review proposed changes to the patient classification system as well as discuss the reliability of the patient classification system for measuring patient care needs.

BEDSIDE REPORT

Evidence based practice indicates patient and family participation in change of shift nursing rounds is of benefit in promoting patient and family centered care. By including the patient and family in this communication process they become active members of the health care team. This greatly enhances the healing process and improves outcomes; both of which increase patient satisfaction as well as compliance with the patient specific plan of care. Additionally, when health care providers engage in patient centered dialog at the bedside, precautionary measures relating to falls risk and pressure ulcer prevention are reinforced in the presence of the patient each shift. This aids in reducing the likelihood of them occurring during the patient's hospital stay and provides ongoing education in advance of the patient's discharge. A side benefit to bedside reporting is its fundamental function as nurse to nurse peer review.

Bedside report was initially piloted at UC Davis in 2007 on one medical surgical unit and one intensive care unit. In 2011 as part of the ongoing efforts to emphasize patient and family centered care, the decision was made to implement bedside reporting rounds as the standard method of patient care handoff for all inpatient units. Since the Children's Hospital units already engaged in bedside reporting, attention was directed to the adult acute care and intensive care units.

In late spring 2011 a workgroup comprised of bedside nurses, nurse managers, and an administrative director was formed to explore the strengths and weaknesses of the current handoff reporting and perceived benefits of bedside report handoffs. The development of training materials, how best to train over 1,000 nurses, and perhaps most importantly, how to have the change in culture be perceived positively remained major challenges.

Fortunately, many training materials remained available from the 2007 pilot projects. Using these, a new PowerPoint presentation was developed along with three short videos demonstrating bedside reporting. Recognizing differences in unit structure and culture, each unit was requested to send four staff members to one of six "train the trainer" sessions during October 2011 with the intent of bringing the presentation and framework for bedside reporting back to their own units. Basic training on the units occurred in November and unit based practice councils were encouraged to "customize" the reporting to best fit their unit needs so long as the basic framework remained.

"Go live" for hospital wide bedside reporting was December 1, 2011. The Center for the Professional Practice of Nursing introduces bedside reporting as the standard handoff methodology on the units during nursing orientation providing an easy transition for nurses new to the system.

The implementation of bedside report handoffs on such a large scale over a short period of time was extremely challenging. However, the benefits with respect to promoting patient and family centered care as well as improved caregiver communication made it well worth the effort!



Left to right: Miguel Medina, Randall Owensby, Steven Elliott, Floricel Oliva-Dizon



Moving PICU/PCICU to Davis Tower 10

How do you move a unit that was physically separated in three locations; Tower 7, a 10 bed pediatric and cardiac intensive care unit (PICU/PCICU), East 7, a six bed PICU/PCICU and East 7 a four bed pediatric special care unit (PSCU) with 96 registered nurses, seven hospital unit coordinators, 11 attending physicians, two child life specialists, one social worker and a nurse manager to one new unit?

This unique team of experts, not only specialize in caring for pediatric patients and their families, but also in critical care. The diagnoses of their patients requiring intensive unit care include; cardiac, respiratory, neurological, gastrointestinal, renal, hematology-oncology, whole system failure and trauma illnesses. Children are hospitalized not only from the greater Sacramento area, but from all of Northern California, Central California, Western Nevada and Southern Oregon.

A \$13 million bond initiative for the Children's Hospital was dedicated to the building of Davis Tower 10 to become a 24 bed PICU/PCICU, seven years ago. The remainder of the budget was to come from fundraising. It was in 2005 that the first little spark of ideas began about what the new unit could and would become. A group of assistant nurse managers, nurse manager and the medical director of the Children's Hospital toured top designed PICU's in the country. This was the same year that a group of nurses discovered the

booms while at the American Association of Critical Care Nurses Conference. Booms are an articulating arm that are mounted to the ceiling and can house oxygen ports, room air ports, suction, the physiological monitor and two drawers for supplies (one of which is lockable), electrical outlets and IV poles. The boom rotates 350 degrees, moves side to side and front to back. It can be arranged anywhere in the room to support the patient. The group was very excited about endless benefits the booms had for their patients and families and decided this was definitely the way to go.

Pictures of other hospitals and booms were then shown to the architect team, who combined those ideas with the multitude of State and Federal Regulations to design a footprint of the new unit. The initial footprints were posted in the old unit for staff to provide input. Surveys were given to staff for design concepts, color palettes and what would turn a sterile, loud ICU environment into one that uses the most innovative technology yet also be a family friendly environment.

