Community

Safe, High-Quality Patient and Family-Centered Care

Leadership
Shared Governance
Research
Evidence-Based Practice
Education
Clinical Expertise

PROFESSIONAL NURSING PRACTICE MODEL

Innovation Collaboration Accountability Respect Excellence
The nurses at UI Hospitals and Clinics are dynamic, energetic, and committed professionals. Patients tell us our nurses are top-notch when it comes to skill, knowledge, compassion, dedication, empathy, and genuine care, and patient satisfaction remarks confirm this.

CNO INTRODUCTION

I am honored to have been appointed Interim Chief Nursing Officer at University of Iowa (UI) Hospitals and Clinics in July 2016, succeeding Chief Nursing Officer Kenneth Rempher, PhD, RN, MBA, CENP, who accepted a new position with Cone Health in Greensboro, NC. In the pages that follow you will find highlights from the Department of Nursing Services and Patient Care during Fiscal Year 2016.

The nurses at UI Hospitals and Clinics are dynamic, energetic, and committed professionals. Patients tell us our nurses are top-notch when it comes to skill, knowledge, compassion, dedication, empathy, and genuine care, and patient satisfaction remarks confirm this. As you read this annual report, you will learn about nurses practicing in a myriad of roles: providing direct patient care; acting as patient safety champions; and influencing and leading changes that improve quality, patient experiences, and healthcare outcomes.

Preparing for the new UI Stead Family Children’s Hospital was a top priority for 2016. Nurses were instrumental in every step of the planning, designing, building, furnishing, and launching. Long before beds were in place and the new hospital was open, nurses were working out operational plans and patient flow, in order to provide seamless care as units and services transitioned to the new space.

In 2016, the entire hospital experienced growth among all services, resulting in numerous “high census” periods, which stressed bed placement and patient flow. Nurses were active participants on an interprofessional team charged with identifying creative solutions without compromising patient care. Our Service Without Territory (SWOT) nursing team was one result and is a prime example of nursing’s ability to adapt and accommodate to rapidly changing situations.

Preparations are in full swing, and documents are being compiled for submission in 2017 for a possible fourth designation as a Magnet® organization. Achieving continuous recognition as a Magnet® organization is much more than simply providing outstanding patient care and achieving positive outcomes, it demonstrates commitment to professional development for nurses, advancement of nurses’ education, and preparation of future nursing leaders. I am confident the Department of Nursing Services and Patient Care will again receive this esteemed designation.

Essential pillars in the Professional Nursing Practice Model continue to be research and evidence-based practice (EBP). This year was marked by the updating and unveiling of The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Healthcare©. For that reason, several examples in this report highlight our international leadership and successes in EBP aimed at improving patient quality and safety; increasing patient satisfaction; improving clinician satisfaction and safety; reducing length of stay and costs; and promoting innovative nursing practice.

Enjoy this Fiscal Year 2016 Nursing Annual Report. I am positive that it will entice you to learn more about the tremendous professionals, the great care, and the numerous nursing opportunities available at UI Hospitals and Clinics.

Sincerely,

Cindy J. Dawson, MSN, RN, CORLN
Interim Chief Nursing Officer
Department of Nursing Services and Patient Care, University of Iowa Hospitals and Clinics
UI HOSPITALS AND CLINICS has sustained a high census for over two years, which has placed significant stress on the Emergency Department (ED) and many inpatient and ancillary services. Surge Capacity is a new institution-wide process focused on safe, timely movement of patients through their hospital stay during times of sustained high census.

The Surge Capacity team consists of more than 20 nurses, physicians, administrators, and ancillary clinicians who have developed a process to mitigate the effects on patients. High census disproportionately affects departments and units at different times. The ED bears the brunt of overwhelming traffic, and some units receive many patients from the operating rooms. Meanwhile, other units may be calmer, with some open beds. Institution-wide awareness is fundamental, and clear communication between departments and units is crucial for optimal use of available resources to facilitate timely patient throughput.

In addition to opening the communication channels, the team used data to develop evidence-based criteria to identify surge levels based on patient census and capacity, and the best action steps for each.

**Level 1:** Normal
**Level 2:** Elevated
**Level 3:** Stressed
**Level 4:** Crisis
**Level 5:** An extreme level used only for the ED

At Level 1, it is “business as usual.” At Level 2, staffing issues at the unit level may be addressed, with an increased focus on discharging patients who are ready to leave. Level 3 widens the scope of concern, enlisting the help of administrative staff to focus on throughput and smart staffing, and canceling or rescheduling non-essential meetings and activities. At Level 4, it is all hands on deck, with clinicians and units working together to maximize capacity, streamline patient discharges, and remain focused on efficiency.

