



# PROFESSIONAL NURSING PRACTICE UC DAVIS MEDICAL CENTER 2013 ANNUAL REPORT



**UC DAVIS**  
MEDICAL CENTER



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## *Letter from the Chief Patient Care Services Officer*

Dear Colleagues,

We spent this past year advancing our professional practice, realizing the power of autonomy and bedside leadership, achieving exceptional patient care outcomes and telling our story. We produced our Magnet documentation which resulted in our Magnet site visit and we prepared thousands of employees for the Magnet site visit in November. The final outcome, which was announced in January of 2014, was that we were indeed a Magnet Hospital again.

We knew after the visit that we delivered exceptional care and considered it to be our norm. The Magnet appraisers found that to be remarkable. This annual report cannot possibly cover all the stories of exceptional care and professional practice compiled in the Magnet document but we have good representative examples. Our Professional Practice Model contains the structure and processes necessary to sustain excellence and Relationship-Based Care is a concept that will guide us in the future.

Last year we established goals to strengthen communication and interdisciplinary collaborations. We succeeded in achieving those goals and we are now in a position to demonstrate and model the way to using Relationship-Based Care to establish interprofessional healthcare teams. Many clinical care sites in the outpatient and inpatient settings have implemented team huddles. Huddles result in consistent plans of care, improved communication among team members, efficiencies in providing care or services, and improved patient experience. When team members are on the same page and patients are included in discussions, we see better compliance with treatments, fewer errors, and improved patient perceptions that we are listening to them.

We are experiencing exciting improvements in throughput and the outcomes are measurable in terms of reduced length of stay and reduced wait times in the Emergency Department. The plan is to increase the use of huddles to enable students, residents, nurses, discharge planners, dietitians, therapists and social workers to engage in interprofessional education and practice. We are preparing healthcare providers for the future and must model efficient utilization of resources. For example, effective huddles make it possible for us to build capacity through efficiency instead of wasting money to build unnecessary hospital beds.

It is my hope that we can build on our success this past year by demonstrating that Relationship-Based Care will improve communications and collaborations with our patients, students, faculty, and staff to achieve the institutional goal of Patient Centered Care.

With warmest regards,

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

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

# MAGNET DESIGNATION

What a year it was! 2013 was a memorable year preparing for the Magnet site visit. It began with the submission of documents in early February. Nurses across the organization helped gather exemplars and write about initiatives that helped improve their work environment and improve patient outcomes. In addition to the abundance of exemplars and initiatives, the required documentation also included validation that patient satisfaction, nurse satisfaction, and nurse sensitive clinical indicators outperformed national benchmarks.

All Magnet organizations have structures and processes in place that encourage nurses to flourish as professionals. Our documents showcased programs and opportunities throughout the health system that nurses take advantage of daily to promote their professional practice. It took four appraisers several months to carefully read through the documentation and validate that all

requirements were met and that the documents had scored within the range of excellent. The notification for a site visit came at the end of July.

Waiting for the phone call from the American Nurses Credentialing Center (ANCC) about a site visit date seemed to take forever. Once we received the dates of November 12 – 15, 2013 there didn't seem to be enough hours in a day to prepare for the actual site visit. Magnet Champions were busy preparing their areas as well as preparing other areas with the Spin the Wheel questions.

Our four day Magnet site visit was exhilarating and inspiring. The Magnet escorts shown below were acknowledged by the appraisers for their professionalism, dedication and passion for their nursing practice and diligently keeping the appraisers to a very tight schedule.



*From left to right: April Travis, RN, BSN, Emergency Department, Yolanda Schjoneman, RN, BSN, Pediatrics Clinic, Hillary Kemp, RN, BSN, CTICU, Sharon Conner, RN, BSN, D5 NICU, Erin Kozlowski, RN, BSN, Davis 14, Kimberly Schaeffer, RN, BSN, Operating Room, Dannika Schauer, RN, BSN, CSC PACU, and Jesse Senestraro, RN, BSN, TRU.*



Shirley Daffin, RN, BSN, Vascular Center and Natalie Merilus, RN, BSN, Cancer Center Clinics

Over the course of four days, just about all inpatient and outpatient care areas were visited. Here is a glimpse of the four day agenda.

#### DAY ONE

- » Medical Center Senior Leadership
- » Patient Care Services (PCS) Executive Council
- » PCS Managers
- » Research Council and Center for Nursing Research
- » Clinical Practice Council and PCS Standards Committee
- » Professional Development Council
- » Quality and Safety Council
- » Governance Council
- » Electronic Health Records
- » Patient Care Department rounds

#### DAY TWO

- » Medical Staff Leadership
- » Nursing Peer Review Committee
- » Unit Based Practice Council Chairs
- » Retention, Recruitment and Recognition Session
- » Ethics Committee
- » Professional Practice Committee
- » Advance Practice Nurses
- » Human Resources
- » Open Forum
- » Private session for any employee upon request
- » Breakfast, lunch and dinner sessions
- » Patient Care Department rounds

#### DAY THREE

- » Clinical Quality Improvement
- » Infection Prevention
- » Case Management and Risk Management
- » Quality and Safety Champions
- » Community Partners
- » Multidisciplinary Teams
- » Lean Six Sigma Projects Teams
- » Center for Professional Practice of Nursing
- » Breakfast, lunch and dinner sessions
- » Patient Care Department rounds

#### DAY FOUR

- » Deans and Directors of Affiliating Schools of Nursing
- » Nurse Residency Program
- » Breakfast sessions



Shirley Shingara, RN, BSN, Lisa Craney, RN, BSN, Helen Chester (PCR), RN, BSN, Angie Marin, RN, MSN, Patty McCabe, RN, BSN, Davis 7 Pediatrics and Meg Baldwin, Staffing Office



Debi Cryder, RN, Darlene Simon, RN, Gina Mumfer, RN, Erin Colmar, RN, Jeannine Tunnell, RN, BSN, Mary Humphrey, RN, Stacy Hevener, RN, MSN, Michelle Tom, RN, BSN, MSICU and Toby Marsh, RN, MSN, PCS



Beverly Smiley, RN, BSN, Alison Shuken, Emergency Department, Kimberly Sommerhaug, RN, MSN, Spine Center, Beverly Schacherbauer, RN, BSN, Cardiology Clinic

On day two an Open Forum session was held in the ACSU auditorium which turned out to be standing room only. Other disciplines came forward to tell heartfelt stories of the quality of nursing care at UC Davis. One of the appraisers commented that she was very pleased with the large attendance and it was obvious to her that UC Davis Medical Center has a culture of quality and multidisciplinary collaboration. In all, the appraisers interviewed 1,298 staff, patients and families. Of which 1,042 were RN staff. The site visit concluded with the Nurse Residency Program session. Nurse residents impressed all four appraisers with their stories of transitioning into the workforce. Nurse residents gave example after example of gratitude for the support and wisdom they had gained from expert mentors. The nurse residents also shared their evidence based practice projects with the appraisers.

The much anticipated and exciting news finally came from ANCC in January of 2014 during a public phone call to Carol Robinson, Chief Patient Care Services Officer in the Cancer Center auditorium. The Commission on Magnet unanimously voted to recognize UC Davis Medical Center as a Magnet organization. Several programs and initiatives were highlighted in the phone call for their innovation. Members of ANCC acknowledged UC Davis not only as a Magnet organization but also as a leader for other Magnet organizations.

Almost exactly a year later, it was finally time to celebrate the year's efforts. Food and Nutrition Services worked countless hours preparing special touches for the day. Staff came to listen to comments from Anne Madden-Rice and Carol Robinson, enjoy the delightful food, have fun taking pictures in a photo booth and celebrate with their colleagues.



Carol Robinson congratulates staff on Magnet Recognition®



Jill Bischel, RN, Perioperative Services



Ellen Kissinger, RN, MSN, Magnet Program Coordinator and Toby Marsh, RN, MSN, MSA, PCS Director

*Bottom Left Photo: Staff gather in the Cancer Center auditorium for the public phone call on the decision to recognize UC Davis Medical Center as a Magnet organization*

*Bottom Right Photo: Food and Nutrition Services provides special touches for staff to enjoy the celebration*



# PULMONARY REHABILITATION PROGRAM

The pulmonary rehabilitation program at UC Davis Medical Center has expanded its services in order to accommodate the growing need for a comprehensive palliative care program for patients with chronic lung disease. We use a multidisciplinary palliative care approach that integrates pharmacy, social work, chaplain services, and the hospice and palliative care team. Although respiratory therapists traditionally have operated pulmonary rehabilitation programs, the UC Davis Medical Center collaborative team comprises a physician, a nurse practitioner as well as respiratory therapists.

Working together, the Pulmonary Rehabilitation Program care team endeavors to alleviate patients' symptoms, provide social support, improve patients' quality of life and empower patients to actively participate in their disease management. The core elements of pulmonary rehabilitation constitute the foundation of our program. An individualized treatment plan is created for each patient, focusing on:

- » Supervised exercise and strength training
- » Education
  - Lung anatomy and disease process
  - Medications
  - Advance directive and POLST forms
  - Breathing retraining
  - Understanding and utilizing oxygen
  - Air pollutions and understanding triggers
  - Nutrition and chronic lung disease

- Benefits of exercise
- Conservation of energy
- Sleep apnea and sleep disorders
- Understanding oxygen durable medical equipment
- Pulmonary function tests

- » Psycho-social assessment
- » Activities of daily living
- » Medication adherence
- » Nutrition and weight management
- » Secretion clearance
- » Diabetes management

The palliative care approach in pulmonary rehabilitation is an integral part of chronic lung disease management. Within the classic pulmonary rehabilitation structure of education and exercise and the addition of Nurse Practitioner Karina Berge, RN, FNP-C, the program is augmented to provide symptom management, supplement specialty care, facilitate communication with physicians and provide referrals for additional resources such as other chronic disease management classes. Together with the respiratory therapists, Karina also facilitates the social work, chaplain, pharmacy and hospice relationships. The program's expanded services will provide disease-directed care in conjunction with palliative care to improve quality of life and quality of care.

At the center of the program will be the patients, and their goals will be the goals of the program. We hope that working in partnership with patients, we will help them achieve the highest quality of life.

## PROFESSIONAL GOVERNANCE

Patient Care Services (PCS) 2013 goals were identified by the Governance Council members based upon the Health System 2011-2016 Strategic Plan, PCS Nursing Strategic Goals for 2011-2016, and the accomplishments and challenges presented by the previous year's goals. The council also considered requirements to achieve Magnet recognition as part of the planning process. Unit based practice councils (UBPCs) and system-wide councils began 2013 creating action plans that aligned their own goals and actions for the year with the PCS goals.

The system-wide councils surpassed expectations with the impact they had on patient outcomes and nurse satisfaction. Below are some of the professional governance system highlights of 2013:

- » The Clinical Practice Council helped strengthen the professional governance structure with educational classes targeted for the bedside nurse to further develop tools to assist the new chairs and co-chairs, understand project management, and the peer review process. This council also made excellent strides in reducing barriers

## PEDIATRIC PALLIATIVE CARE PROGRAM

Pediatric Palliative Care provides a multidisciplinary approach to alleviate the pain (physical, social, psychological and spiritual) and suffering of children diagnosed with life limiting or chronic illnesses, along with their families and medical providers. It may be initially combined with cure-oriented, disease modifying care and then intensifies when that form of care is no longer available.

UC Davis Children's Hospital is a tertiary hospital that provides services to children across Northern California with advance disease states. Given the highly complex medical population that such hospitals serve, statistically 3-5% of the patients will





in patient flow through the Patient Transfer and Admission Workgroup.

- » The Quality and Safety Council focused on many projects including improving patient outcomes with hospital acquired conditions, medication safety, and sepsis mortality reduction. The Quality and Safety Council also created a quarterly award to recognize departments and nurses that are exemplary in quality and safety with the UC Quality in Action Award.
- » The Research Council further expanded the Virtual Journal Club and Evidence-Based Practice Toolkit. They also were lead in organizing the Professional Governance Celebration and further strengthened the event with a two day conference style structure.
- » The Professional Development Council developed two specialty certification review courses for the Medical-Surgical Nurse and Certified Nurse Operating Room. Additionally, the council has made strides in assessing the current clinical ladder and work toward the ladder's redevelopment. Continued work was done to educate and promote the understanding of the Professional Practice Model and how to relate the model to everyday practice.
- » The Governance Council continued to strengthen the professional governance structure through setting guidelines for

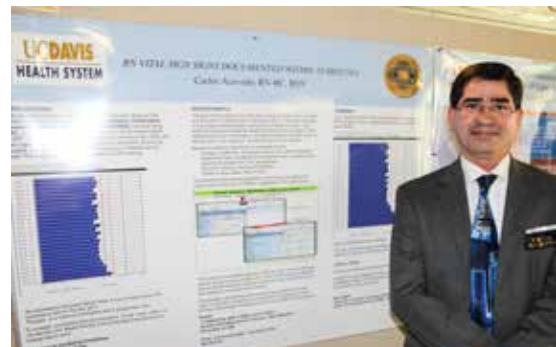
allocation of time and helped spread the conceptual framework to other hospitals in the area. Additionally, nurse recognition was a focus and UBPCs were publically recognized for their contributions in The Insider.

Regular meetings with the UBPCs and system-wide councils' chairs and co-chairs at the Nurse Practice Council (NPC) All Here Days helped facilitate communication and create a collaborative environment. UBPCs continue to share best practices and learn from one another.

Magnet designation was one of the most noteworthy achievements that the UBPCs and system-wide councils helped to accomplish during the Magnet review in 2013. Magnet appraisers were impressed with UBPC initiatives and projects occurring to improve patient outcomes and the work environment. The Professional Governance Structure continues to grow as other disciplines create their own UBPCs. Governance Council looks forward to 2014 with the new set of goals and even higher expectations for the year to come.



Linda Horvath, RN, BSN, SICU



Carlos Acevedo, RN-BC, BSN, Tower 4



Left to right: Mandy Jeppesen, RN, PCCN, Kanya Idury, RN and Christina O'Meara, RN, Davis 6

not survive even when the most advance care is provided. Pediatric Palliative Care assures that we are able to provide the most aggressive management of children's disease states with advance symptom management and family support throughout the continuum of their care.

To meet the growing needs of our pediatric patient population, an interdisciplinary team called STEPS (Support Therapies and Enhanced Palliative Services) started providing services in April of 2013. The team consists of physicians, a nurse practitioner, social workers, child life specialists, chaplains and other support staff. In its first year the STEPS have consulted on 43 patients with challenging conditions incorporating medical, spiritual, cultural and holistic care

in a family centered manner.

The mission of the STEPS is to enhance the care for children and families living with life – altering, complex condition that span the course of the disease. Services provided by STEPS include:

- » Aggressive pain and symptom management
- » Enhancing meaningful quality of life
- » Coordination of care inpatient, outpatient and home care
- » Facilitate communication with medical care teams
- » Support for patients and families to alleviate stress
- » Spiritual guidance



Beenu Aneja, RN, MSN, FNP, Pediatric Palliative Care Nurse Practitioner

## NURSE RESIDENCY PROGRAM

2013 marked the one year anniversary of our University Healthcare Consortium (UHC) Nurse Residency Program. It was definitely a year filled with celebration, the beginning of new careers for many new nurses and evolving changes to an established program in its early stages.