The wish list... light colored, friendly paint, bright but adjustable lights, low lying designs to distract children, no harsh straight lines, as much glass as possible, computers everywhere, enough electrical outlets, a boom and a headwall, lots of suction, a couch bed for families, a comfortable patient chair, a rocker, two

TV's, and don't forget – conference/report rooms, break room, office space and a family waiting area. And add in a nurse call system with pagers, all new phone system, and a HUGS security system. The architects did it!

In 2010 a mock room was erected for staff to visit, evaluate booms and give feedback – room designs were changed based on the feedback. In spring of 2011, a move committee, of 20 staff and ancillary services was established. It consisted of multiple subcommittees that would meet weekly to monthly. They would solicit input from staff on their topics, formulate a plan and execute it. The subcommittees included: equipment management, supply carts/room/linen redesign, medication station design, room set up, central monitoring, new unit education and training, actual move implementation and the VIP/Donor Open House tours. Because of the fact that they were moving from three locations to one and increasing bed capacity, the entire project was approached with the attitude of improving workflow, organization and logic.

From staff that was directly involved to those that held down the fort in the old unit, each person had a role and did it well. Each staff member had to attend 12 hours of new unit training due to the changes in the infrastructure, the new equipment and emergency procedures. The entire team worked hard and participated in problem solving to create their new home, a unit they are all proud of and the care they can provide not only to their patients but also to their families.

Left Photo: Left to right, front row: Nancy Murphy, Donal Grohosky, Mary Cignarella, Angie Eller

Left to right, back row: Mary Pat Hartman, Yvette Feldman, Katherine Schulke, Cindy Fuentes, Michelle Foster, Debra Bamber, Anne Patterson, Shelley Bloom, Sherrie Nameth.

Right Photo: A typical PICU/PCICU room

Employee Apparel Program

2011 was a preparation year for the introduction of the new Employee Apparel Program and dress code policy change. The goal of this program was to have staff that provide direct patient care to be in easily recognizable uniforms.

A committee of direct patient care staff was formed to look at different style uniforms and make strategic decisions related to the implementation of this program. Two different uniforms were selected; a scrub uniform for staff providing direct patient care and a non scrub uniform for staff that has direct contact with patients and families in a professional capacity of assisting with appointments and information.

The first and second quarter of the 2011 year was the planning phase. The committee looked at other universities and health systems that had implemented similar programs. The biggest challenge in implementation was the wide spread location of over 4,000 staff throughout the health system, from Davis to Rocklin. Over the third and fourth quarters, three different large fitting events were held where staff were able to try garments on and place orders. Effective January 3, 2012 the new dress code policy was implemented and UC Davis Health System has a new professional image to support our goals of excellence.

Left to right, front row: Katie Huiras, Stacey Salvato, Laurie Brown, Meredith Roth, Chris Martinez. Left to right, back row: David Reza, Becky Reynolds, Heidi Nolan, Pam Anderson.



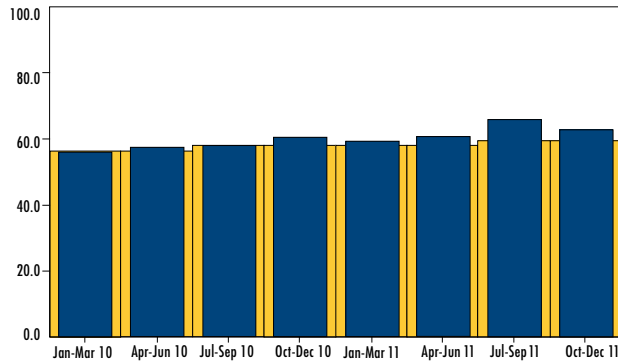
PATIENT SATISFACTION

Professional Research Consultants (PRC) is the research organization that provides us with our patient satisfaction data. Randomly selected patients receive a personal phone call following discharge from the hospital, a clinic appointment, surgery or a home care visit and asked a series of questions that reflect their experience. Measuring patient perceptions educates us on how our patients feel about the services we've provided. Although the survey asks questions related to the entire experience and about interactions with all members of the health care team, several of the questions asked are specific to the quality of nursing care received.