“If appropriate action steps are taken at Levels 2 and 3, we’re much less likely to get to Level 4,” says Joelle Jensen, MSN, RN, NEA-BC, Director, Throughput and Patient Flow. At every level, clinicians provide each patient the exceptional compassionate care they expect from UI Hospitals and Clinics. Jensen hopes to see the Surge Capacity action steps become second nature to staff, with automatic actions that effectively address potential situations.

“The goal is to assure that we have a universal language about sustained high census that everyone understands,” says Jensen. “If we look at our 4 p.m. census for the last two months, we’ve been at ‘Level 5’ in the ED 17% of the time. And all units were at ‘normal’ just one day out of ten.”
Hospitals Can Be Noisy Places.
In an effort to bring down noise levels and improve the patient experience, the interprofessional Quiet Initiative Workgroup developed a series of action items to enhance quietness at UI Hospitals and Clinics.

Quiet Initiative Posters: New HUSH (Help Us Support Healing) posters are displayed in inpatient units and feature clinicians from the individual units. “Patients and clinicians often recognize the people on the posters because they see them on the unit. This recognition adds to the posters’ effectiveness,” explains Emily Wynn, BSN, RN, MBA, CCRN, Interim Associate Chief Nursing Officer.

Quiet Time: Quiet times have been standardized throughout the hospital. Every day from 12:30 to 2:00 p.m., unit lights are dimmed, patient stimuli is reduced, and conversations are conducted in softer tones. “Yacker trackers” use lights to signify if noise levels are appropriate, with green indicating a correct level. This time period was selected because it is typically after team rounding and lunch and is generally a slower time of day. Quiet times in Behavioral Health units are individually set to reflect their patient-centered activities.

Quiet TV Channel: An in-room TV channel with information for patients and visitors was developed. Patients, families, and visitors can learn how UI Hospitals and Clinics is working to maintain a quiet environment and how they can help. Information is also provided about available sleep aids for patients (ear plugs, disposable headphones, eye masks).

Quiet Equipment: In addition to human voices, hospital equipment can be very noisy. The initiative included measures to reduce the noise made by tube stations, infusion pumps, and monitors. Even carts were evaluated to ensure they have the quietest wheels.

Quiet Initiative Improves Patient Experience
Consistent messaging about the Quiet Initiative appears on clinician badges and is displayed on screen savers, in elevators, and on social media.

Clinicians also hold each other accountable to adhere to the Quiet Initiative policies. Since the program was adopted in late 2015, UI Hospitals and Clinics has seen an improvement in patient satisfaction scores related to noise. The program is now in Phase 2, expanding to the ambulatory and perioperative areas.
DISRUPTIVE BEHAVIORS, exhibited by patients or their family members, have a negative impact on hospitals, clinicians, and other patients. These behaviors include verbal aggression or harassment, drug-seeking behavior, and physical harm or threats of physical harm, that can be triggered by a number of factors related to illness, addiction, or even just the stress of being in the hospital.

In 2012, UI Hospitals and Clinics embarked on an interprofessional effort to develop and apply an alert in the electronic health record of those who pose potential risk. The program went live in 2013 and has resulted in a significant reduction in disruptive behavior calls.

“The size of our institution made the number of incidents seem less frequent, but we were finding that there were individual patients who had more than their fair share of disruptive incidents. The Disruptive Behaviors Program creates a pattern and process to consistently deal with people who are disruptive,” says John Wagner, MA, RN-BC, Director, Behavioral Health Services.

Generally, the team has found that addressing a patient or family member about their disruptive behavior and putting them on notice that the behavior will not be tolerated often results in the person self-correcting. For persistent issues, however, a warning is placed in the patient’s electronic health record, which will be seen by the scheduling nurse and other caregivers each day. Caregivers are cautioned not to allow the warning to bias any healthcare decisions for the patient but to proceed with caution and report any difficulties.

A 2016 evaluation of the program looked at 26 patients and measured Safety and Security and Code Green (behavioral emergency) calls in the quarter before and three quarters after an alert was applied in their electronic health record. Results indicated that 60% of these patients had no further active security calls. There was a 70% reduction in Code Green calls and a 280% increase in preventative security calls after the alert was placed.