Nurse residents from cohorts two and three graduated from the Nurse Residency program in May and August of 2013. The graduation ceremony was an opportunity for nurse residents to showcase their evidence based practice projects to their peers, preceptors, facilitators and nurse managers. The presentations were followed by a pinning ceremony in recognition of the nurse resident's successful transition from advance beginner to competent professional nurse.

Three groups of nurse residents, cohorts four, five and six were hired in 2013:

- » Cohort four included 27 new graduate nurses from: E4, E6, E8, D12, D14, Pre-op, T3, T8, and TNU.
- » In June, cohort five welcomed 39 nurse residents to: CTICU, D7, D8, D11, D12, D14, E6, E8, GI Lab, MICU, MSICU, PICU, SICU, T3, and T4.
- » Cohort six greeted 25 nurse residents who began their journey in early September and joined colleagues in the following units: Burn Unit, E4, E6, L&D, MSICU, NICU, OR, Patient Care Resources, T3, T4, and T8.

The one year anniversary of the start of the Nurse Residency Program ended the research participation component with UHC.

This yielded an opportunity for change and growth of the program. Some noted changes to the nurse residency program include:

- » Monica Aguilar, RN-BC, MSN was welcomed as the new program coordinator in early September.
- » A unit-based facilitator model was implemented in early August. Each unit with representing nurse residents had the opportunity to be mentored by a facilitator from their own unit. This expansion grew from eight facilitators overseeing the preceptors and supporting the nurse residents to 21 facilitators by the end of 2013.
- » To make the classes more interactive, a portion of the nose to toe simulation (managing of the changing patient condition) was implemented at the Center for Virtual Care. This was created by the Center for the Professional Practice of Nursing (CPPN) educators, Karrin Dunbar, RN, BSN and Jim Hill, RN, MSN.
- » To socialize the nurse residents with the health system and its initiatives, cohorts four and five began participating in the National Database of Nursing Quality Indicators (NDNQI) skin survey championed by Wound Care Specialist, Holly Kirkland-Walsh, RN, FNPC, GNPc.
- » A few groups from cohorts two and three had the opportunity to showcase their evidence based practice projects in a poster format at the annual Professional Governance Day in November.

Future plans are based on discussions and recommendations from the facilitators and educators, as well as feedback from the residents. The facilitation of the nurse residents' transition from advance beginner to competent professional nurse is a collaborative effort and at the hands of all members of the Health System.

## PSYCHIATRIC PATIENT CARE IN THE EMERGENCY DEPARTMENT

In early 2013, the Emergency Department (ED) was struggling with a burgeoning psychiatric population, holding an average of 12-15 patients per day. Many factors contributed to this increase to include closure of psychiatric clinics and a decrease in Sacramento County inpatient beds due to budgetary constraints.

Boarding was a primary issue, although care issues, elopements and violence were also problematic. The ED administrative nursing team met to design and implement the care improvements for psychiatric boarding patients in the summer of 2013.

The finalized Psychiatric Care Bundle includes:

- » A single pod was set aside for boarding. This pod was made "flexible" in that rooms were able to be stripped of all equipment in less than two minutes and bins/racks were purchased to keep the

equipment away from psychiatric patients and safe for future use. The room stripping was done 100% of the time for all boarded psychiatric patients for their safety.

- » Belongings were removed immediately from all psychiatric patients, for the safety of staff and patients alike and sequestered in a special storage area.
- » Psychiatric technicians were hired and trained as sitters and also to perform duties such as activities of daily living. All patients on 5150 holds were continuously monitored and evaluated by these staff. Working collaboratively with the Psychiatry Department and the ED nurses, violence and the potential for violence decreased markedly.
- » FYI signage, a red card with FYI printed on it was placed outside the door of

every patient who had a current or past history of violent behavior in the ED. This warning was intended to be a silent warning to all incoming staff that the patient might have unpredictable behavior and a past history of violence.

- » Purple hospital gowns are worn by psychiatric patients for easy identification and in case of elopement. This has assisted UC Davis Police and staff to easily identify these patients when and if they eloped.
- » Initiation of Code Elopement. Any patient attempting to elope or in process initiates the Code Elopement overhead page in the ED. All staff were trained to report and respond, based on simple overhead descriptions of the missing patient. Since implementation in fall 2013, the elopement rate has gone to zero cases.



Pastel colored kites, candles, flowers and paper hearts decorated the MIND Institute auditorium and courtyard for the families and staff.



## JOY BREWER, RN

*D3/T3 University Birthing Suites*

Joy Brewer is a familiar face on D3/T3 University Birthing Suites, she has been a nurse for 30 years and 22 of those years have been at UC Davis Medical Center. She enjoys working at an academic center that offers continuous learning and a culture of interdisciplinary collaboration. Joy has worked in many different areas but truly enjoys OB, where she gets to welcome new babies into the world.

As a young girl Joy enjoyed music and singing, and also dreamed of becoming a nurse. She spent many years surrounded by children and was constantly amazed with their love and generosity. Their ever ready and giving spirit inspired her to write a song about children.

Joy played the guitar and sang the song she wrote at the UC Davis Children's Hospital first Celebration of Life event last September. The gathering provided a beautiful and peaceful venue for families and staff to remember the lives of the children who passed away at UC Davis Children's Hospital in 2011 and 2012.

Twenty-two families (75-100 people) attended the event. They shared stories with other families and staff, displayed photos of their children, signed a remembrance book and wrote special messages to their children onto a paper heart and attached it to a large paper kite displayed in the courtyard.

## FOR THE CHILDREN

*Written by Joy Brewer*

*Time and time again,  
I see it in their eyes,  
they're loving me no matter what I do,  
you know it moves me.*

*They're reaching with their hands,  
and loving with their hearts,  
there is no word to use that will explain,  
the way it heals me.*

*If I had love like the children,  
love like the children,  
then I could be,  
so free,  
if I could touch like the children,  
think of you before I think of me,  
Maybe...*

*Well you might say,  
that isn't true they're not all this way,  
but I believe we all were born to love,  
and you might say that some just try to disobey,  
but you're missing out on what comes from above.*

*Love like the children,  
love like the children,  
and you could be,  
so free,  
Hmmm...love like the children.  
Oh... touch like the children.*



Left photo: Aries Santos, RN, right, oncology nurse for AIS Cancer Center in Bakersfield participated in the UC Davis Cancer Care Network One-on-One Mentoring program. Santos spent two days in the Adult Infusion Center working with Apinya Vorasaph, RN, BSN, OCN.

Right photo: Left to right: Eloisa Martin, RN, BSN, D8, Caitlin Crawford, RN, BSN, D8 with Rideout oncology nurses Debbie Osgood, Cher Rau, and Karen Schoening, discuss a quality improvement poster at Professional Governance Day.

## International Fellowship Exchange of Nurse Practitioners

At the Sigma Theta Tau conference held in Vienna in 2007, the President of the Affiliation of the Academy of Nurse Practitioner's in Taipei, Dean Tsay, expressed interest in developing a liaison with academic medical centers in the United States. Dr. Tsay developed and organized the Taiwan Nurse Practitioner Organization with a desire to collaborate with the American Academy of Nurse Practitioners to achieve global experience and facilitate the international practice of board certification. This began an international fellowship exchange of nurse practitioners from Taipei to the United States. In 2008, this was accomplished with the University of Miami and Jackson Health System and now includes an affiliation with the University of California, Davis.

The inaugural trip took place this past December when UC Davis nurse practitioners hosted fellow Taipei nurse practitioners. Nine nurse practitioners including Dean Tsay and Professor Heng-Hsin Tung joined the nurse practitioner team at UC Davis to observe professional practice. The international collaboration fostered an exchange of nursing practice in the professional life of nurse practitioners across the continuum. The Taipei nurses observed practices in trauma, emergency department, CTICU, SICU, PICU, and NICU. This was an exceptional experience for the nurse practitioner international fellowship and facilitated world experiences.

## SHARING RESOURCES WITH ONCOLOGY NURSES IN THE UC DAVIS CANCER CARE NETWORK

The Cancer Care Network partners with many departments in the UC Davis Health System, including UC Davis Comprehensive Cancer Center, Patient Care Services, the Center for Health and Technology, Health Information Management, Betty Irene Moore School of Nursing, Center for the Professional Practice of Nursing, and Nursing Research. The many UC Davis departments and staff members enthusiastically support the mission of the Cancer Care Network to improve the quality of cancer care in the community.

### UC DAVIS NURSING PROFESSIONAL GOVERNANCE MODEL MOVES TO CANCER CARE NETWORK SITES

When the nurses at Rideout Cancer Center, Marysville wanted to form a professional governance council, UC Davis nurses Brittny Caldera, RN, BSN, PCCN and Christine Fonseca, RN, BSN, OCN made trips to Marysville to facilitate the process with on-site workshops and support. Karen Shoenig, RN, OCN, an oncology nurse for Rideout Cancer Center commented, "We formed our council because we saw it as a way to empower our nursing staff to use our knowledge and skills to help direct our own professional practice and to create an environment that fosters collaboration and promotes excellence."

The council at Rideout improved call triaging and interprofessional communication. The team is also involved with starting a PICC insertion program and the center's conversion from paper charts to an electronic medical record. The enthusiasm for the professional governance model by nursing motivated the clinic medical assistants to form a council as well.

Mercy Cancer Center in Merced took a slightly different approach to their council by having both inpatient and outpatient nurses as members of one council. The group meets monthly with Cancer Care Network staff and developed a process for getting cancer patients admitted to the designated oncology-focused unit and improved communication across the continuum of care. The council also sponsored an Oncology Supportive Care and Oncologic Emergencies course that was taught by Kay Harse, RN, MS, AOCN, manager of the Cancer Care Network.

### ONCOLOGY NURSING EDUCATION VIA VIDEO CONFERENCE REACHES ACROSS THE STATE

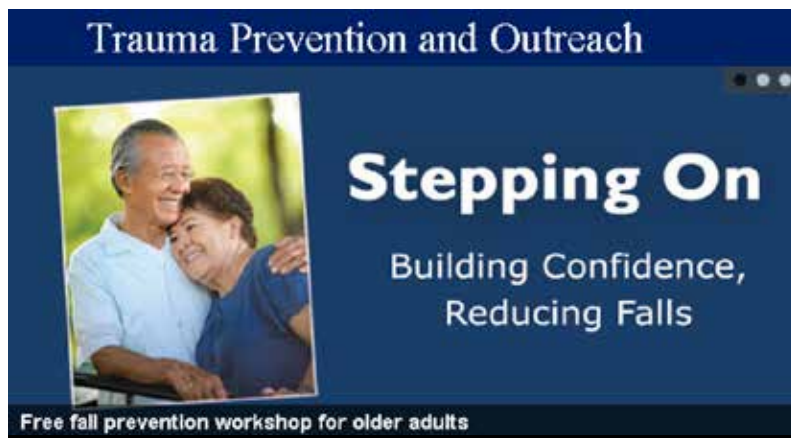
Oncology nurses in the UC Davis Cancer Care Network find it difficult to get to oncology-specific continuing education events when they work in Truckee, Marysville, Merced, and Bakersfield, areas with smaller groups of oncology professionals, said Terri Wolf, RN, MS, OCN, nursing and quality coordinator for the Cancer Care Network. To address this issue, the network formed an education committee of nurses from each network affiliate cancer center. The group decided to use the existing videoconference network, originally established for virtual tumor boards, for quarterly after-work education programs. The first program "Managing Chemotherapy-Induced Nausea and Vomiting" launched October 23, 2013. The didactic portion was lead by Patricia Palmer, RN, MS, AOCNS, Davis 8 clinical nurse specialist with assistance from Devon Trower, RN, OCN, Adult Infusion, and pharmacists, Maily Trieu, PharmD and Tara Tsukamoto, pharmacy student. After the education portion each network site presented a case study for discussion. Participating nurses reported learning type of anti-emetic medications to use for different patient risk and improved combinations of antiemetics. Future programs include Chemotherapy-Induced Peripheral Neuropathy and ONS Congress Highlights. These videoconferences have resulted in practice changes and have been attended by nurses, pharmacists, medical oncologists, and social workers. UC Davis nurses and staff also are invited to participate.

# NEW PROGRAMS

## STEPPING ON

Falls remain the leading cause of death among older adults and in 2013 the Trauma Prevention department increased outreach efforts to reduce these deaths through Stepping On, a community based senior fall prevention program. Piloted at UC Davis Medical Center in November of 2012, the Stepping On program empowers older adults to carry out health behaviors that reduce the risks of falls. The program has been proven to reduce falls by 31% among participants completing the workshops. Stepping On workshops offer weekly sessions for seven consecutive weeks that cover a wide range of fall prevention topics including exercise, vision, medication, and home modification. Using a model of interdisciplinary collaboration, Christy Adams, RN, BSN, MPH, Trauma Prevention Coordinator has brought additional UC Davis partners from Physical Medicine and Rehab, Pharmacy, Ophthalmology, Emergency Medicine, and Family and Community Medicine to provide content expertise at workshops. The small-group setting follows an adult learning, peer led model that reinforces learning over the seven week period. The workshops are facilitated by Christy Adams and an adult health educator from the trauma prevention program.

In 2013, Trauma Prevention was able to offer six Stepping On workshops in the community, providing comprehensive fall prevention education to 49 seniors. With ongoing data collection including a three month follow up on self-reported falls among participants, the program is being evaluated for effectiveness in reducing falls. Anecdotally, the success of the program can be measured in the overwhelmingly positive response by participants and their affirmation of the empowerment the classes provide. Participants complete the seven-week workshop with an increased sense of control, improvement in strength and balance and a reduced fear of falling. With an ever growing list of over 100 seniors waiting to enroll in one of only four workshops offered by the Trauma Prevention department each year, program coordinator Christy Adams quickly recognized the urgent need to develop additional fall prevention resources in the community. In 2014, UC Davis Medical Center will be offering the first Stepping On workshop leader training in Northern California. The three-day class will teach health care providers how to prepare for, implement, and evaluate the Stepping On program in their own community.



## PEDIATRIC SEPSIS IN THE EMERGENCY DEPARTMENT

Pediatric sepsis accounts for approximately 42,000 cases annually and is the leading cause of illness and death among children in the United States, behind asthma, appendicitis, and poisonings. Overall mortality ranges from 5-10%, with increased mortality in children with underlying medical conditions. Pediatric deaths due to sepsis are more common than death from cancer, 7-9% of all childhood deaths are due to sepsis.

The national Pediatric Septic Shock Collaborative was established in 2011. The inaugural 47 healthcare centers consist of children hospitals and related institutions as well as community based hospitals throughout North America and Canada. The aim of the collaborative is to improve the quality of care for children with suspected septic shock. The goal is to decrease pediatric mortality rates due to sepsis by accurately and quickly administering needed fluids to infants and children who are dehydrated. The collaborative has two areas of focus: a quality improvement arm and a research investigations arm. The quality improvement piece involves the development of meaningful and robust quality measures that will help better evaluate the quality of care delivered to children with suspected sepsis. This includes the triage tool criteria developed by the UC Davis Pediatric Emergency Department (ED).

UC Davis Pediatric Emergency Department is the first ED to initiate this care bundle. "Pediatric Sepsis" is a new care bundle designed to identify and rapidly treat septic pediatric patients who present to our ED's Triage. The bundle has clearly identified triggers, is easy to follow and was developed collaboratively by the Emergency Department (ED) Pediatric Core Nurses, ED Educator and Dr. Cheryl Vance, Pediatric Sepsis Champion. The program was launched in early 2014 at UC Davis Medical Center's ED as a result of the collaborative planning and work in 2013.