UC Davis nurses across all settings continue to demonstrate excellence in the care they provide to patients and their families by exceeding national benchmark PRC scores

Left to right: Karen Bott and Cheryl Cannon studying the variety of uniform options during a fitting event

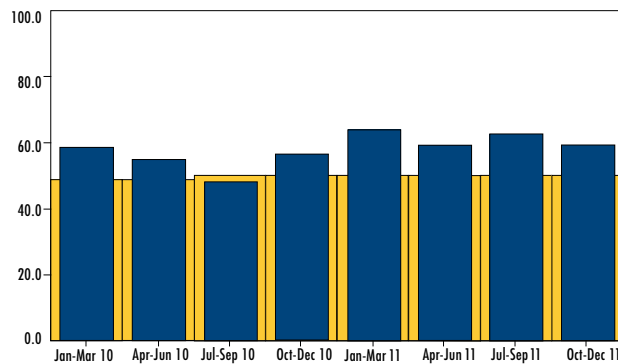




% Excellent	56.1	57.3	58.1	60.5	59.4	60.9	65.8	62.8
Inpatient 50th percentile	56.5	56.5	58.1	58.1	58.1	58.1	59.5	59.5
N of Cases	676	689	683	669	688	690	690	654
Norm Year	2009	2009	2010	2010	2010	2010	2011	2011

◀ Inpatient Units Overall Quality of Nursing Care

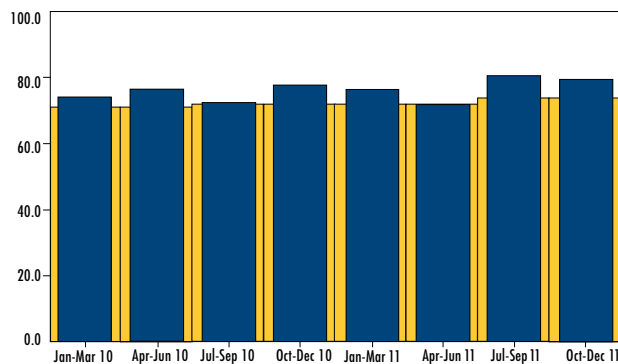
Inpatient Nursing Units outperformed the national benchmark for excellence 6 out of the last 8 quarters



% Excellent	58.9	55.0	48.2	56.9	64.1	59.6	62.9	59.3
ED 50th Percentile	49.1	49.1	50.3	50.3	50.3	50.3	50.4	50.4
N of Cases	197	200	197	197	198	198	194	199
Norm Year	2009	2009	2010	2010	2010	2010	2011	2011

◀ Emergency Department Overall Quality of Nursing Care

Emergency Department Nurses outperformed the national benchmark for excellence 7 out of the last 8 quarters



% Excellent	74.3	76.7	72.7	78.2	76.7	71.8	80.7	79.8
Out Surg 50th Percentile	71.4	71.4	72.0	72.0	72.0	72.0	74.0	74.0
N of Cases	148	150	139	147	150	149	150	297
Norm Year	2009	2009	2010	2010	2010	2010	2011	2011

◀ Outpatient Surgery Overall Quality of Nursing Care

Outpatient Surgery Nurses outperform the national benchmark for excellence 7 out of the last 8 quarters

Medical Missions

The main purpose of a medical mission is to deliver care to areas of the world where it is nonexistent or substandard. Most of us are aware of the dire need for assistance in developing countries and we had some extraordinary nurses that gave hope to suffering people by delivering nursing services and health care where crisis and disaster exist throughout the world, regardless of race, religion, politics or sex. These nurses have dedicated themselves to improving the quality of life throughout the world.



Len Sterling performs a contracture release from an old burn on a 12 year old girl.

MALI

In late September, Dr. Maguina, Plastic Reconstruction Surgeon and Len Sterling RN, BSN, MBA, Nurse Manager of the Burn Unit joined a ReSurge International team of medical professionals from Australia, Vietnam, and the United States to provide burn care and plastic surgery reconstruction for the children of Mali. The team composed of nurses, therapists, surgeons, and translators working harmoniously during 12-14 hour days. On the first day at Gabriel Touré Hospital, a makeshift clinic was set up and 101 children received preoperative screening. The following eight days yielded some 75 surgeries on complex cleft lips, cleft palates, burns and scar releases from previous injuries.

HAITI

In late August, four emergency department nurses stepped out of their comfort zone and into the nursing experience of healthcare in Haiti. Francis Noriega, RN, BSN, CCRN, Danise Seaters, RN, Heather Koplin, RN and Jamie Meyers, RN, MSN, volunteered at the only critical care hospital in Haiti. They worked 12 hour variable shifts on a medical-surgical nursing unit, an intensive care unit and in the emergency department.