THE IOWA COMPREHENSIVE EPILEPSY PROGRAM provides specialty services to patients who have epilepsy and related conditions. Part of this program is the Video EEG Monitoring Test, a specialized EEG test in which the patient is constantly monitored for 3-5 days over a video screen. This allows the team to observe brainwave activity during the time a seizure or spell is occurring. The test documents one or more of a patient’s typical spells, in order to determine the cause, nature, and optimal treatment.

Due to high capacity rates in the ED, epilepsy patients arriving at UI Hospitals and Clinics for their tests did not always have a hospital room available to begin the test at the planned time. The Epilepsy Monitoring Unit team identified the need to improve the patient experience and repurposed a room on their unit into a designated admission suite for Video EEG patients in situations where a regular hospital room was not available. They ensured the room was outfitted with the correct technology and would be safe for patients with risk factors. Volunteer Services helped provide amenities to make the space more enjoyable. The room allows the patient to begin their test on time which enhances the patient experience.

Daniel Lose, DNP, RN, CNML was the Nurse Manager on the Epilepsy Monitoring Unit when the use of the admissions suite was formalized and saw several benefits of the new program.

“This innovative solution has helped not only one unit, but the whole hospital,” he says. “A lot of our patients like not having to start their treatment in a hospital bed. Our clinicians like not having to start the patient’s experience with an apology from us because we don’t have a room for them. This process allows the ED to have access to beds, while still letting the Epilepsy Monitoring Unit begin treatment of their patients as scheduled.”
UIHC WORKS WITH CRITICAL ACCESS HOSPITALS, IMPROVES TRANSITIONS OF CARE FOR RURAL PATIENTS

IN 2012, the UI Carver College of Medicine received a three-year Transitions of Care research grant, from the Centers for Medicare and Medicaid Services, focused on rural patients. The grant improved coordination of care for adults with complex medical issues who were discharged from UI Hospitals and Clinics back to their rural communities and funded a care coordinator position at each of the partnering critical access hospitals (CAHs).

UI Hospitals and Clinics partnered with ten CAHs in nine Iowa counties. Post-hospital coordination of care between urban tertiary care medical centers and rural communities is often poor, leading to unnecessary and costly readmissions, frequent ED visits, and duplication of services.

When grant funding ceased in 2015, the hospital integrated key interventions and strategies from the grant care model into the hospital care coordination processes. UI Hospitals and Clinics continues to partner with five of the CAHs but with modifications determined by the respective hospitals. Since July 1, 2015, 846 patients have been enrolled and educational offerings continue for the CAHs and ACO/Alliance partners. The College of Medicine holds monthly videoconferences with continuing education credit on a wide range of healthcare topics. Local care coordinators provide in-home assessments as indicated and use their discretion regarding how long to follow the patients. The College also continues to serve as a liaison to the CAHs and provides them with clinical support. Data are shared with the CAHs in the form of monthly reports on admission and discharge disposition of their patients, as well as providing early intervention to resolve medication and discharge barriers. A structured hand-off process to local care providers is in place, and the patient receives a discharge follow-up phone call.

It is a priority for UI Hospitals and Clinics to build and strengthen relationships with community partners and to engage them in their patients’ discharge process. Effective transitions of care enhance cooperation by actively facilitating timely communications among clinicians and care settings. CAHs are valued members of the patient’s healthcare team, and this relationship enhances mutual accountability for the well-being of our shared patients.
In a partnership between UI Hospitals and Clinics and Mercy Medical Center-Dubuque, Iowa’s first hospital-based ambulance service expanded to a third community in early 2016. AirCare3, in Dubuque, joins AirCare helicopters in Iowa City and Waterloo to increase the flying range and improve the speed of care for patients in the tri-state (Iowa, Illinois, and Wisconsin) area.

Since 1979, more than 30,000 patients have flown with AirCare. UI Hospitals and Clinics operates Iowa’s busiest helipad, with an average of 2,500 landings and takeoffs each year. Newborn infants, just minutes after being born, make up AirCare’s smallest patients. AirCare has brought more than 3,000 patients to the UI Stead Family Children’s Hospital Neonatal Intensive Care Unit and Pediatric Intensive Care Unit.