# PRE-TREATMENT PHONE CALL FOR NEW CHEMOTHERAPY PATIENTS

## “MAKING THE HAPPENING EASIER”

The UC Davis Comprehensive Cancer Center provides infusion services for oncology patients receiving chemotherapy. It also provides services for cancer related clinical trials. New chemotherapy patients were presenting to the Adult Infusion Room unprepared for their first treatment. For many, a week or more had passed since their physician had presented their chemotherapy plan, this time lapse had created anticipatory anxiety. In addition, these plans did not include crucial information regarding the infusion room experience. Patients were not fully aware of the length of treatment, infusion room expectations, and the need to pre-hydrate and bring their chemotherapy related medications. Nor were they uniformly informed about food, guests, parking, cell phone use and other information. Nurses were using precious chemotherapy teaching time resolving preventable problems and conflicts. This impeded the teaching process, slowed unit efficiency and throughput, and also contributed to last minute appointment cancellations.

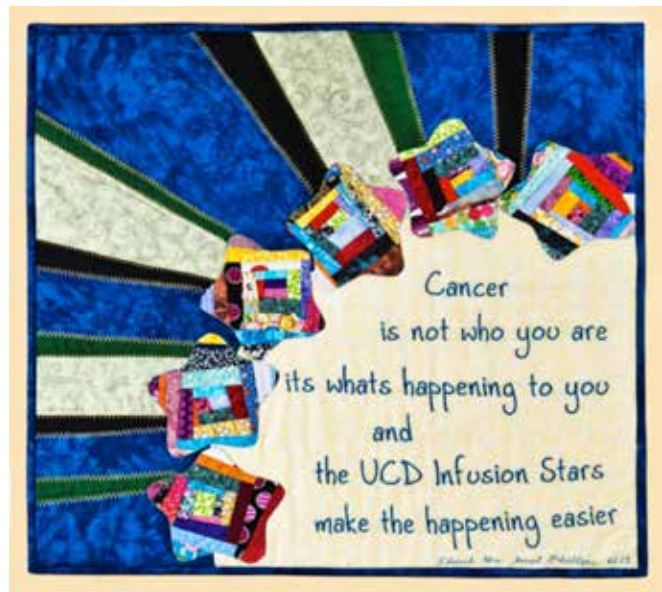
Ruth Pina, RN, BSN, Clinical III, and Denise Fleming, RN, BSN, Clinical III, partnered to lead a unit based, nurse led performance improvement project designed to evaluate whether a nursing pre-treatment education phone call would decrease anxiety and improve the overall experience for new chemotherapy patients. Using the Define, Measure, Analyze, Improve, Control (DMAIC) model, the nursing staff was surveyed to identify contributing factors and proposals for change. Literature was reviewed regarding the effects of pre-procedure patient phone calls in other medical settings. This information was used to establish the feasibility of implementing the model in the Adult Infusion Room. Other goals of this project were to establish a therapeutic relationship, decrease treatment time and help to identify potential barriers prior to the appointment, which could help eliminate last minute cancellations.

Nursing and management worked collaboratively to author a nurse driven, infusion center specific New Chemotherapy Patient Education Phone Call Template. Kristian Proshak, RN, Clinical II, wrote a corollary Electronic Medical Record smartphrase cue designed to create consistency and ease of documentation. A survey was developed to evaluate the impact of the calls on the patients' experiences. Information was disseminated to staff at morning huddle prior to pilot implementation. The program was launched in October of 2013, with calls being placed the evening prior to the patients' arrival.

The survey assessed 40 patients over a one-month period, with 19 providing feedback. One hundred percent of respondents reported that the calls increased their satisfaction and reduced their anxiety. Patients stated the education increased their feelings of control and confidence. They valued having realistic expectations and appreciated having a pre-established relationship on their first

day of treatment. Additional benefits included the identification of treatment obstacles or scheduling conflicts so that management could be notified and preemptive planning could occur. Nurses reported an increase in receptivity to teaching and shortened length of stay (LOS) because the patients were more prepared on arrival. This greatly improved overall efficiency. The appreciable enhancement of the patient experience motivated the nurses to make the change sustainable, and the program was quickly expanded to include non-chemotherapy patients.

With the guidance of Barbara Rickabaugh, RN, MSN, NE-BC, of the Center for Nursing Research, Denise Fleming wrote an abstract of the project that was accepted for publication and for a podium presentation at the Oncology Nursing Society Congress in Anaheim on May 1, 2014.



*Receiving a diagnosis of cancer is an overwhelming, frightening and sometimes catastrophic change in the lives of chemotherapy patients. The text of this quilt, a gift created by a beloved patient, inspired the project by reminding staff that their mission as nurses is to “Make the Happening Easier.” For the nurses of the Adult Infusion Center, this pre-treatment education call project proved to be one more way they can reach, teach, and empower new patients as they begin their journey of healing.*

## EMPLOYEE BREASTFEEDING SUPPORT PROGRAM

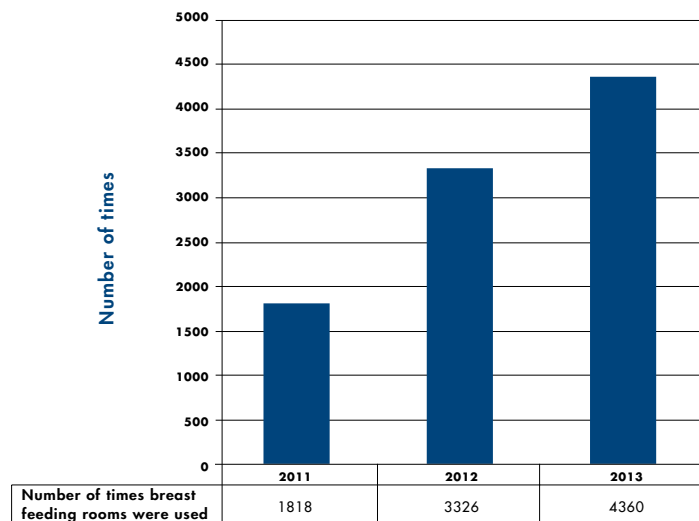
At the end of 2012, Cheryl Burstiner and Debbie Albert became the lactation team for UC Davis Medical Center. Cheryl had a 14 year history with UC Davis, much of it as a labor and delivery nurse and as support person for the UC Davis Breastfeeding Support Program. Debbie, a lactation consultant with over 20 years of lactation experience, was new to UC Davis but brought experiences with her from several realms.

In the beginning of 2013, the pair began a “Dare to Dream” theme that changed the UC Davis Employee Breastfeeding Support Program. Meetings started with human resources, and soon after, Marina Podoreanu, UC Davis Health System Work Life Balance Coordinator, became the human resources liaison for the program. At this point, a triumvirate was created that would lead to three Employee Excellence Awards in Social Responsibility. In addition, in 2013 UC Davis Medical Center received the Mother-Baby Friendly Workplace Award from the Breastfeeding Coalition of Greater Sacramento and the International Board Certified Lactation Consultant (IBCLC) Lactation Care Award.

With coordination of the lactation team and human resources, meetings were established creating a village of support persons for this program; which now has quarterly meetings that include liaisons from human resources, facilities planning, environmental services, and volunteer services as well as representatives from the sister program at UC Davis Campus. The program also has a lactation intern volunteer that regularly travels to the 13 pumping rooms established across the health system to collect sign in sheets, and report on the status of the rooms. There are five breastfeeding support rooms in the main hospital, as well as rooms located in the Broadway Building, Lawrence J. Ellison Ambulatory Care Center (ACC), Mind Institute, Medical Education Building and the Cannery. Plans are underway for additional rooms in Ticon II and other areas.

Data in the graph below show a significant increase in employee use of breastfeeding rooms. Employees can apply online, attend prenatal breastfeeding classes, participate in the UC Davis Breastfeeding Support Group and receive private assistance at the UC Lactation Clinic, as well as receive support from Cheryl and Debbie. In spring 2014, UC Davis Medical Center applied for the first UC Davis System Lactation Award. Their basic premise is simple: *Employees who feel supported in their choice to provide breast milk to their children will forward that support to their patients.*

### USE OF BREAST FEEDING ROOMS



Left to right, Breastfeeding Support Team: Marina Podoreanu, Cheryl Burstiner, RNC, IBCLC and Debbie Albert PhD, BSN, IBCLC. Cheryl is holding the Mother-Baby Breastfeeding Friendly Award.

## NO ONE DIES ALONE

At UC Davis Medical Center, more than 500 deaths happen each year and unfortunately sometimes patients die without family present. In April 2013, the No One Dies Alone program began. Through the efforts of volunteers this program provides a reassuring presence to dying patients who would otherwise be alone. With the support of the nursing staff, No One Dies Alone volunteers offer patients the most valuable of human gifts, a dignified death and a compassionate presence.

No One Dies Alone patients are those who are on comfort care, are a do not resuscitate (DNR) and expected to die within 48-72 hours. A No One Dies Alone vigil can be activated by any staff member through the on-call chaplain.

Volunteers come from throughout the health system and are available to sit with patients at any time of the day or night. They graciously give their time and understand that death knows no time frame and that they may be called in the middle of the night. Volunteers provide no medical care and are there to sit with the patient, perhaps hold their hand or read to them. Since its inception, No One Dies Alone has provided 133 hours of staff volunteer time for one to two patients per month.

## OPERATION APPRECIATION

Workplace recognition demonstrates that employee's efforts are acknowledged and valued. Nurses on Davis 11 Trauma Nursing Unit analyzed their employee engagement scores (Morehead survey) and identified that recognition was a topic they wanted to focus on. Tracking their data helped them identify that nurses would most like their work to be distinguished.

The Unit Based Practice Council (UBPC) not only wanted to improve recognition on their unit, but foster that good will among other hard working departments within the hospital. UBPC member Andy Scheeler, RN, BSN suggested Davis 11 start an appreciation day on the 11th of every month; this idea became Operation Appreciation. On the 11th day of every month, a department is chosen whose employees will be recognized with a thank you card and goodies and celebrated for their consistent excellence... always!

Units that have been recognized since implementation in 2013 are:

May - Environmental Services

June - Emergency Department

July - PACU

August - NSICU

September - CTICU

October - Peds/PICU

November - Davis 6

December - MICU

January 2014 - Inpatient and outpatient pharmacy

February - Patient transport and lift team

Davis 11 nurses hope that fellow employee's will not only feel appreciated, but that continued support and teamwork will be encouraged throughout the UC Davis Medical Center family. The Trauma Nursing Unit is proud to be a part of such a collaborative and compassionate health care team.

*Trauma nursing unit nurses from left to right: Carolyn Cords, RN, Brianna Youmans, RN, BSN and Kenna Jeske, RN prepare goodies to deliver to CTICU last September.*



## DEVELOPING NURSES TO LEAD TRANSFORMATION AT THE POINT OF CARE

### EMERGING NURSE LEADERS

In January 2013, The Center for Professional Practice of Nursing's first cohort of the Emerging Nurse Leaders (ENL) began their first year of the two year intensive training program. The program's vision is to sustain positive change at the point of care and build the next generation of nurse leaders. The program aims to provide clinical nurses with the skills, network and guidance they need to effectively lead and shape the future of nursing at UC Davis Health System. This first group includes 22 clinical nurses from across the health system, selected for their leadership potential and dedication to the nursing profession.

During the program, participants engage in interactive and instructive activities focused on decision making, change management, leadership skills, and communication techniques. The program elements include:

### IN-PERSON SEMINARS

- » Four dynamic, core seminars taught by professionally recognized teachers and facilitators.
- » Monthly seminars utilizing small-group learning, role plays, and case studies to foster immediate application of new skills and tools in leadership behaviors.

### MENTORSHIP

- » Each ENL participant is paired with a nurse mentor who exemplifies nursing leadership and can provide knowledge, support and guidance to the ENLs in navigating the complex and demanding roles in clinical and managerial leadership.

### EXECUTIVE COACHING

- » Participants receive professional development coaching which includes discussion of personal assessments and individual goal setting.

### LEADERSHIP PROJECT

- » Participants complete an organizationally aligned evidenced-based project, from development through implementation and evaluation.

### *What members of the cohort are saying about their first year in the program?*

"Prior to participating in the Emerging Nurse Leaders Institute, I was content to be a clinical leader for the rest of my career. I joined the program to develop my skills as a leader at the bedside. After 10 months of seminars and salons in this program, I felt confident and excited to step into management in an ANII role. Through the Emerging Nurse Leaders Institute, I have discovered my potential



*The Emerging Nurse Leaders  
Inaugural Cohort (2013) includes:*

*Standing left to right: Jodi Coltes  
Warfield, RN, BSN, Dawn Love, RN,  
Catherine Runne, RN, Mary Heatlie,  
RN, BSN, Kimberly Mason, RN, BSN,  
Paige VerSteeg, RN, Jolanda Jackson, RN,  
Marissa Charles, RN, Romy Perry-Ali,  
RN, BSN, Kristine Ahlberg, RN, BSN,  
Christine Fonseca, RN, BSN, Carolyn  
Rhoads, RN, BSN, Kerri Stuart, RN,  
MSN, Calene Roseman, RN, BSN*

*Front row left to right: Sarah Bernardy,  
RN, BSN, Rachael Farrell, RN, BSN,  
PHN, Shannon Romero, RN, Kelly  
Colburn, RN, BSN, Kellie Perez, RN,  
Kimiko McCulloch, RN, MSN, Leana  
Aston, RN, BSN, Kathleen Guiney, RN,  
MN, MS, Not pictured: Melisa Jager, RN*



and I am developing the skills necessary to lead nurses in a supervisory role.”

“One crucial part of the program is the pairing with mentors. The mentor has assisted in many different ways from simple meetings to discuss goals, to reviewing abstracts and supporting nursing research projects. It is important to have this mentor in order to be truly successful.”

“This program provides the bedside nurse the confidence to grow, investigate new ideas and produce the change that is needed in our profession.”

“The program is unique as it opens up opportunities to seek new career paths that are of professional interest; however, without guidance or clear direction, it is difficult to know how to proceed. I hope to take advantage of this and provide UC Davis a successful future leader.”

“One of the things I have seen change in me has been viewing the health system outside of my bubble of the ICU. I have embraced education and research more, and without the ENL program, I am not sure if I would have applied to graduate school. I never thought of applying for an IRB and wanting to prepare a manuscript in my research.”



*by Kimberly Mason, RN, BSN*

In 2013 I had the opportunity at UC Davis to change careers and refocus my perspectives. I was accepted into the Emerging Nurse Leadership program, which advanced my knowledge and endorsed me to be exposed to an incredible mentor and become educated in the appropriate modalities of furthering my career.

With this opportunity, I was able to collaborate with new colleagues and submit abstracts. I have now been accepted to multiple conferences

worldwide featuring several topics. I will be presenting at the National Teaching Institute, American Association of Critical-Care Nurses (NTI, AACN) in Colorado regarding autoimmune diseases. I will also be presenting at the International Neonatal Association Conference, (INAC) in Valencia, Spain and at the International Advanced Nursing Practice Conference (IANP), Helsinki, Finland regarding immunizations and pertussis.

A nursing career represents a vast amount of opportunities and differential diagnoses; which allows for endless learning. All the abstracts that I have submitted have stemmed from patients that I have encountered. I enjoy being proud of where I work and love to provide many others with the education that I have experienced and encountered. I encourage other nurses to further their knowledge and submit abstracts and publications within organizations that are part of their professional career.