Jamie Meyers found the greatest needs were basic primary care, preventative care, obstetrical care and orthopedic surgery related to traumas from accidents and violence. Many women in Haiti have complications from routine child birth and infants subsequently suffer poor outcomes.

Due to the lack of basic medical care many patients' developed gangrenous extremities from uncontrolled diabetes. These nurses worked collaboratively with other medical professionals from across the United States and Haiti, providing the best care possible with the little resources they had.

CAMEROON

Holly Kirkland-Walsh, RN, FNPc, GNPc, traveled to Cameroon, Africa as part of Project HOPE's Volunteer Medical Rotation Program at the Maria Rosa Nsimim Hospital in the capital city of Yaounde.

Holly conducted a needs assessment and discussed plans to promote and market the hospital to insurance companies and develop organizational and management skills.

As a result of her contributions, the following were implemented at Maria Rosa Nsimim Hospital in Cameroon:



Holly Kirkland-Walsh rounding in a post partum unit.

- Project HOPE volunteers will make daily rounds with nurses and doctors to evaluate and discuss every patient's progress
- The use of hand sanitizer between patient's
- Nurses being cross-trained to work in other areas



Holly Kirkland-Walsh at Project Hope in Cameroon with a hospital administrator.

- A check off skills list for charge nurses to aid with the orientation of nurses being cross trained
- An admission form for patients
- A community outreach program for free weight and blood pressure checks



Dave Rowen, in Santa Cruz, Bolivia, in the OR monitoring and hand ventilating his patient

ROTAPLAST INTERNATIONAL

Over the past 10 years, a UC Davis Medical Center team of Certified Registered Nurse Anesthetists (CRNA's): William Prosser, MSN, CRNA, Emily Campbell, MSN, CRNA, Gary Stock, MSN, CRNA, Kelly Bias, MSN, CRNA, Dave Rose, MSN, PhD, CRNA, Sharyn Babbitt, MSN, CRNA and Dave Rowen, MSN, CRNA, have actively participated in Rotaplast International's medical missions to provide free surgical treatment for children with cleft lip and palate anomalies who would not otherwise receive treatment. Rotaplast International is a unique organization that partners with Rotary Clubs worldwide to provide free medical treatment, education and promote international goodwill. Collectively this team has completed over 20 missions in countries such as Vietnam, India, Bangladesh, China, Mexico, Brazil, Bolivia, Nepal and Peru. These missions are an ongoing labor of love for this group and has changed their lives in many different and unique ways and they will all agree that it has reinvigorated their spirit and passion for nursing.

GIVING BACK

by Sharyn Babbitt, MSN, CRNA

The energy is high, the days long, the work hard, and each day invigorating. A team of strangers from around the world comes together with the common goal of helping people in a powerfully unique experience. This is a snapshot of my medical missions, traveling the world with Rotaplast International.

Since 2008, I have been on four missions as a nurse anesthetist: Karaikal, India in the spring 2008; Aracaju, Brazil in the summer of 2009; Cebu, Philippines in October 2010; and the Dominican Republic in June 2011.

My trips have included teams of 20-30 people, both medical and non-medical. Our missions have been to provide surgery for cleft lip and palate repairs, as well as reconstructive burn scar revisions. On average, we performed between 110-140 procedures during our week of operating. There are generally four surgeons, four anesthesia providers, four circulating nurses, as well as two recovery room nurses. This allows us to run three operating rooms for the seven

days we provide surgery. The missions are usually two weeks in length, allowing a day or two for travel to our location, one day for pre-op clinic and OR setup, seven days of surgery, one day of post-op clinic and packing, a day off somewhere in the middle, and then the return trip home.

The impact of the surgeries we perform is dramatic, both for the patients and the team. Oftentimes, the shame associated with a cleft lip or palate is so dramatic that parents will keep their children out of school and away from public situations. So the work the team is performing is transformational on so many levels.

It is an honor and privilege for me to be able to utilize my skills as a nurse anesthetist to help change the lives of people around the world. The experience has had a nearly indescribably profound impact on my life. It is an experience that I recommend to my colleagues regularly, and I hope to continue my participation on future missions, with Vietnam and Colombia at the top of my "Where to next?" list.