AirCare is designated by the Commission on Accreditation of Medical Transport Systems (CAMTS) for quality and safety practices. It is the first and only Iowa-based air ambulance service to receive CAMTS accreditation.
The SWOT (Service Without Territory) team was created at UI Hospitals and Clinics in the Spring of 2016 to help bedside nurses when expert nursing support is needed for short periods of time; for example, during periods of sustained high census and high acuity.

The SWOT nurse provides timely assistance with bedside workflow fluctuations as well as other activities requiring critical care or clinical nursing expertise. This team assists by freeing up frontline nursing staff so they can focus on patient needs to assure optimal and safe care. The Weekend Option SWOT nurse service began in April 2016.

The SWOT nurses catalog the tasks, unit/division, and time it took to complete the supportive tasks. Currently, there are over 3000 entries. The graphs show how the SWOT nurses have supported frontline nurses at UI Hospitals and Clinics.

The most frequent calls for the SWOT team involve assistance with difficult IV starts and lab draws, clinical resource, and transport. The Intensive & Specialty Services (ISS) and Medical Surgical Services (MSS) divisions are the largest users.

The SWOT team continues to actively recruit talented critical care nurses who wish to be part of this pioneer program at UI Hospitals and Clinics.
IMPROVED QUALITY METRICS

The Department of Nursing collects, benchmarks, and analyzes a number of nursing sensitive indicators to improve patient outcomes.

1. NICHE DATA
Iowa has the fifth oldest patient population in the United States. The Department of Nursing has chosen to participate in the Nurses Improving Care for Healthsystem Elders (NICHE) program to help improve outcomes for our older patients. UI Hospitals and Clinics is the only hospital in Iowa to receive NICHE exemplar status. The Department tracks quarterly indicators specifically for patients 65-85 years of age and for those over 85 years of age. Patients in these age groups are at high risk for falls, and the Department has implemented many prevention strategies for these age groups. Efforts including those by the NICHE team for this population has resulted in a fall rate as low as 1.78 per 1000 patient days in Q2 2016.

2. CHG TREATMENT COMPLIANCE AND CLABSI RATE
In the past, UI Hospitals and Clinics has been challenged by central line-associated blood stream infection (CLABSI) rates above national benchmarks. In July of 2015, the Department of Nursing began a chlorhexidine 2% (CHG) daily treatment protocol for all adult inpatients based on a recommendation from the Centers for Disease Control and Prevention to reduce CLABSI. Eligible inpatients, approximately 400 per day, receive this treatment daily. The Department of Nursing, with assistance from Health Care Information Systems, incorporated an audit tool in the electronic health record to track compliance with CHG treatments. The goal is to achieve a daily compliance rate of 90%. By July of 2016, the aggregate CHG treatment compliance rate for all inpatient units was being sustained at >90%. As the CHG treatment compliance rate rose to 90%, the CLABSI rate dropped.
3. CAUTI RATE
Catheter-associated urinary tract infection (CAUTI) rates at UI Hospitals and Clinics varied over the last year but were generally near or below national benchmarks. CAUTI reduction efforts are addressed by an interprofessional team committed to reducing the use of urinary catheters in our patients and improving insertion techniques. In addition, the use of daily dashboards alerting clinicians to catheter days has decreased catheter utilization rates, resulting in reduced CAUTI rates across the hospital.

4. HAPI RATE
Hospital-acquired pressure injury (HAPI) incidence at UI Hospitals and Clinics has been below 2% for the last four quarters. The use of unit-based skin experts and the trialing and use of multiple new products have contributed to this low rate. One targeted project in 2016 was the reduction of HAPI occurring from positioning in the operating room. Use of five-layer, soft, silicone, foam dressings decreased HAPI rates in prone surgical cases scheduled for ≥4 hours. The hospital also saw a decrease in occipital HAPI rates, by using a fluidized positioning device, in supine cardiothoracic surgical cases scheduled for ≥4 hours.

5. FALLS
Continued close surveillance of falls by the Department of Nursing Falls Committee, the use of administrative coordinators for Nurse Managers to help track falls, and the presence of falls champions on all units have helped stabilize fall rates. The hospital also has increased the use of low beds, and is using motivational interviewing to improve understanding of issues surrounding falls prevention. The inpatient overall falls rate is < 30 per 1000 patient days and the falls with injury rate is < 20 per 1000 patient days. Outpatient falls remain low due to fall prevention strategies in the clinics.
A patient’s call light can be their lifeline, but issues with delayed call response have been an increasing issue nationwide in healthcare. When the patients are children, a quick response to calls can be even more critical.