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**Kathleen Guiney, RN, MN, MS** is the ENL Program Coordinator. She works with an advisory committee, mentors, and Academic and Staff Assistance Program (ASAP) staff to support the Emerging Nurse Leadership program.

## NURSES LEADING THE WAY

CHRISTI DELEMOS, MS, CNRN, ACNP  
DEPARTMENT OF NEUROLOGICAL SURGERY



Christi DeLemos, MS,  
CNRN, ACNP

In 2013, Christi DeLemos was elected President of the World Federation of Neuroscience Nurses (WFNN), an international nursing organization composed of 24 member nations, dedicated to promotion and development of neuroscience nursing throughout the world. Prior to her election in 2013, she has held positions of increasing responsibility and played a critical role in hospital based education for neuroscience nurses. Christi served as

the local president of the American Association of Neuroscience Nurses Sacramento chapter and on the board of Directors of the WFNN. As a board member, she represented 5,000 members of the United States based American Association of Neuroscience Nurses. During her four year term on the board of directors for the WFNN, she created an international nurse mentor program, hosted a nursing professor from Japan and served on the scientific planning committee for the 12th Quadrennial Congress held in Gifu, Japan. Over the coming summer, she will work with international volunteers to create a video learning resource to teach the techniques of neurological assessment worldwide.

Christi also serves as a consultant for a multi-center FDA and Department of Defense compliant education project aimed at educating communities about use of exception from informed consent in emergency brain injury research. She has authored several book chapters in medical surgical nursing texts, serves as a lecturer for advanced practice and neuroscience nursing certification programs and participates on several quality improvement councils including professional governance and hospital based quality council. She is also a clinical associate professor (volunteer series) at the University of California San Francisco in the department of physiological nursing.

In her role as president of the World Federation of Neuroscience Nurses, she hopes to expand existing educational resources for nurses worldwide by embracing open online educational resources and develop a structure for medical volunteerism for nurses in the neuroscience field.

BONNIE RAINGRUBER, RN, PHD  
CENTER FOR NURSING RESEARCH

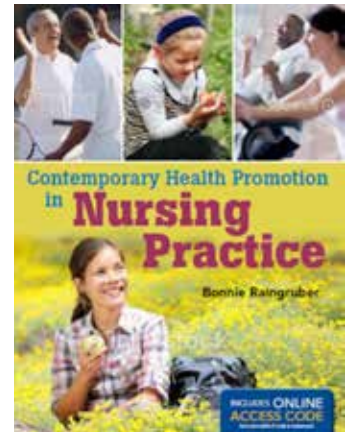
Dr. Bonnie Raingruber was pleased to learn her book “Contemporary Health Promotion in Nursing Practice” by Jones and Bartlett was selected for a first place award in the American Journal of Nursing 2013 Book of the Year within the Community-Health category. Barbara Glickstein, Co-director of the Center for Health, Media and Policy at Hunter College, City University of New York nominated the book. Ms. Glickstein cited the recent passage of the Patient Protection and Affordable Care Act in emphasizing the importance that nursing plays in promoting the health of individuals and families.

The book includes content on a variety of topics including epigenetics, plasticity, genomics, social determinants of health, health disparities, health literacy, nursing informatics, biometric screening, telehealth, community-based participatory research, health screening tools, outcome evaluation, rural health promotion, neighborhood mapping, entrepreneurship, reminiscence therapy, mutual storytelling, street theater, photo-voice, and motivational interviewing. The nurse’s role in health promotion is emphasized by using a historical, theoretical and philosophical perspective. Advocating for and involving clients in their care, improving access to care and engaging in health policy work is critical if nurses are to have an expanding role and voice in the future of healthcare delivery. At no time in our history have social pressures, economic and environmental uncertainties, and the complexity of the healthcare delivery system posed more challenges to the health of individuals, families and communities than currently exist.

This book was written to encourage nurses to take on a leadership role in health promotion, disease prevention, and healthcare advocacy. Each chapter includes a “Check-Your-Understanding” section that encourages readers to complete critical thinking activities, evidence-based applications, matching exercises, fill-in-the-blank activities and a section titled “What-Do-You-Think” in which readers reflect on their views, engage in case studies, and apply content to their practice.



Bonnie Raingruber, RN, PhD



## IT'S HUDDLE TIME

In the beginning of 2013, surgical oncology (ONC) patients were routinely being admitted to Davis 12, primarily a vascular and surgical gastroenterology (SGI) unit. Dr. Khatri knew firsthand the benefits of daily huddle time, a gathering of all disciplines to discuss the patient plan of care and to prepare the patient for discharge. His service had been participating in daily huddles on D8 and he wanted to see that multidisciplinary collaboration continue for ONC patients on Davis 12. In order to successfully implement the huddle, nurses from D12 consulted with D8 nurses and observed the huddle process. Under the leadership of Nurse Manager Mary Lee-Fong, RN-C, MSN, NE-BC, AN II Melinda Breight, RN-C, BSN, D8 Clinical Nurse Specialist Patti Palmer, RN, MS, AOCNS and Dr. Khatri the huddle was successfully implemented in February 2013 for ONC patients.

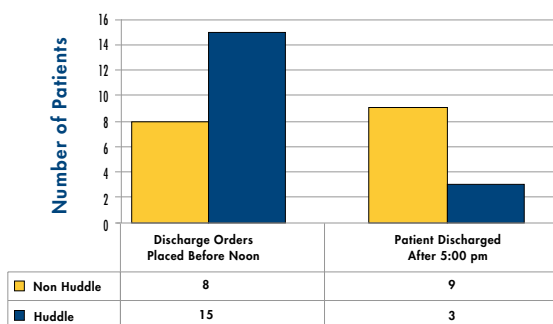
Davis 12 nurses immediately noticed improvements in collaboration and communication with the ONC service. Nurses found that their patient's discharge was a quicker smoother process and there didn't seem to be as many discharge issues compared to other services on D12. Nurses began tracking and analyzing discharge data on the ONC and surgical GI (SGI) patients. Data collected was the time orders were put into the computer by the physician to the actual time the patient was discharged. After 6 weeks and a group of 24 patients from both ONC and SGI services, data showed that the patients on the ONC service who had participated in huddle, had orders written in the computer earlier in the day and were also discharged much earlier than the SGI patients.

With the success of the ONC service huddle, the multidisciplinary huddle was being expanded to the SGI service. Similar data were being tracked and analyzed and physicians on the SGI service were interested to see if the huddle would have an impact on the discharge process. After six weeks, data showed that the SGI service had reduced its average discharge process from four hours to an amazing two and a half hours.

Although the data collected showed an impressive improvement, there was another noticeable benefit. The unit culture had changed on D12; collegial relationships had formed and the work environment had improved for all disciplines, which all leads to better patient outcomes. The huddle gave the opportunity for all disciplines to collaborate and be more efficient. Preliminary patient satisfaction results in early 2013 using Professional Research Consultants, Inc. (PRC) showed improvement in the following questions: Nursing Instructions/Explanations of Treatment/Tests, Doctor's Communication with Patient Family and Overall Team work between Doctors, Nurses, and Staff.

Davis 12 has recently implemented huddle for the vascular and gynecology service patients and will soon add the urology service patients.

IMPACT OF HUDDLE ON DISCHARGE PROCESS DAVIS 12

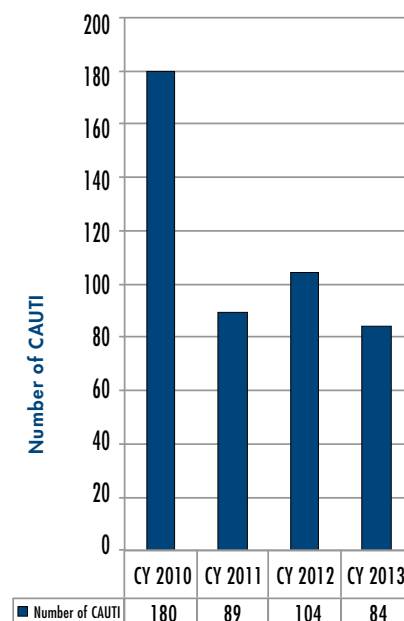


## CAUTI

The Catheter Associated Urinary Tract Infection (CAUTI) Committee, comprised of an interdisciplinary collaboration of physicians, nurses, and information technology (IT) professionals, identifies opportunities for improvement by reviewing evidence based practices, analyzing CAUTI related data, and utilizing process improvement methodologies (e.g. Plan-Do-Study-Act [PDSA] cycles and Lean Six Sigma process mapping). Goals for 2013 included: 1) CAUTI rates to outperform the mean of a nationally established benchmark as evidenced by greater than 51% of the reporting units outperforming at least 5 of the previous 8 calendar year quarters and 2) develop a maintenance bundle for management of urinary catheters.

To accomplish these goals, the following actions were taken: 1) documentation in the EHR was streamlined, 2) a CAUTI bundle was developed and is monitored via a daily report, 3) ongoing education for nurses and physicians occurs, and 4) the revised Policy and Procedure was approved and implemented. Plans for 2014 include expanding the ICU urine culture algorithm to the acute care units. The graph below depicts a downward trend in the number of CAUTI.

NUMBER OF CAUTI



Dr. Khatri and the ONC service during a huddle on Davis 12.



# SUCCESS OF PREVENTING VAP IN THE PEDIATRIC INTENSIVE CARE UNIT

Ventilator associated pneumonia (VAP) is a leading nosocomial infection that results in increased ventilator days, length of stay and cost of hospitalization. VAP rates hovered at four times the National Healthcare Safety Network benchmark (7.86 per 1000 ventilator days) in the Pediatric Intensive Care Unit (PICU) in 2010 despite a variety of initiatives to prevent these infections. Given the lack of success in VAP reduction, an interprofessional unit based team was recruited: Alyssa MacMurphy, RN, BSN, CN II, Amy Lorente, RN, MSN, CNS, Cheryl McBeth, RN, BSN, AN II, Eunice Butler, RN, MS, CN II, Jennifer Mattice, RN, MS, Q&S Champion, JoAnne Natale, MD, PhD, Medical Director PICU, Katherine Schulke, RN, BSN, CN III, Marie Goren, RN, BSN, Infection Prevention, Rosa Montes, RN, BSN, CN II and Vu Tran, RN, BSN, CN II. Through regular meetings, the team was able to assess the current practice and develop evidence-based VAP prevention bundles to create a clearly defined, easily performed, and age-specific PICU VAP Prevention Bundle. The bundle significantly impacted the delivery of safe, effective and efficient care by defining clear, concise measures which eliminated the variation in practice.

The PICU VAP prevention bundle consists of five elements:

- » Age-appropriate oral care
- » Proper suction technique
- » Maintenance of cuff pressures
- » Aspiration precautions
- » Head-of-bed elevation

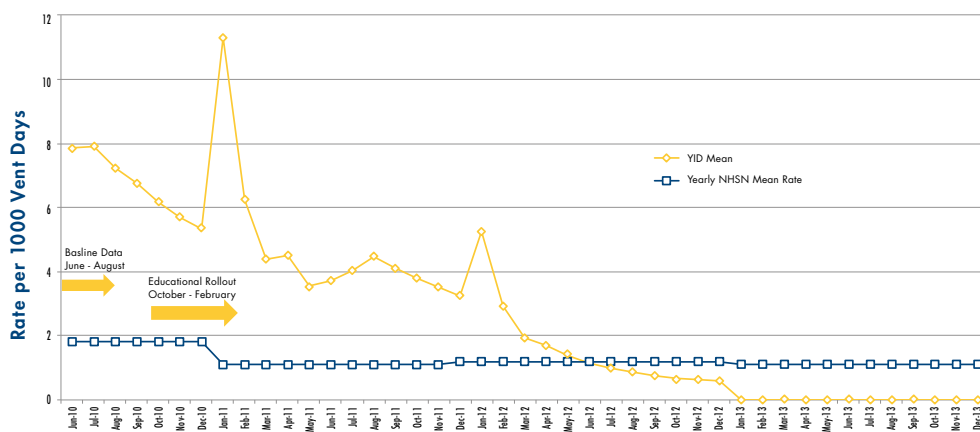
Once the PICU VAP Prevention Bundle was developed, a five-month education campaign began. This included an interprofessional staff in-service, posters, quizzes, and bedside signs reflecting one of the five specific elements. To monitor the compliance, weekly audits were completed by nurses on the VAP team. The bedside nurses embraced the bundle and their excellent care has resulted in improved patient outcomes.

Fifteen months after initiating the VAP bundle, the 2011 VAP rate declined by 47% to 3.25 per 1000 ventilator days. The significant reduction in the VAP rate demonstrated the effectiveness of the new standardized age specific oral hygiene products, bedside bundle prompt signs, and medication and nursing orders embedded in the ventilator order sets in the electronic medical records. Thirty months after initiating the PICU VAP Prevention Bundle, the rate has steadily declined to zero.

Bedside nurses have established a culture of excellent, safe, and quality care that incorporates VAP prevention as a priority. With the success in VAP reduction over the last three years, 15 potential VAPs have been prevented with an estimated cost

savings of 1.2 million dollars. To sustain compliance to meet unit and hospital goals, the VAP team was expanded into a No VAP Committee of seven pediatric interprofessional members. The education, monitoring, and auditing are ongoing and are continually adjusted to support the highest quality of care and the lowest VAP rate. The current VAP rate is zero but most noteworthy is the two years that the PICU has been VAP free. The nurses in the PICU take pride in their success of VAP prevention and celebrated with goodie bags, a lunch for day shift and a pizza party for night shift on the two year anniversary.

PICU VAP MEAN RATE COMPARED TO NHSN BENCHMARK



Pediatric VAP Team. Left to right back row: Rosa Montes, RN, BSN, Alyssa MacMurphy, RN, BSN, Katherine Schulke, RN, BSN, Cheryl McBeth, RN, BSN, Jennifer Mattice, RN, MS, and Eunice Butler, RN, MS

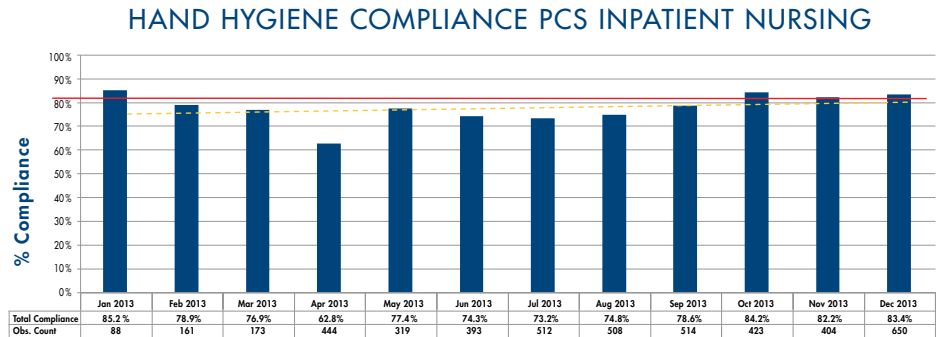
Left to right front row: Vu Tran, RN, BSN, Marie Goren, RN, BSN, and Amy Lorente, RN, MSN, CNS

# HAND HYGIENE

The Centers for Disease Control and Prevention (CDC) states that hand washing is the single most important procedure for preventing healthcare acquired infections. Per the CDC, an estimated two million patients get a hospital-related infection every year and 90,000 patients die from their infection.