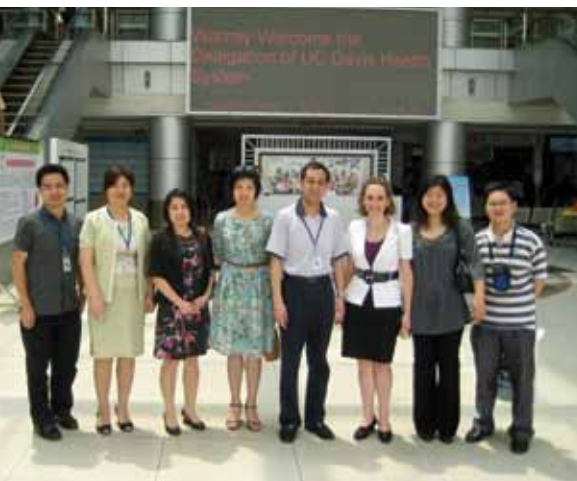
MEDICAL MISSIONS/ CONTRIBUTING TO COST SAVINGS

INTERNATIONAL RELATIONS

In May 2011, Joleen Lonigan, RN, MSN, NE-BC traveled with a private, international company Global Advantage Talent Education (GATE) to China. The purpose of the trip was to develop international relations and share the professional practice of nursing from the United States.

Wenting Gao MFA, a UC Davis alumni, and Joleen Lonigan traveled to two regions in China and visited four Chinese nursing schools: Guangzhou Medical University School of Nursing, Southern Medical University School of Nursing, Capital Medical School of Nursing and Peking Union Medical College School of Nursing. At each of the universities a bilingual presentation was given to nursing students in bachelor and master programs. The focus of the presentation was to highlight nursing education, nursing employment, work environment conditions, economic impact on nursing and nursing leadership in the United States. There was also an opportunity to tour the nursing schools and hospital, meet with international educators, nurses and students.

Joleen Lonigan third from right, visiting a hospital in the Southern Region of China in Guangzhou



WOUND CARE

This past fall, nursing and purchasing came together to review the advanced wound care and traditional wound care procedures and to also explore products that provided clinical benefits as well as cost effectiveness. The process for this task force was to assess current standards of practice for wound care and to review options that were available. A wound care fair with all contracted vendors was held and provided an opportunity for the task force to listen and ask questions of vendors. The task force had the opportunity to examine the product lines and evaluate how different products could be used to benefit the current standards of practice. This interaction with the direct care staff, vendors and product lines was invaluable. After the event the task force convened and finalized what vendors would be selected to provide the majority of products to our hospital.

The selected vendors included Molnlycke for alginates, compression, contact and foam. Coloplast was selected for hydrocolloids, hydrogel, wound cleansers, interdry dressings. Selected for antimicrobials was Convatec. Based on the decisions, it is anticipated that \$32,020 would be saved on a total historical annual spend of \$232,787.

Traditional wound care was also standardized to the dermacea line from Covidien. On a book of business of \$356,812 a savings of \$134,329 is expected.

Among the benefits of this project was a full review of wound care products which resulted in a high degree of standardization through the product lines with cost savings.

Participating in this task force from nursing: Bo Vang-Yang, RN, Elizabeth Funke, RN, MSN, FNP-C, CWOCN, Holly Kirkland Walsh, RN, FNP-c, GNP-c, Jeanette Harrison, RN, MSN, CCNS, Larisa Kuzmenko, RN, Leonard Sterling, RN, BSN, MBA, Linda Mimnaugh, RN, MSN, CNS, CWON, Veronica Marquez, RN, Denise Barton, RN, Laurie Schmitt, RN, BSN, Tessie Peeler, RN, WCC, Patrick Lastowski, RN, BSN, MBA Purchasing, (chair).

SUSTAINABILITY, REPROCESSING AND SAVINGS

UC Davis Medical Center has incorporated sustainability in its strategic plan, with a goal to achieve cost savings and reduce environmental impacts, without compromising patient care. Reprocessing programs support the goal for sustainability by diverting used medical supplies that might otherwise be discarded as medical waste or add to the landfill. Hospitals have the opportunity to purchase the reprocessed devices at a reduced price, and can achieve significant savings for high-volume items.