The Patient and Family Experience Committee at UI Stead Family Children’s Hospital recognized the need to improve the call response process on 3 John Colloton Pavilion (3JCP), a 31-bed unit with a patient population ranging in age from newborn to 18 years of age. Specialty areas include hematology/oncology, bone marrow transplant, renal, renal transplant, endocrine, gastrointestinal, liver transplant, urology, general surgery, neurosurgery, and trauma.

This interprofessional committee developed a new process to improve response times and patient education on what to do if assistance is needed. Patients in the unit are assured that their nurse or a team member will come to their room every hour, but if they need anything in the meantime, they should use their call light rather than leaving their room to find their nurse.

Patients are given a handout that explains 1) when to push the call light, 2) what to say when they push the call light, and 3) what will happen after they push the call light.

The committee also developed a script for nurses to use to educate patients about the call system and set their expectations, and for the unit clerk to use when responding to a call. Unit clerks are encouraged to be proactive and personable in their exchanges with patients.

A new triage system helps ensure that calls are answered promptly. Nurses partner with each other to cover times when they are not available to answer calls from their patients. If the patient’s primary nurse is busy, the call goes to his or her partner. If the partner is busy, the call goes to the charge nurse. If the charge nurse cannot respond, an alert goes to the management team or charge designate. If a patient is calling out for a second time, the call receives high priority.

This call response initiative, implemented in April 2015, has improved service and patient care. The unit’s Press Ganey Patient Satisfaction Score on “Nurses’ Promptness to Call Button” increased from a score of 76.2 (1st percentile) in March 2015 to 97.2 (99th percentile) in July 2015.
According to American College of Surgeons and Surgical Infection Society data, surgical site infections are the most common type of hospital-acquired infection and are responsible for 20% of infections acquired in hospitals.

In November 2015, a team with members from nursing and infection control at UI Hospitals and Clinics began conducting infection control rounds in the Main Operating Room. These rounds initially consisted of monthly rounds lasting from 60-90 minutes and were conceived in preparation for a visit from The Joint Commission. Within a couple of months of beginning these rounds, the group expanded to include the Medical Director, supply chain staff, and environmental services staff. A representative from compliance is also invited to attend.

During infection control rounds, team members take pictures of areas needing improvement in order to provide a visual for clinicians when educating them about remaining “Joint Commission ready.”

“The pictures and information collected during rounding helped us make some great improvements to our environment of care as well as appropriate product selection for surgical skin antisepsis and surgical hand antisepsis,” says team member Michelle Mathias, BSN, RN, Clinical Coordinator, Perioperative Nursing Services.

The process has been deemed so successful for the Main Operating Room that it has been rolled out to the Ambulatory Surgery Center as well.
According to the Centers for Disease Control and Prevention, medical errors are the third leading cause of death in the United States, contributing to 440,000 premature deaths each year. This problem is exacerbated by a lack of health information technology systems using evidence-based indicators in the clinical environment.

At UI Hospitals and Clinics, an interprofessional team of members from nursing, engineering, and health care information systems set out to design a health information technology dashboard using iconography and dynamic reporting to communicate real-time patient risk information to clinicians. The dashboard appears on the patient’s electronic health record and in workrooms on 11 units.

The team was dedicated to using human-centered design and created the dashboard so that it would use symbols effectively, minimize errors, provide support, require minimal training, and maximize awareness.

“We used human factors and engineering principles to create an intuitive design that would address patient risk and improve quality of care,” explains Laura Cullen, DNP, RN, FAAN, Evidence-Based Practice Scientist and team leader.

Focus groups helped inform the dashboard design, which was then assessed based on 10 heuristic design principles and a system usability survey. The team made revisions based on these results, including easy-to-interpret color-coding, making content fit the screen to avoid scrolling, and linking an individual score/cell to the associated area in the patient’s health record. Evaluators used the dashboard prototype to plan patient care and document or change orders related to patient risks.

“This new dashboard encourages us to think differently, staff differently, and care differently to improve outcomes for our high-risk patients,” says Cullen.

In 2017, the dashboard will continue to be evaluated on active units and will be expanded to others, with unit-specific adaptation as needed.
The Research Internship Program, through the Office of Nursing Research, Evidence-Based Practice and Quality, engages nurses in generating new knowledge around a clinical question. In 2015, research intern Robert Anderson, BAN, RN, CCRN, Staff Nurse and a team of nurses, with mentorship from Charmaine Kleiber, PhD, RN, FAAN, Nurse Scientist, initiated a feasibility study of 10 healthy volunteers to assess the potential impact of Continuous Lateral Rotation Therapy (CLRT) on pressure injuries.