How well do we wash our hands? Would you be surprised to know that in the fall of 2011 UC Davis Medical Center had an overall compliance rate of 40%? Since then, the hand hygiene project has been implemented, with the goal to decrease the rates of hospital acquired infections by increasing compliance with hand hygiene.

Under the guidance of the Central Line Acquired Blood Stream Infection (CLABSI) Prevention Committee, a goal of 80% compliance was set for all nursing areas. Using the Targeted Solutions Tool® developed by The Joint Commission, the hand hygiene project was rolled out in a step-by-step manner to all inpatient nursing areas. Each unit identified a group of staff who attended a two hour class to be trained as auditors and coaches for their own area. The goals for the training classes were to ensure that all auditors are monitoring to a uniform standard, as well as to raise awareness of



■ Total Compliance

appropriate hand hygiene performance. Trained staff members are asked to step in as “Just in Time” coaches any time they witness hand hygiene missed opportunities.

Most of the individual areas started with compliance rates in the 30-40% range. Within a few months of auditing and coaching, many areas saw great improvement. Overall, the inpatient nursing combined compliance has seen outstanding improvement, and the goal of 80% has been met for the last three months of 2013: October 84.2%, November 82.2% and December 83.2%. Aggregate nursing compliance, which includes both inpatient and participating outpatient areas, has also improved with rates in July 2013 of 61.9% to

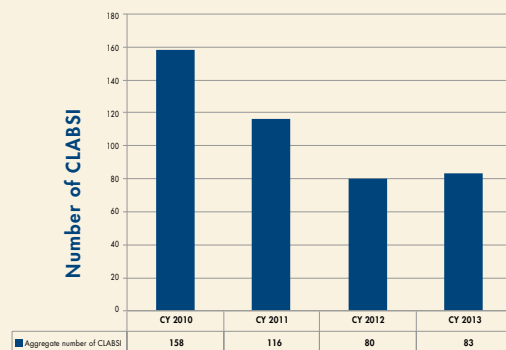


the December 2013 rate of 79.7%. The graph above shows RN aggregate data for Patient Care Services inpatient areas.

# CLABSI

The Central Line Associated Bloodstream Infection (CLABSI) Prevention project has been in place for many years. The current CLABSI committee merged with the expertise of the IV Resource Committee four years ago. In the time since the two groups have begun collaborating in earnest, many successful rapid cycles of improvement have been implemented with excellent results. Utilization of Swabcaps® continue and periodic usage audits, show high compliance and decreased CLABSI rates. The committee has been working on standardizing IV tubing set ups and are finalizing central line maintenance bundle and documentation for nurses and physicians. The IV Resource Committee, which has representation from all units, meets monthly to work on policies and education and also conducts monthly audits of line and dressing maintenance. The Hand Hygiene initiative, modeled after the Joint Commissions Targeted Solutions Tool®, was selected for the year-long Quality Fellows program. As such, the project co-leads have received individualized lean six sigma quality improvement mentoring over the past year. Inpatient RN compliance is above 85%, with whole-house/all provider compliance at 75%. The Hand Hygiene,

### AGGREGATE NUMBER OF CLABSI



CLABSI, and IV Resource Team all report to the PCS Quality and Safety Council and each maintains a project website where staff can go for additional resource information and performance data.

Through everyone’s diligence our CLABSI numbers and rates continue to decrease.

# Early Mobility

The Gordon and Betty Irene Moore Foundation awarded UC Davis Medical Center an ICU Awakening and Breathing Coordination, Delirium Monitoring, and Exercise/Early Mobility (ABCDE) Grant in 2011 with project go-live on April 3, 2012. This evidenced based practice intervention supports patients to be placed in a protocol that includes sedating patients less deeply when possible, frequently assessing them for pain and signs of delirium in addition to getting patients up and mobilizing early in the hospitalization to help rebuild their mental and physical health.



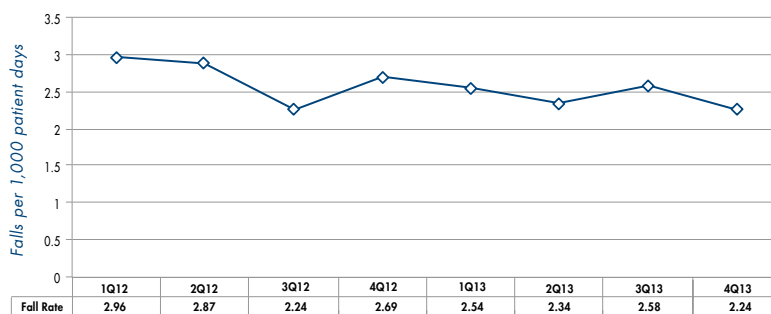
MICU patient shown above with members of the interdisciplinary team, benefits from early mobility interventions.

In 2013, all goals outlined by the Moore Foundation Grant were met as shown in the table below.

EARLY MOBILITY GOALS AND ACHIEVEMENT	
Moore Foundation Grant Goal	UC Davis Medical Center Achievement
2 day reduction in hospital-wide length of stay for patients admitted to an intervention unit	2.7 day reduction in hospital length of stay
10% reduction in ICU length of stay for patients admitted to an intervention unit	11% reduction in ICU length of stay
Implementation of the evidence-based practice ICU-ABCDE bundle intervention, incorporating management of delirium, sleep, sedation, and mobility, for at least 85% of ICU patients who meet the inclusion criteria	89% bundle compliance (D/E components)

Based on the successful implementation of the Early Mobility Program in the three intervention units (MICU, MSICU, and SICU), education and training of nurses, physical therapists, respiratory therapists, and lift team are currently underway with plans for hospital wide implementation of the Early Mobility Program by July 2014.

## UCDMC INPATIENT FALL RATE



# FALLS

Falls during hospitalization can lead to serious injuries and death. In addition to the physical suffering of patients, these injuries can have a substantial impact on hospitals. Increased financial costs and length of stay can result from a fall. Falls are reported to Collaborative Alliance for Nursing Outcomes (CALNOC) and National Database of Nursing Quality Indicators (NDNQI) for bench marking against other hospitals. In addition, Magnet requires organizations to outperform the national benchmark for falls the majority of the time.

In 2013, the fall rate ranged from 2.24 to 2.58 falls per 1,000 patients days. This represents a slightly decreased rate from 2012. In July 2013, UC Davis Medical Center received the CALNOC Award for Sustained Excellence for Achieving Best Performance in Reducing Injury Falls for two consecutive years.

Many of the unit based practice councils continue to focus on prevention of falls as a clinical indicator. Several interventions have been implemented or trialed in an attempt to decrease the fall rate on various inpatient units:

- » East 6 conducted a trial on the use of a yellow bedspread and socks to match the yellow wristband to increase identification to all staff of patients with a high fall risk.
- » D11/TNU trialed the “posey” bed alarm/ chair/ toilet alarm system. The feedback from the staff was the preference for larger bed alarm pads and also to remain in the bathroom or directly outside the door without distractions while the patient was in the bathroom.
- » D8/Oncology/BMTU has a trial in progress using a bed that acts as a bed alarm as well as monitors the movement patterns of the patient. By reviewing the normal patient movement patterns, the RN can offer toileting that corresponds to times the patient would normally be moving and therefore prevent falls.

The Center for the Professional Practice of Nursing (CPPN) offers an excellent class “Falls-Keeping Your Patient Safe”, this class continues to be well attended by staff. In spring 2014, a Fall Prevention Volunteer Program will be starting. The volunteers will make rounds on all inpatients that are designated with a high Morse fall risk score. They will observe the environment for potential fall risks and reinforce fall prevention and inventions with the patients and families. It takes a team to prevent falls!

# Hospital Acquired Pressure Ulcers

Pressure ulcers represent a major burden of illness and reduce the quality of life for patients and their caregivers. Multiple studies describe an increase in morbidity and mortality associated with pressure ulcers. Hospital readmissions, length of stay, and hospital charges are all greater in patients with pressure ulcers. The hospital stay for a single pressure ulcer may increase up to five-fold and charges may increase by \$2,000-11,000. Life-sustaining devices such as tracheostomy tubes, endotracheal tubes, ventilator masks, nasogastric tubes, oxygen tubing, and other such devices require the use of materials that tightly adhere to skin to prevent malfunction but these devices can also cause pressure ulcers to develop.

To further strengthen our robust wound care team, we have recruited nurses from the Emergency Department (ED), Operating Room (OR), and the Burn Intensive Care Unit (BICU) to act as champions for the identification and prevention of pressure ulcers in their clinical areas. We have introduced a best practices pathway for patients at risk of developing hospital acquired pressure ulcers (HAPU) during prolonged ED, OR, and BICU stays. Products to be used as prevention interventions are stored to allow easy access for nursing staff. In addition, the hospital policy specifies that nurses do not need a physician's order to implement these interventions to prevent pressure ulcers.

Additional system improvements include:

- » The wound team has further identified HAPU that have occurred due to devices. These devices have been fixed devices (ET tubes and tracheostomy tubes) as well as immobilization devices (casts and c-collars). The wound team collaborates with the nurses within the ICUs and orthopedic areas to assure device related pressure ulcer prevention measures are implemented.
- » A root-cause analysis is performed on every HAPU. This information is used to guide patient care in areas that have specific patient needs. For example, the wound team has met with the Pediatric Intensive Care Unit (PICU) to discuss wounds that occur on immobile patients who are on extracorporeal membrane oxygenation (ECMO) and Neuro ICU staff for patients who have prolonged use of a c-collar.
- » The wound team meets with the multidisciplinary wound team weekly to discuss patient nutrition, wound treatment and mobility issues of all patients who have experienced HAPU. All patients' with HAPUs are treated and educated by the wound team. On discharge the plastic surgeon (from the wound team), who is familiar with the patient, continues to treat the wound until the wound is closed. This transition of care has improved patient wound healing and patient satisfaction.
- » A list of all patients with pressure ulcers is generated weekly and sent to the wound team nurse practitioner for follow up. This EMR generated list is used to identify patients who need early intervention and patients who have previously been admitted for chronic pressure ulcers. This list is compared to

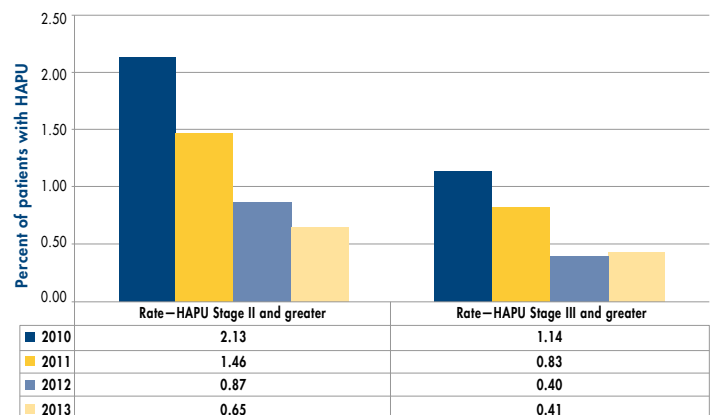


the hospital incident report list to assure early identification and treatment of all patients with pressure ulcers.

- » A wound website is available to all staff to guide decisions on pressure ulcer prevention products, education for staff and patients and for documentation guidelines for wound care. The wound website provides ease in access to patient education forms, forms for supplies to be delivered to the patient's home, and discharge information for printing.

Wound assessment and care is a highly specialized area of medicine; specialized training is needed to provide the tools to assess, treat, and document complicated wounds. Yet, the specialist is not available 24 hours a day. In this level I trauma center with 619 licensed beds, teaching all medical students, nurses and physicians best practices for prevention, identification and treatment of wounds was an immense job for the Skin Wound Assessment-Treatment team (SWA-T). The development of a wound website has aided in this education. These combined efforts have contributed to a significant year-over-year decrease in HAPU.

## HOSPITAL ACQUIRED PRESSURE ULCERS

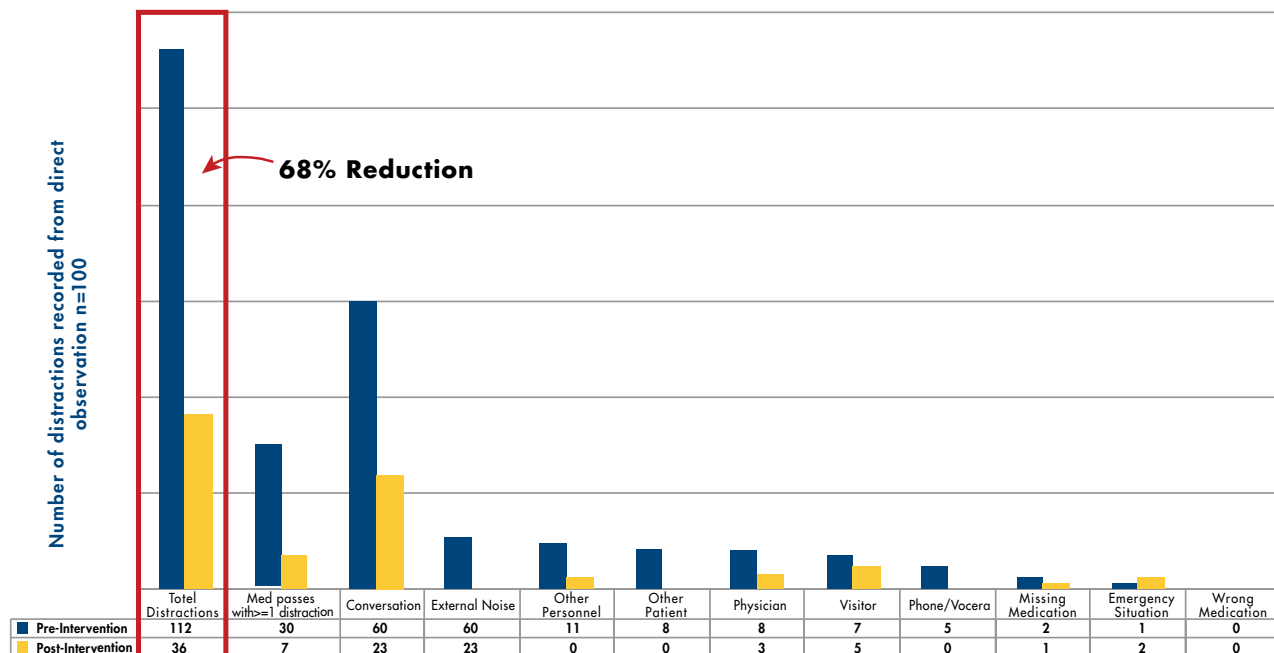


## Reducing Distractions during Medication Administration

After successful implementation of a pilot project aimed at reducing distractions during medication administration, a second pilot project was launched in the Post-Anesthesia Care Unit (PACU) in 2013. The implementation phase of this pilot included: education about distractions, placement of “Do Not Disturb” signage above the pyxis and medication preparation areas, red tape on the floor in the same areas to designate the “Quiet Zone”, a medication protocol checklist, and a post-it reminder on the pyxis machine with two new catch phrases; “No Talk in the Box” and “No Talk While You Walk”.

The post-intervention results showed a 68% reduction in distractions observed during the medication administration workflow. Staff surveys revealed that the education module was the most effective intervention followed by the red tape on the floor and the post-it catch phrase reminders. The least effective intervention identified was the “Do Not Disturb” poster which is currently being redesigned with staff input for the next target unit. The next target for this project will be the Children’s Hospital.