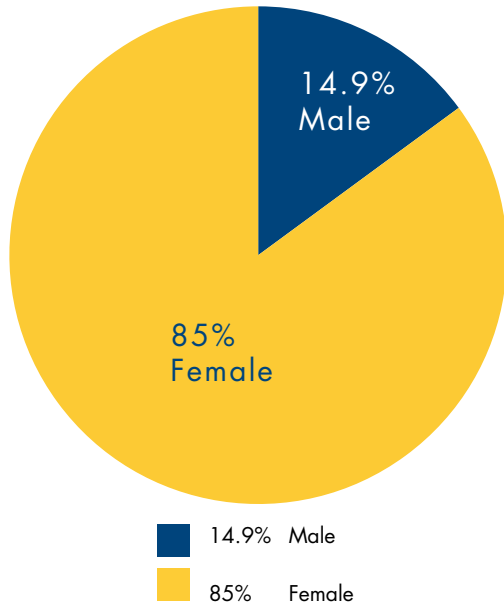
Operating under federal regulations, monitoring and approval, third-party reprocessors collect specified single-use medical devices at the hospital donor site, for decontamination and remanufacturing, including tests to ensure functional quality equivalent to that of the original equipment manufacturer.

Alternate leg pressure (ALP) sleeves are routinely used for prophylactic treatment for deep vein thrombosis. In 2011, almost 16,000 ALP sleeves were recovered from patient care service (PCS) units, resulting in a diversion of almost four tons of waste. In addition, over 12,000 reprocessed ALP sleeves were purchased in 2011 at a reduced cost, resulting in over \$26,000 in savings.

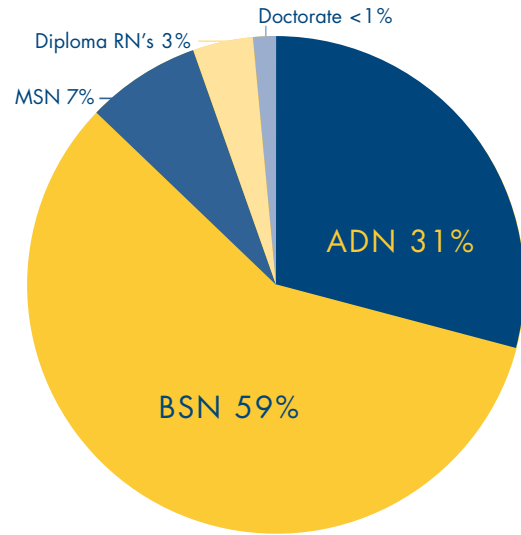
In 2012, reprocessing opportunities in the PCS units will continue to expand. Collection of used blood pressure cuffs started in December 2011. Pulse oximetry sensors are also planned for collection in 2012. Reprocessing and purchase of these, and other single use medical devices, will continue the trajectory of waste diversion and cost savings that PCS spearheaded in 2011.