CLRT is used in intensive care units for early mobilization of ventilated patients by mechanically rotating them laterally left-center-right in bed. Existing research supports its use for the treatment of pulmonary diseases and for the prevention of ventilator-associated pneumonia by mobilizing secretions in the lungs. The purpose of this study was to determine if CLRT could reduce pressure injuries using three positioning scenarios to determine if there were differences in skin interface pressures, skin integrity, or perceived discomfort:

1) CLRT only
2) CLRT with static wedge (30°)
3) Static wedge (30°)

A Hill-Rom Total Care SpOrt® bed was equipped with a pressure mapping device. Ten healthy volunteers were placed in each positioning scenario for 30 minutes and interface pressures were recorded. CLRT alone demonstrated statistically lower interface pressures on ischial tuberosities (p<.05) as compared to any use of a static wedge. Statistically higher pressures were noted on the heels in CLRT alone (p<.05).

No difference was noted between static wedge alone and CLRT with wedge. Pain was noted by seven of 10 subjects with wedge positioning, by six of 10 subjects with CLRT with a wedge, and by one of 10 subjects with CLRT alone. The results of the study support the use of CLRT to decrease pressure on capillary beds and also to decrease patient pain. The team published their results in Heart & Lung and presented at several conferences.

Anderson, principal investigator (PI) and lead author of the journal article, explains the impact of this study on patient care.

“Our findings do not replace the importance of nurses assessing patients, but they did result in the acquisition of many new Hill-Rom beds in the ICUs so that all patients who can benefit from CLRT have access to it,” he says.

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RESEARCH INTERNS PROJECTS

There were four Research Interns in the 2015-2016 cohort.

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<td>Effect of Meaningful Recognition on Registered Nurses’ Compassion Satisfaction and Compassion Fatigue</td>
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<td>The Relationship Between Lymphedema and Past Surgical Arm Precaution Adherence in Breast Cancer Survivors</td>
<td>Lindsay Gaskell, BSN, RN, OCN</td>
<td>Kelly Petrulevich, BSN, RN, OCN Geralyn Quinn, MSN, RN, OCN Jane Utech, MSN, RN, OCN *Charmaine Kleiber, PhD, RN, FAAN</td>
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<td>Implementing Motivational Interviewing of Oncology Inpatients at the Time of Admission into an Evidence-Based Practice Fall Prevention Program</td>
<td>Deborah Sheikholeslami, BSN, RN-BC, OCN</td>
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* Office of Nursing Research, Evidence-Based Practice and Quality Research Mentor

NURSING RESEARCH GARNERS ATTENTION

HILLARY STORM, MSN, RN
Nursing Practice Leader and Michelle Mathias, BSN, RN, Clinical Coordinator have received accolades for their work on reconciling incorrect surgical sponge counts. Originally submitting the research for a poster presentation, Storm and Mathias were instead chosen for a podium presentation at the March 2016 American Nurses Association Conference in Orlando, FL.

The research was a collaborative effort between frontline nursing staff and the UI College of Nursing’s Victoria Steelman, PhD, RN, CNOR, FAAN, Associate Professor.

When the information was presented by Staff Nurses at the 2015 Association of periOperative Registered Nurses (AORN) conference, it won first place in the research category. The presentation was then transformed into a manuscript for AORN Journal and was published in November 2015 as “The Hidden Costs of Reconciling Surgical Sponge Counts” by V. M. Steelman, A. G. Schaapveld, Y. Perkhounkova, H. E. Storm, & M. Mathias.
BEHAVIORAL EFFORTS TO REDUCE PEDIATRIC OBESITY

THE CARDIOMETABOLIC CLINIC at UI Stead Family Children’s Hospital was developed in 2011 to diagnose and recommend treatments for overweight/obese children who also have an obesity-related disease. The team treating patients at the clinic recognized a need for a concurrent behavioral weight loss program to teach children and their parents the skills necessary to live a healthier lifestyle. In response to this need, Lucas Carr, PhD, Assistant Professor, Health and Human Physiology and Sharon Tucker, PhD, RN, PMHCNS-BC, FAAN, Director, Nursing Research, Evidence-Based Practice and Quality, received funding from the Stead Excellence Award to develop the Healthy Hawks Program, a comprehensive, multi-component, family-based, behavioral weight loss program for obese children and their parents.