REDUCING DISTRACTIONS PILOT-PACU/CSC



## Patient Transfer and Admission Workgroup

The Patient Transfer and Admission Workgroup, part of the Clinical Practice Council, was formed at the end of 2012. Concerns from nurses throughout the organization were brought up at the Clinical Practice Council meetings regarding patient transfers and admissions occurring at change of shift. Staff nurses were recruited from the emergency department, post-anesthesia care unit, intensive care units, acute care units and ambulatory services to study this issue. The workgroup also included representatives from the Performance Excellence department, Patient Care Services department, Environmental Services, and Patient Escort.

The purpose of the workgroup was to analyze the timeliness of transfers and admissions to ensure prompt access for

patients to receive a bed assignment and to minimize the number of patient transfers and admissions that occurred during change of shift. The initial goal was that at least 50% of patient transfers and admissions would occur within one hour of receipt of the transfer or admission order and notification that the assigned bed was clean and available. The workgroup set out to characterize the reasons for admissions and transfers at change of shift, identify barriers to timely transfers and discharges, determine patient transfer duration, and state barriers to communication of patient needs.

The workgroup collected data using a questionnaire that asked nurses to characterize the reasons for transfer delays. Based on the questionnaire results, the

workgroup created a best practice reference list. This list includes recommendations for the sending unit and the receiving unit. The suggestions for the sending unit include developing a plan to transfer patients in a timely manner, having the nurse call report as soon as possible, not delaying the transfer or admission to perform tasks that can be done on the receiving unit, considering nursing staff availability to transport the patient to receiving unit, requesting expedited floor orders from responsible physician teams, and the use of patient handoff reports to give patient report. The recommendations for the receiving unit include immediate assignment of a nurse to the transferring patient, designating a nurse to receive report for transferring patient, picking up a patient from sending unit, and calling for early report.





# RESTRAINT REDUCTION IN THE ICU SETTING

From September 15, 2012 to January 15, 2013, the MSICU piloted an Institutional Review Board (IRB) approved study titled *Nurse Perceptions of the Restraint Decision Wheel and Restraint Use in the Medical Surgical ICU*. A major challenge for intensive care unit (ICU) nurses is balancing the need to prevent patients from removing therapeutic devices such as central lines, feeding tubes and endotracheal tubes, while meeting the federal regulations of the national accrediting standards of The Joint Commission (TJC) and the Centers for Medicare and Medicaid (CMS). Prior to the initiation of this study, it was found that the MSICU used restraints more frequently than the national average of like ICUs and the overall average for all adult critical care units. In an effort to create a change in perception on restraint use, and ultimately, a reduction in restraint use while maintaining patient safety, a pilot study was conducted.

The goals of the study were to evaluate if a decision support tool called the Restraint Decision Wheel would assist the bedside ICU nurse in making decisions to restrain or not to restrain a patient. Also, if restraint use could be reduced in the MSICU after the nurses received education on the use of restraints and have a decision algorithm (Restraint Decision Wheel) to assist them in deciding whether or not to restrain or to perform additional interventions and alternatives to prevent the patient from removing therapeutic devices. In addition, the use of restraints was to remain consistent with policies and procedures.

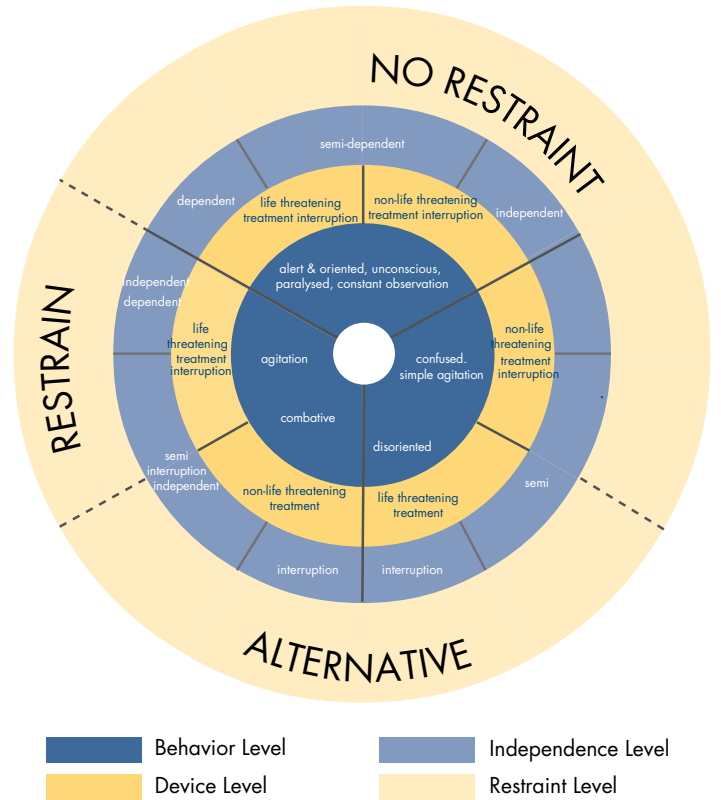
This study lasted for four months. Baseline data was collected and nurses participating in the project received education on the use of the Restraint Decision Wheel and current nursing policies and procedures of restraint use. Additional education was provided on a one-on-one basis to the staff as needed.

During month's two to four, the Restraint Decision Wheel was implemented into practice by participating nurses. At the end of the study the MSICU nurses were asked to complete a survey on their perceptions of restraint use. The survey addressed the nurses' perception on the need for restraints, and the effectiveness of the Restraint Decision Wheel, and monitoring and documentation.

During the course of the study there were no endotracheal tubes, chest tubes, gastrointestinal tubes, or ventriculostomy tubes dislodged by an unrestrained patient. The MSICU had a nearly 50% reduction in restraint use with patient census, patient acuity or ventilator days not having a significant effect on the use of restraints.

As a result of this study, the Restraint Decision Wheel was added to restraint policy IV-69 and a hospital-wide initiative to reduce the overall restraint use in the hospital has begun. A restraint

RESTRAINT DECISION WHEEL



**DIRECTIONS**

To aid in making a decision on the application of restraints, start with the inner circle to select the level of the patient's behavior. Next move outward to select the level of device the patient has. Then move outward to identify the patient's level of independence. These three levels provide support for the levels of restraint on the outer circle, no restraint, alternative prior to restraint, and immediate restraint.

committee has been formed and is charged with the responsibility to advance evidence-based practice by promoting the use of alternatives to restraints and when alternatives are ineffective, to monitor restraint utilization, documentation and safety. The committee's goals for 2014 are to reduce the overall restraint use in the hospital by 20% and to outperform the National Database of Nursing Quality Indicators (NDNQI) benchmark for five out of the last eight quarters.

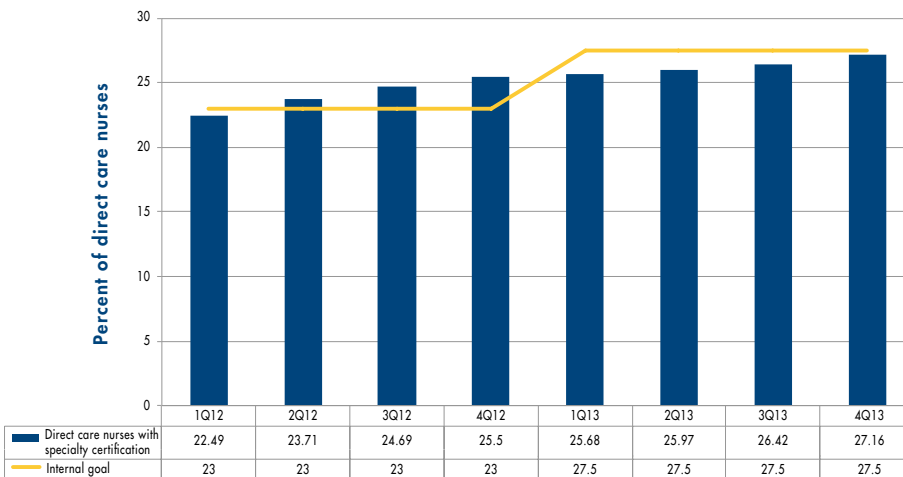
The Primary Investigator for this study was Stacy Hevener, RN, MSN, CCRN, AN II, MSICU. The co-investigators for the study are Barbara Rickabaugh, RN, MSN, NE-BC, Center for Nursing Research and Toby Marsh, RN, MSN, MSA, FACHE, NEA-BC, Directors of Hospitals and Clinics.

## Nursing Specialty Certification

Nurses achieve specialty certification credentials by obtaining; specialized education, experience in a specialty area, and passing a board certified exam. Specialty certification holds numerous benefits, not only for the nurse, but for the patients and their families. Patients and families expect knowledgeable and competent nurses to care for 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. More importantly, specialty certification contributes to better patient care.

UC Davis Medical Center encourages nurses to obtain specialty certification with rewards and recognition provided through a specialty certification differential.

### DIRECT CARE NURSES WITH SPECIALTY CERTIFICATION



### THE TEN MOST COMMON NURSING SPECIALTY CERTIFICATIONS OBTAINED AT UC DAVIS MEDICAL CENTER:

- Critical Care, CCRN
- Oncology Nurse, OCN
- Medical–Surgical Nurse, CMSRN
- Perioperative Nurse, CNOR
- Neonatal Intensive Care Nurse, RNC-NIC
- Inpatient Obstetric Nurse, RNC-OB
- Pediatric Nurse, CPN
- Orthopedic Nurse, ONC
- Family Nurse Practitioner, FNP-BC
- Progressive Care Nurse, PCCN

## SPECIALTY CERTIFICATION FOR ONCOLOGY NURSES

The UC Davis Cancer Center is one of 41 cancer centers designated by the National Cancer Institute (NCI) as a Comprehensive Cancer Center in the United States. It is the only NCI designated center serving the Central Valley and Inland Northern California, a region of more than six million people. The UC Davis Comprehensive Cancer Center (UCDCCC) is surveyed every three years by the American College of Surgeons and Commission on Cancer to ensure practice standards are met, and accreditation is continued.

For the most recent survey cycle a new nursing care standard was introduced which requires that oncology nursing care be provided by nurses with specialty knowledge and skills and that competency is evaluated annually. Nursing Standard 2.2 also specifically looks at the number of trained chemotherapy nurses and the percentage of nurses who have specialty oncology nursing certification (OCN). At the October 2013 survey the UCDCCC received commendation (a 1+ rating) for the nursing care standard achieving over 30% oncology specialty certification, having a process to assess competency, and ensuring oncology nurses have the knowledge and skills needed to give excellent patient care to cancer patients.

The mission of UCDCCC is to break barriers to beat cancer throughout the region, the nation and the world through evidence-based practice, patient-centered care, and by improving outcomes through research, education, prevention and the reduction of cancer health disparities. One of the focus areas is to educate new generations of cancer professionals.

In 2013, 33% of UC Davis oncology nurses had obtained OCN certification. The Adult Infusion Center nurses achieved 65% certification, the Pediatric Infusion Center nurses reached 90% certification, the Outpatient Oncology Clinic nurses achieved 31% certification, and D8 Hematology/BMT nurses achieved 20% OCN certification. This achievement is not only important to the mission of the UCDCCC but also speaks to the dedication of the nursing staff. We expect these numbers to grow in 2014 as more oncology nurses set the goal to become specialty certified.

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- Zrelak P.A., Romano P.S., Tancredi D.J., Geppert J.J., Utter G.H. (2013). Validity of the AHRQ Patient Safety Indicator for Postoperative Physiologic and Metabolic Derangement Based on a National Sample of Medical Records. *Medical Care*, Sept;51(9):806-11. doi: 10.1097/MLR.0b013e31829c8b91
- Zrelak P.A., Tancredi D.J., Utter G.H., Grogan L., Cuny J. & Romano P.S. (2013). How accurate is the AHRQ patient safety indicator for hospital-acquired pressure ulcer in a national sample of records? *Journal of Healthcare Quality*, Oct 1. doi: 10.1111/jhq.12052.
- Zrelak P.A., Utter G.H., Sadeghi B., Cuny J., Baron R., & Romano P.S. (2013). Using the Agency for Healthcare Research and Quality patient safety indicators for targeting nursing quality improvement. *Journal of Nursing Administration*, 43(10):S51-60.

## STOP THE REFLUX: AN UPDATE ON TREATMENT FOR SYMPTOMATIC VARICOSE VEINS

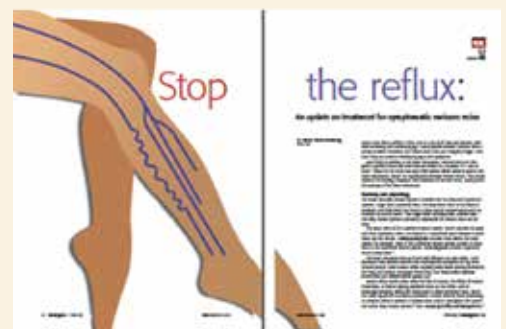
by *Kristen Armstrong, RN, BSN*

When I came to UC Davis in 2007, I would have never believed that I would one day write a manuscript let alone have it published with continuing education units



(CEUs) attached to it. When I came to the vascular center, I was so surprised how often the doctors published articles. Since developing the vein program and learning more about the treatment for venous disease, I realized how complex the disease is. I am an avid reader of *Nursing* 2013, now *Nursing* 2014 and have never read anything about venous disease. I realized how little health care professionals actually knew about it.

Our doctors that run the vein program really encouraged me and were eager to help me get started. I didn't want to take all their time so I started at ground zero by reading the small print in the back of the magazine that listed the contact information for writers. While traveling down the path to publication, I frequently asked the vascular staff to help



me understand the language that I had never heard before. Being that I was new to all this, I was also so impressed with how supportive the editors at the magazine were. I expected them to not want to bother with an inexperienced writer. I must have pinched myself 100 times before I could believe the journal accepted my article. It was a two year process but very exciting. Because it was such a nice experience, I am considering writing another.