NURSES BY NUMBERS

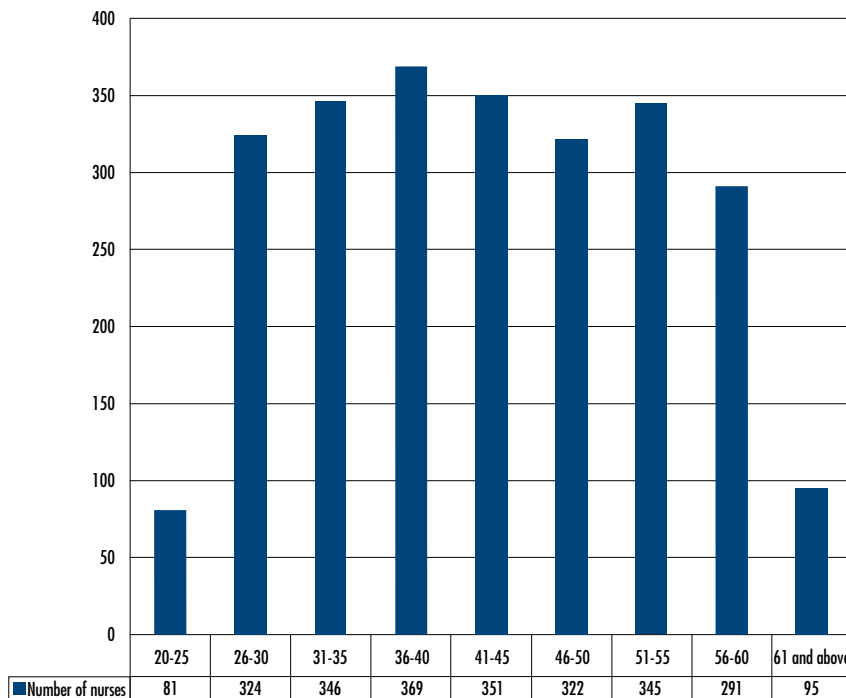
UC Davis Health System Nurses Gender



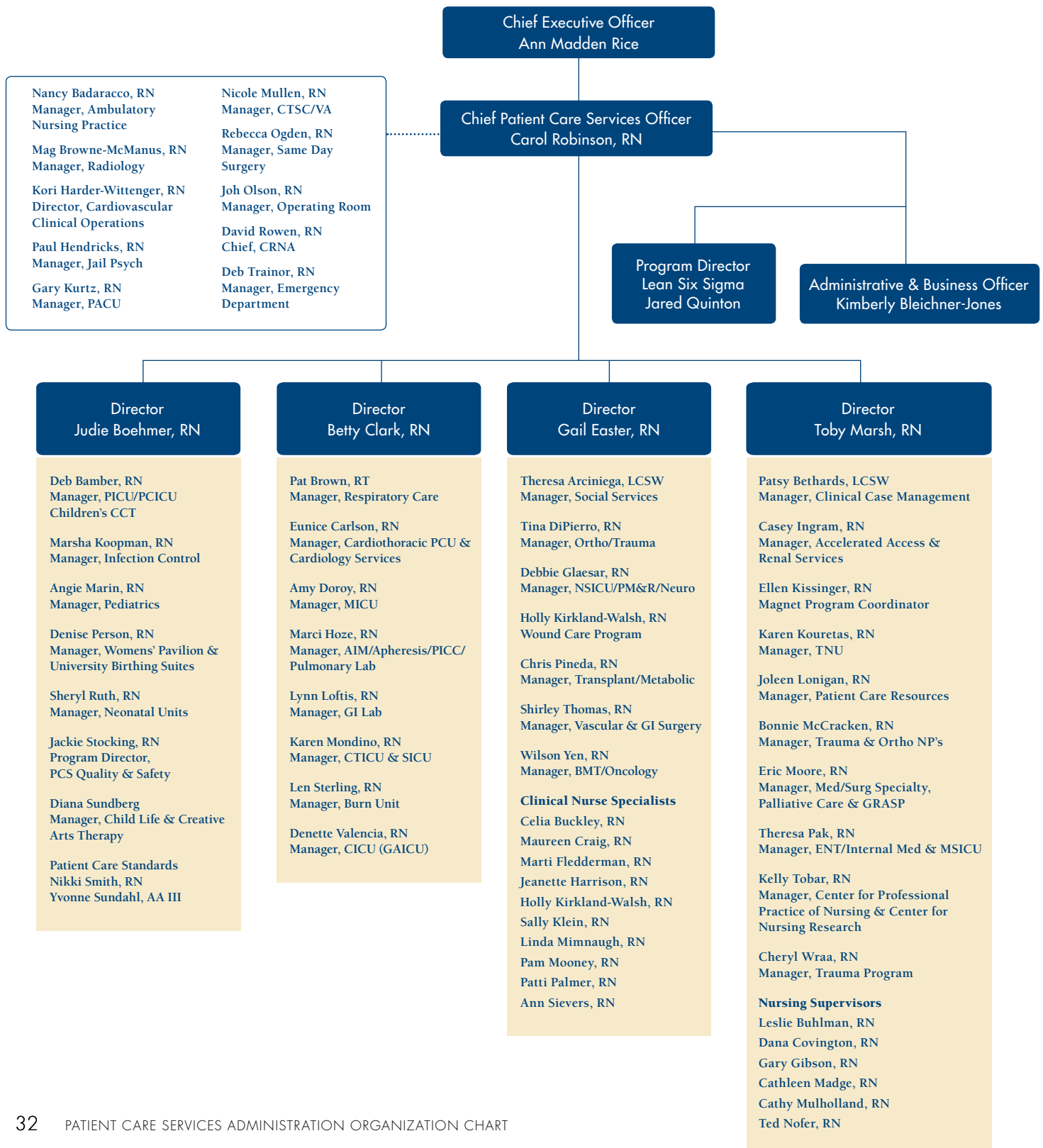
Overall RN Degrees



Number of Nurses by Age Group



Patient Care Services Administrative Organization Chart



PROJECT LEAD

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*A special thank you to all the extraordinary nurses who dedicate themselves everyday to the
Professional Nursing Practice at UC Davis Health System*

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