Of the 15 families that originally participated in the Healthy Hawks Program, 10 successfully completed it. Fifty percent of parents and 42% of children completing the program lost weight by the end of 10 weeks. The care team observed improvements in health behaviors such as physical activity and fruit and vegetable intake in both parents and children. Participants reported significant improvements in their level of happiness, enjoyment in life, appearance, mood, desire to have fun, physical wellbeing, family’s health, self-confidence, and energy level. Given this success, the team has requested funds to hire a half-time Senior Behavioral Health Consultant to serve as a dedicated program coordinator for the Healthy Hawks Program.

WELLME IN 3 © GETS PATIENTS MOVING

ABOUT THREE YEARS AGO, Sharon Tucker, PhD, RN, PMHCNS-BC, FAAN, Director, Nursing Research, Evidence-Based Practice and Quality developed a series of 23 short, 3-minute videos called WellMe in 3 for clinicians at UI Hospitals and Clinics to incorporate physical activity into their workday. Research has suggested that short bursts of activity throughout the day can be as beneficial as one longer episode of exercise.

Meanwhile, Linda Abbott, DNP, RN, AOCN, CWON, Nursing Practice Leader and others in the Holden Comprehensive Cancer Center had been promoting physical activity to help people living with cancer manage their symptoms and side effects from treatment. Abbott started using the WellMe in 3 videos created for clinicians as a tool to get patients doing more physical activity. But the team soon realized that it would be best if they had videos made specifically with, and for, patients living with chronic health conditions.

Tucker and Abbott applied for a grant through the American Nurses Association Foundation and were awarded $10,600 to develop an exercise video series for patients. They put together a team of people including Kim Eppen, MPT, PhD, Clinical Specialist, Rehabilitation Therapies; Evan Paelmo, nursing student, research assistant and Iowa Biosciences Academy Scholar; Helena Laroche, MD, Assistant Professor, Internal Medicine; and Laith Abushahin, MD, Clinical Assistant Professor, Internal Medicine, to develop videos and conduct this study. They started by inviting people living with chronic health conditions to participate in a focus group. They also invited patients to participate in the filming of the videos.

In the spring of 2016, 12 new WellMe in 3 videos were produced. The videos contain follow-along instruction on different types of light exercise and stretching routines, safety during physical activity and one on incorporating physical activity into the day.

In July 2016, Abbott and the group started enrolling participants in a study to test the effectiveness of using the new videos in patients with chronic health conditions. Paelmo, a Research Assistant, “has been invaluable,” Abbott says, in coordinating participants and research visits.

Involvement in the study lasts one month. Participants gradually increase the frequency they use the videos, working up to several times per day by the end of the month. Participants also evaluate the videos, and they wear an armband to measure activity level.

Recruitment closed at the end of 2016, but data analyses are still underway. The study team received positive feedback from participants who reported that the videos helped motivate them to be more active throughout the day and generated interest in other types of exercise. Once the analysis is complete, the group plans to roll the videos out to more patients.
PILLAR 4: EVIDENCE-BASED PRACTICE

PREVENTING FALLS RELATED TO NEEDLESTICK PROCEDURES IN THE FAMILY MEDICINE CLINIC

NEEDLESTICKS CAN BE ACCOMPANIED by anxiety, fear, emotional distress, and pain which can cause healthy patients to experience vasovagal syncope (fainting), resulting in falls and injuries. A team of Nurse Managers, Staff Nurses, and Medical Assistants, led by Deborah Steinbaker, MA, RN, MBA, NE-BC, Nurse Manager, Family Medicine Clinic, developed an EBP pilot project using the Iowa Model as the framework.

The team determined that available literature provided evidence that the use of counter-pressure maneuvers (muscle tensing exercises) can minimize or delay the vasovagal response. The pilot project, based in the Family Medicine Clinic, was designed to determine whether the literature findings were supported in the outpatient setting.

The project began with pre-implementation questionnaires and interviews with clinicians and patients. Clinicians were then educated on the relationship between needlesticks and fainting/falls, the basics of vasovagal syncope responses to needlesticks, the definition and demonstration of muscle tensing exercises using a stress ball, and the handout for educating patients about how clinicians can help them avoid a fall after a needlestick.