## PRESENTATIONS

PRESENTER	DEPARTMENT	TITLE	CONFERENCE	CONFERENCE LOCATION
David D. Rose, CRNA, PhD	Anesthesia	Podium: Functional Hemodynamic Monitoring and Minimally Invasive Monitor	Hawaii Association of Nurse Anesthetists, February 8-10	Honolulu, HI
Debra Burgess, RN, BSN, MHA	Quality and Safety Department	Podium: Improving Glycemic Control in Cardiac Surgery	United Healthcare Quality Series, February 27	National Webinar
Kathleen Guiney, RN, MN, MS	CPPN	Podium: Developing Nurse Managers Through Competency Based Informatics Education	Health Information Systems Management Society 13th Annual Conference and Exhibition, March 3-7	New Orleans, LA
Debra Burgess, RN, BSN, MHA	Quality and Safety Department	Poster: Improving Glycemic Control in Cardiac Surgery	UC Davis Health System's Annual Integrating Quality Symposium, March 12	Sacramento, CA
Catherine Adamson, RN, BSN, and Linda Cooke, RN, BSN, CCRN	Quality and Safety Department	Poster: Ventilator Associated Pneumonia: A Lean Six Sigma Tiger Team Approach to the Collection of High-Quality Respiratory Culture Samples	UC Davis Health System's Annual Integrating Quality Symposium, March 12 AND Association for Professionals in Infection Control and Epidemiology Annual Conference, June 8-10	Fort Lauderdale, FL  Sacramento, CA
Maile Mauer, RN	Quality and Safety Department	Poster: Hand Hygiene: Breaking Down Barriers to Compliance	UC Davis Health System's Annual Integrating Quality Symposium,	Indianapolis, IN
Marilea Higdon, RN, CCRN	Quality and Safety Department	Poster: Quality and Safety RN Champion Role	UC Davis Health System's Annual Integrating Quality Symposium, March 12	Sacramento, CA
Miguel Medina, RN, BSN, and Charles Johnston, RN, MS	Quality and Safety Department	Podium: The Ventilator Associated Pneumonia (VAP) Bundle in the Cardio-Thoracic Intensive Care Unit (CTICU): A Retrospective Evaluation of a Quality and Safety Initiative at UC Davis Medical Center	UC Davis Health System's Annual Integrating Quality Symposium, March 12	Sacramento, CA
Kimiko McCulloch, RN-BC, MSN, and Meredith Hansen, RN, MSN	Trauma Nursing Unit	Podium: Improving RN Retention through peer mentorship	King International Nursing Group Conference, April 5-6	Bennington, VT

## PRESENTATIONS

PRESENTER	DEPARTMENT	TITLE	CONFERENCE	CONFERENCE LOCATION
Amy Doroy, RN, MS	MICU	Poster: Early Mobility in the ICU: Changing Unit Culture and Improving Patient Outcomes	Western Institute of Nursing, April 9-12	Anaheim, CA
Kay Harse, RN, MS, AOCN, Terri Wolf, RN, MS, OCN, and Scott Christensen, MD	Cancer Care Network	Poster: Leveraging the strengths of an academic health system to improve community cancer care	2nd annual Oncology Nursing Society Congress, April 26	Washington, DC
Charles Johnston, RN, MS, and Soman Sen, MD	Quality and Safety Department	Podium: Do Ventilator Associated Prevention Bundles Work in Burn Intensive Care Units?	American Burn Association Annual Meeting, April 23-26	Palm Springs, CA
Terri Wolf, RN, MS, OCN, Kay Harse, RN, MS, AOCN, Patricia Palmer, RN, MS, AOCNS, Wilson Yen, RN, MSN, NE-BC, and Anne Beatie, RN, BSN, OCN	Cancer Care Network	Poster: Using ONS Pillars to Develop a Multi-Dimensional Approach to Quality Community Oncology Nursing Care	Oncology Nursing Society Congress, April 25-28	Washington, DC
Terri Wolf, RN, MS, OCN	Cancer Care Network	Podium: Men's experiences of head and neck cancer: Role disruption, identify changes and illness work	38th Annual Oncology Nursing Society Congress, April 26	Washington, DC
Shelley Bloom, RN, MSN, PNP	PICU	Podium: Nurse Practitioners Improve Health Care Quality in Rural Nepal	Sigma Theta Tau Spring Education Conference, April 28	Savannah, GA
Larisa Kuzmenko, RN, WCC, Oleg Teleten, RN, MS, WCC, and Holly Kirkland-Walsh, MSN, FNPc, GNPc, CWCN	Patient Care Resources	Podium and Poster: eWound Care Specialist	Symposium on Advanced Wound Care, May 1-5	Denver, CO
Ron Ordonez, RN, MSN	Patient Care Services	Poster: Fixed it: Preventing device related pressure ulcers at UCDCM	Symposium on Advanced Wound Care, May 1-5	Denver, CO
Charles Johnston, RN, MS	Quality and Safety Department	Poster: The Effect of Quality and Safety Nurse Champions in the Prevention of Ventilator Associated Pneumonia (VAP)	National Patient Safety Foundation Annual Patient Safety Congress, May 8-10	New Orleans, LA
Maile Maurer, RN, and Marilea Higdon, RN, CCRN	Quality and Safety Department	Poster: Nurse Champion, Benefits of Change Agents at the Bedside	American Association of Critical-Care Nurses' National Teaching Institute and Critical Care Exposition, May 18-23	Boston, MA

PRESENTER	DEPARTMENT	TITLE	CONFERENCE	CONFERENCE LOCATION
Virpal Donley, RN, BSN, and Sherri Reese, RN, BSN, CIC	PICU and Infection Prevention/Hospital Epidemiology	Poster: Vigilance and CLABSI Rates	American Association of Critical-Care Nurses' National Teaching Institute and Critical Care Exposition, May 18-23	Boston, MA
Amy Doroy, RN, MS	MICU	Poster: Early Mobility in the ICU: Changing Unit Culture and Improving Patient Outcomes	American Association of Critical-Care Nurses' National Teaching Institute & Critical Care Exposition, May 18-23	Boston, MA
Elvira Balinsat RN, BSN, CRNI, Jessica Dalziel, RN, BSN, MICN, and James Hill, RN-BC, MSN	Emergency Department	Poster: Reducing Blood Culture Contamination Rates in the Emergency Department	National Infusion Nurses Society Conference, May 20-22	Charlottesville, NC
Sandra Ellingson, DNP, NNICUNP, Kimberly LaBronte, PhD, NNP, and Mary Wyckoff, PhD, NNP	NICU	Podium: The Lived Experience of Iatrogenic Sequelae	National Neonatal Advance Practice Nursing Forum, May 29-June 1	Washington, DC
Mary Manaloto, RN, MS, Chris McKinney, RN, BSN, and Jan Shepard, RN, BSN	Quality and Safety Department	Poster: Focus on Sepsis-The Role of Quality and Safety Nurse Champions	UC Davis Health System's Annual Integrating Quality Symposium, March 12 AND Quality and Safety Education for Nurses National Forum, May 30-31	Sacramento, CA  Atlanta, GA
Carolyn Cook, RN, MSN, Mandy Williams, RN, BSN, and Helena Veerkamp, WHNP-BC	Women's Pavilion	Poster: Implementing an Obstetric Triage Nurse Competency Program	2013 Association of Women's Health, Obstetric, and Neonatal Nurses Conference, June 15-19	Nashville, TN
Amy Kuzmich, RN, CPNP, MS, Angelina Luper, RN, BSN, and Jessica Yen, RN, BSN	Pediatrics D7	Poster: Outperforming the CLABSI Benchmark: A Multifactorial Approach to Changing the Culture on a Pediatric Unit	Pediatric Nursing 29th Annual Conference, July 11-13	Philadelphia, PA
Karrin Dunbar, RN, BSN, MSc	CPPN	Podium: Sepsis and Technology-Incorporating Simulation and the EMR in Clinical Education	2013 Health Information Technology Summit, July 22-23	Denver, CO
Kathy Tong, MD, Sharon Myers, RN, MA, Patricia Poole, PharmD, Jennifer Nguyen, PharmD, Erin Griffin, PhD, and Bridget Levich, RN, MSN	Heart Center	Poster: A Multidisciplinary Approach at the Primary Care Level Improves Heart Failure Care	Heart Failure and Stroke Association, September 22	Orlando, FL

## PRESENTATIONS

PRESENTER	DEPARTMENT	TITLE	CONFERENCE	CONFERENCE LOCATION
Maile Mauer, RN	Quality and Safety Department	Poster: Lean and Six Sigma to Reduce Ventilator Associated Pneumonia	National Association for Healthcare Quality Annual Educational Conference, October 6-9	Louisville, KY
Cathy Adamson, RN, BSN	Quality and Safety Department	Poster: Breaking Down Silos in Healthcare: Quality and Safety Nurse Champions	National Association for Healthcare Quality Annual Educational Conference, October 6-9	Louisville, KY
Roxann Moritz, RN, Laurie Vazquez, FNP, and Nicole Hansen, RN, MSN	Clinical Research Center VA Medical Center	Poster: Focused Assessment Guides	2013 International Association of Clinical Research Nurses, October 19-24	San Diego, CA
Anne Fekete, RN, Laurie Vazquez, FNP, and Nicole Hansen, RN, MSN	Clinical Research Center VA Medical Center	Poster: Assuming New Roles in Research-A Journey of Enlightenment and Lessons Learned	2013 International Association of Clinical Research Nurses, October 19-24	San Diego, CA
Judy Yamasaki, RN, BSN, CBN, and E. Souza, MPH, RD	Bariatric Surgery Clinic	Poster: Novel Approach to Adjustable Band Success: maximum lifestyle modifications with minimal band adjustments	American Society of Metabolic and Bariatric Surgery, November 11-16	Atlanta, GA
Kay Harse, RN, MS, AOCN, Terri Wolf, RN, MS, OCN, and Scott Christensen, MD	Cancer Care Network	Poster: Leveraging the Strengths of an Academic Health System to Improve Community Cancer Care	2nd Annual American Society of Clinical Oncology Quality Symposium,	San Antonio, TX





# Betty Irene Moore School of Nursing Continues to Grow

The Betty Irene Moore School of Nursing at UC Davis is currently in the midst of a period of tremendous growth; in size, breadth, depth, reach, collaboration and impact. The growth is along several fronts, including education and research.

Last summer, the school welcomed its first nurse practitioner and physician assistant master's-degree students. For the first time, these clinically focused programs extend the school's offerings into the direct care arena; preparing clinicians, with an emphasis on primary care in underserved and rural areas. The nurse practitioner and physician assistant programs are combined programs, and the students are integrated with medical students in their learning. Through this vital program, the school further realizes its commitment to interprofessional education as it prepares the clinicians of tomorrow.

This spring, the inaugural class of eight Doctor of Philosophy students is expected to graduate. The eight men and women represent diverse backgrounds and experiences and include informatics experts, clinical managers, rural nursing educators, nurses with area health systems and two UC Davis nurses, Lori Madden and Sheridan Miyamoto.

School leaders are vigorously developing plans for a new program to prepare new nurses. From the earliest days of the partnership, UC Davis and the Gordon and Betty Moore Foundation agreed this innovative new nursing school should prepare nurses at all levels, including an entry-level program to prepare nurses for the future.

Over the past year, faculty completed a feasibility study examining the needs in the nursing workforce, national trends in education, and a market analysis, all in collaboration with our regional and national advisers.

The faculty of the Nursing Science and Health-Care Leadership Graduate Group, who lead the graduate programs, are also developing plans to offer the Master's Entry Program in Nursing. This is an accelerated educational program designed for those who earned a bachelor's degree, or higher, in a field other than nursing and also completed nursing prerequisite courses. The 18-month program combines the coursework and clinical experience necessary for the registered nursing license. Graduates earn a Master of Science in Nursing degree and are eligible to complete the national registered nurse licensing exam.

Beyond the growth of the educational offerings, the school's partnerships and collaborations continue to flourish. These relationships are essential to both research and education programs at UC Davis.

Partnerships within UC Davis Health System and UC Davis are thriving as nursing faculty develop the school's research programs, contributing the nursing-science perspective to the study of society's greatest health problems. Each nursing faculty member participates in at least one or more research projects involving not only multiple health professions but other disciplines, such as engineering and nutritional biology. One area of particular focus is a collaboration with the UC Davis Cancer Care Coordination Research Group, an interprofessional team of experts, both researchers and care providers, who aim to improve the quality and costs of care for cancer patients and their families. The vision is to better the full spectrum of the family's care experience, each step along the way.

**Left to right:**

*Susan Edwards, RN, NSICU, Lori Madden, UC Davis nurse practitioner, Jaclyn Montano, RN, BSN, NSICU. Lori is one of two UC Davis Health System nurses who anticipate receiving their Ph.D. degrees from the Betty Irene Moore School of Nursing this spring.*



## MEDICAL MISSIONS

### POP WUJ, GUATEMALA

by Christine Sitts, RN, BSN

This past July I spent three weeks volunteering and learning medical Spanish in Xela, Guatemala. Pop Wuj is a non-profit organization founded by locals who identified multiple needs within their community. Pop Wuj currently manages a stationary clinic, mobile clinic, sustainable community development program, family support center, reforestation program, safe stove project, child nutrition program, and scholarship project to name a few. Pop Wuj is also a Spanish school offering people an opportunity to immerse in the local community and culture.

Pop Wuj is always in need of medical supplies. I was able to obtain items from a non-profit organization called MedShare that recovers medical supplies from hospitals that otherwise would be thrown away. Many hospitals, including UC Davis, currently have a medical supply recovery program that facilitates diversion of such supplies, preventing landfill waste and helping those in need. It was extremely rewarding to bring these supplies all the way from California. Working as a nurse at the bedside I see how much we throw away. One day I hope to see a MedShare collection bin in every unit as we are throwing away many supplies that could be utilized abroad.

At Pop Wuj I participated in the medical program which included volunteering in the stationary clinic, mobile clinic, home-stay with a local family, and Spanish lessons.



The clinic opened at eight in the morning, however there would be a line of patients before 6:00 am. Patients traveled far by bus to receive much needed medical treatment. Common diagnoses treated include those associated with not having access to clean water, such as various parasites and infections, respiratory infections, diabetes, heart disease, skin infections, and malnutrition are among the other common treated conditions in Guatemala.

In the stationary clinic I would triage, consult, prepare prescriptions, and provide patient education. The mobile clinic rotates among various remote communities that would not have access to medical care otherwise. A challenging aspect was that many patients only spoke a form of Mayan. Often, physicians trained in Guatemala have a difficult time interpreting as multiple dialects exist within the Mayan language family. Also, many of these patients implement alternative therapies and have varying approaches to healing. This had to be taken into account as this affected the way patients described their symptoms.

During my free time at Pop Wuj I was also able to participate in ongoing community projects including building stoves for families who cook with open fires indoors. The Safe Stove Project builds free covered stoves that funnel smoke outside the cooking area which prevents many respiratory issues that affect children and adults. These stoves are also 50% more efficient which decreases cost to families and prevents deforestation.

*Left Photo: Safe Stove Project – on the left are stoves typically seen in Guatemala, on the right are stoves that were built by the Safe Stove Project. Funneled stoves help prevent respiratory issues.*

*Right Photo: A three year old Zimbabwe child admires his cleft lip repair on postoperative day two. Children in the United States typically have their cleft lips repaired as infants. Children in Zimbabwe only have an opportunity for surgery when a group such as Operation of Hope participates in a volunteer medical mission.*

### ZIMBABWE

by Joleen Lonigan, RN, MSN, NE-BC

In August three UC Davis Medical Center employees volunteered for a surgical medical mission in Zimbabwe with a non-profit organization called Operation of Hope. Travis T. Tollefson, MD, MPH, FACS, Associate Professor in the Plastics and Reconstructive Surgery Department is the Medical Director of Operation of Hope. This was his 13th medical mission trip to Zimbabwe, where his focus is on the repair of cleft lips and palates in children. Dr. Tollefson brings a different resident on each medical mission and recruits pediatric nurses. Last year Shannon Poti, MD participated as a surgeon and Joleen Lonigan, RN, MSN, NE-BC joined the team to offer direct nursing support of patients pre-operatively and post-operatively. Joleen is a returning volunteer making the August 2013 trip her third volunteer trip with Operation of Hope.

The medical mission extended over nine days, two days were for preparation, one day of medical screening, five days of surgery and one final clean-up day. Over 200 hundred patients were seen on screening day by the team of 14 volunteers. The team consisted of three surgeons, one pediatrician, one anesthesiologist, two nurse anesthetist's, four nurses and several non-medical volunteers. Forty two patients received free cleft lip or palate surgery and post-operative nursing care at Harare Central Hospital. Patients that were unable to receive surgery were offered an opportunity to return in April 2014 when the organization would return for another medical mission. Typically, Operation of Hope participates in two volunteer surgical medical missions to Zimbabwe a year.



# MSICU NURSES VOLUNTEER IN HAITI

by Stacy Hevener, RN, MSN, CCRN

In September I had the opportunity to volunteer through Project Medi-Share and spent seven days in Port-a-Prince, Haiti at Hospital Bernard Mevs. Besides myself and my co-worker, Sally Drennon, there were nurses from the United States, Canada, and England. We also had the pleasure to work with a physician assistant, and physicians from the United States, Canada and Tasmania.

I went with the purpose to provide education and assist in any way possible. We were told that we had to be flexible and might be required to work in areas we were not as familiar with, so I was also intrigued by the challenge to be offered. With that being said, I was very nervous about where I would be working, and was afraid that I would not be of much use. However, I quickly discovered that it was an “all hands on deck” approach to take care of patients coming into the ED, and the ICU, and this included the pediatric ICU as well.

The differences in patient care standards and resources between the hospitals in the US and Haiti are astounding and difficult to describe. This hospital is the country's only critical care and trauma hospital and has the only newborn and pediatric intensive care units for the sickest premature infants and children. It also is the center for multiple rural community health clinics, and is a major cholera treatment facility with the nation's most advanced prosthetics facility. With all this hospital



Front row right: Sally Drennon, RN, BSN being held by Stacy Hevener, RN, MSN both of T7 MSICU, along with other members of Project Medi-Share.

has to offer, they are chronically and critically short of resources from portable suction and suction canisters to gloves, linens and cleaning supplies. Medications are difficult to obtain so patients are often under medicated, supplies are often not cleaned between patient use, and the families of the patients are responsible for supplying their loved ones with food, linens and basic essentials.

During our one week medical mission, we worked in unbelievable conditions. The heat and humidity were unbearable, the spaces cramped, and there were significant language barriers. By the end of the week I was exhausted, but very satisfied that I was able to contribute to the health and well-being of both adults and pediatric patients that I helped to care for. Providing essential cultural knowledge and translating when needed, the Haitian staff was amazing to work with. This was a very rewarding and challenging experience.

## NICARAGUA

by Craig Ackerman, RN

Last year found me on my way to Nicaragua for a three week mission trip to visit my daughter who was volunteering for nine months in a jungle clinic. I was warned that there were few amenities. There was no running water or electricity. Water was saved during the downpours by routing into cisterns to use during dry spells for cooking and bathing. We only cooked two meals a day because it took so much time to cook our food and then clean up. No microwaves or ovens. Beans were cooked over an open fire. Outhouses (thunder holes) had to be checked before using for any poisonous snakes and to scare the cockroaches away. We washed our clothes down at the stream beating the clothes on the rocks.

Down around the equator, the sun rises and sets about 6am/6pm year round so bedtime came early since the batteries didn't support the light bulbs too long. Communication was by ham radio. It was pretty austere but

after a few days, I adapted. I did experience a couple days of technology withdrawal since I was hours away from any signal. No Facebook or email!

My first ten days there was spent visiting neighboring villages 3-15 miles away. We traveled in a flatbed 2 ½ ton 1964 Army truck from Viet Nam. Here in the states, it would have been junked forty years ago but it is a prized commodity there. Our team worked at small clinics giving immunizations to the children and well-baby check-ups. Parents are starting to accept the idea that vaccinations might be a good thing for their children. Many still resort to the traditional healer when a member of their family is ill. My daughter experienced this first hand. She was called out with another nurse to see a sick newborn. The baby and mother had sticks, twigs, mud, and poultices all over their bodies. They transported the baby two hours by jeep to the nearest hospital for antibiotics. A few days later the parents came and took the baby home against the doctor's advice. They wanted the traditional healer to treat the baby instead.

A few days later, my daughter visited the family again just hours before the baby died. She was pretty devastated.

During this time, we also had several men come in with machete wound, infections and punctures from sticks and various other illnesses. The machete is the people's most “high tech” tool.

The last week I was there, they needed two foundations poured for new elementary school rooms. Not too hard to do until I realized that we had to go to the river and dig our own sand and gravel to mix with the concrete. That took several days getting our supplies prepared. Nothing is easy or happens quickly in these situations. When we mixed the concrete by shovel, we had to pull our water up from the well by hand in five gallon buckets. It was a good reminder of how fortunate I am to be living in the U.S. We take so much for granted. When I feel like complaining about circumstances in life, my mind goes back to what the people in Nicaragua are dealing with every day.

# HIV/AIDS FIELD CARE FOR THE HEALTH CARE PROVIDER (UGANDA SUPPORT MISSION)

by Christine Pineda, RN, MSN

In January a medical team of nurses from: T3/Women's Pavilion, D3/Labor & Delivery, Emergency Department, and T8/Transplant along with a nurse practitioner, pharmacists, a physician, a physician assistant and others set out for Kaihura, Uganda on a medical mission in partnership with a non-government organization (NGO) and the people of Kaihura. The objectives of the medical mission were to assess, evaluate, and demonstrate evidence based practice care of new and ongoing HIV patients from different cultures.

Alecia Hanson, RN, MSN, currently a CN II on T3/Women's Pavilion started the Uganda Support Mission project in 2010 as a MSN nursing student at UCLA and has since led several teams to Uganda. 2013 marked Alecia's 6th medical mission to Uganda.

With the support of Christina Pineda, RN, MSN, Gail Easter, RN, MSN, NEA-BC and Carol Robinson, RN, MPA, FAAN, NEA-BC, Alecia developed a paid leave course; HIV/AIDS Field Care for the Health Care Provider, through the Center for Professional Practice of Nursing (CPPN).

Diseases such as HIV, malaria, syphilis and typhoid are still major concerns in Uganda. Much of the time was spent testing, treating and educating of these diseases as well as prevention and education of other diseases. Visits were conducted in remote homes, clinics, schools, churches and a prison. Better operational strategies were also implemented in clinics to improve efficiency. Below is a table of diseases that were identified and allowed for treatment to be started.

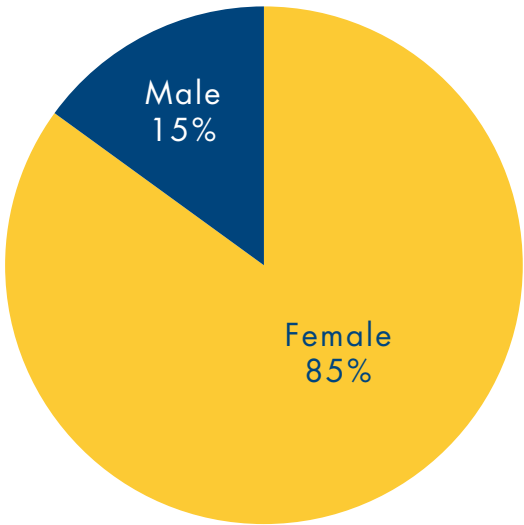
Kaihura Outreach 2013									
Outreach Day	Patients seen	HIV tested	Positive HIV	Malaria tested	Positive Malaria	Syphilis tested	Positive Syphilis	Typhoid tested	Positive Typhoid
Kaihura Day 1	207	81	2	59	8	31	0	9	2
Kaihura Day 2	240	56	4	40	9	34	0	9	2
Nyamba	175	118	3	33	9	20	2	13	2
Butiti	174	72	11	14	2	2	2	0	0
Total	786	327	20	146	28	107	4	31	6



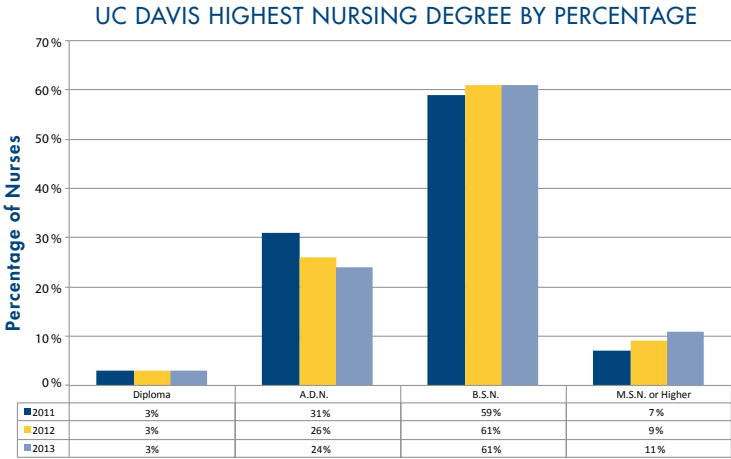
Left to right, back row: Rich DiBella (PA)\*, Nick Nowak (Pharm D)\*, Kat Haight (Pharm D), Mariah Teeter (EMT)\*, Carolyn Cook (D3/T3-AN2), Pamela Mendoza (Pharm D), Peg Freitag (ED-CN2), Dr. Deb Adey (Transplant Nephrology), Alecia Hanson, (T3-CN2), John-Paul Farsight (Construction Manager)\*, Cheryl Patzer (T8-AN2), Katie Sasser (NGO representative). Front row: Larissa Krichun (L&D- CN2), Joy Vongspanich (Pharm D), Chris Pineda (T8-NM) and Karen Natsuhara (Transplant NP). \*Non UCD employees

# NURSES BY NUMBERS

## UC Davis Health System Nurses Gender

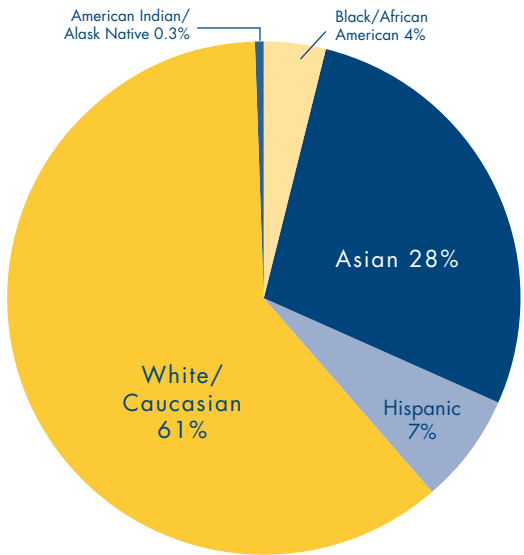


## Overall RN Degrees

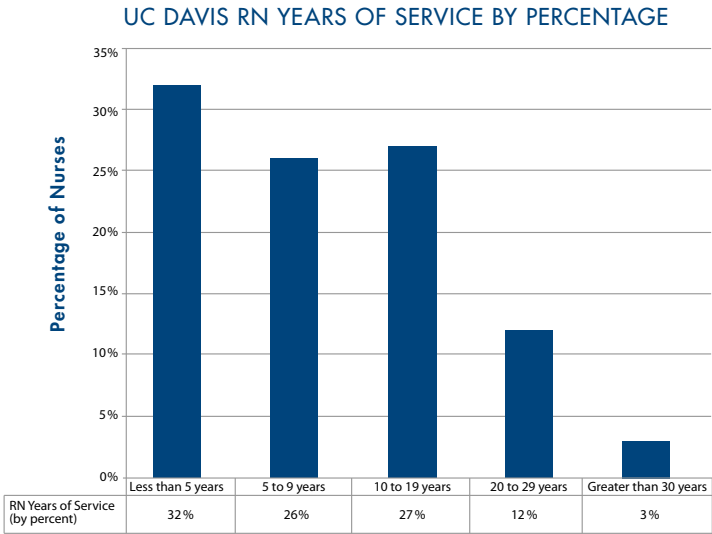


**43** Average Age of UC Davis Nurse

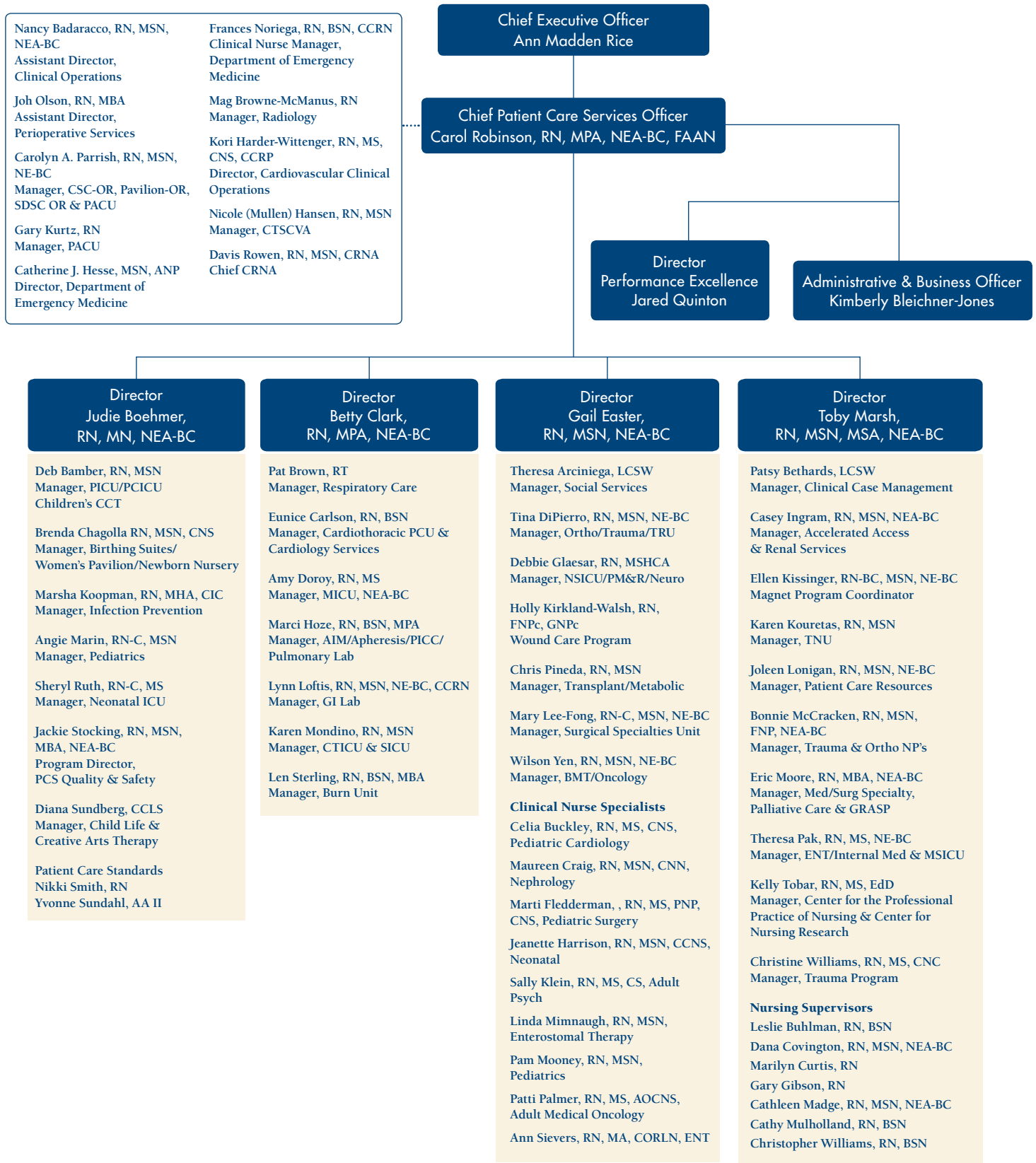
## Nurse Ethnicity/Race



## RN Years of Service



# Patient Care Services Administrative Organization Chart



## PROJECT LEAD

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*A special thank you to all the extraordinary nurses who dedicate themselves every day to the Professional Practice of Nursing at UC Davis*

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