Clinician responsibilities include:

- Screen patients for risk of vasovagal syncope with needlesticks
- Provide written and verbal education and demonstrate how to grip the stress ball and tense the hand/arm not receiving the needlestick
- Offer pain-reducing options
- Offer water, juice, or crackers if patient has not eaten in the past four hours (unless contraindicated or potential to interfere with lab test results)
- Have patient sit or lie down and instruct patient to perform exercise throughout the procedure
- Monitor the patient's report of pre-syncope symptoms or observable signs during the procedure
- Observe patient after the needlestick procedure; a vasovagal response may occur up to 30 minutes after a procedure
- Document the patient's response and, if response is experienced or observed, add an alert in the patient's electronic health record
- File an incident report if patient becomes unconscious, displays seizure-like activity, or falls

Evaluation of the project is in process. Pre- and post-implementation data suggests improvements in clinician knowledge and perceptions as well as a reduction in falls.
PAIN MANAGEMENT INTERVENTIONS FOR NEEDLESTICK PROCEDURES

NEEDLESTICKS FROM IMMUNIZATIONS, blood draws, and intravenous catheters are common pain-causing procedures in ambulatory settings. In 2013, the Ambulatory Nursing Pain Committee started an EBP project focused on ensuring the use of a standardized approach when offering interventions for management of adult and pediatric needle stick pain. “Literature shows that needle fear can dramatically affect future healthcare decisions,” says Trudy Laffoon, MA, RN-BC; Nurse Manager. “If the fear is severe enough, it may negatively impact future health seeking behaviors, such as immunizations.”

Evidenced-based pain management toolkits were developed that included the Buzzy®, a device that uses vibration to disrupt pain recognition and ice wings to reduce pain sensations; stress balls; and other distraction items. Funds awarded to the Department of Nursing from the 2014 Magnet Prize designation were used with additional funding from Volunteer Services.

Implementation strategies increased clinician awareness and use of the interventions. Over 500 clinicians from ambulatory settings attended the initial hands-on pain competency stations to familiarize themselves with the recommended interventions. A questionnaire distributed before and after the training revealed increased knowledge related to the interventions, 57.5% to 69.1%.

The content was incorporated into ambulatory orientation. Committee members have presented at internal and external continuing education offerings and conferences and have created adult and pediatric patient education handouts.

“We wanted to educate and empower clinicians in ambulatory settings to place protocol orders for patients who may benefit from the interventions; simply offering it as an option can be incredibly impactful,” says Carmen Kealey, MA, RN; Nursing Practice Leader.

To help measure success, the committee worked with organizational leaders to add a new question, “Our sensitivity to your pain,” to the ambulatory Press Ganey patient satisfaction surveys in 2015. Scores are regularly reported throughout the organization.

“We’ve accomplished some wonderful things,” says committee chair Michele Farrington, BSN, RN, CPHON; Clinical Healthcare Research Associate. “But we need to remain vigilant to sustain and integrate these improvements in all ambulatory settings, so we can continue to positively impact the patient experience.”
OVERUSE OF THE EMERGENCY DEPARTMENT (ED) has a negative impact on available capacity as well as costs. The ED at UI Hospitals and Clinics developed an interprofessional ED Care Coordination Program (EDCCP) to reduce unnecessary ED encounters for certain patients. This population includes patients who have had eight or more ED visits at UI Hospitals and Clinics in a three-month timeframe. The program is intended to improve quality of care, improve patient satisfaction, and help control costs.

The EDCCP program began in May 2014 with 17 patients and now has approximately 100. The original 17 patients had a combined 306 total ED visits in the six months prior to being in the program. After six months of having the EDCCP in place, those 17 patients had 142 ED visits. The estimated cost savings to UI Hospitals and Clinics from May 2014–May 2015 for those 17 patients was $600,000.

In 2015, an EBP project, using the Iowa Model, was initiated to identify additional ways the ED Nurse Navigators could intervene to reduce unnecessary ED encounters for these patients. ED Nurse Navigators now have a standardized way to communicate with these patients during and after ED visits. Communication with these patients includes principles of motivational interviewing to improve patient education and identify and address barriers to obtaining appropriate care following an ED visit. A big part of the effort is to assist patients in selecting a primary care provider, setting up a plan of care, and addressing issues that may impact their ability to attend appointments. Ten EDCCP patients participated in the EBP project pilot. The ED visits in a three-month timeframe for this group were reduced by 66%.

“These patients often have very complex cases. The ED Care Coordination Program improves interprofessional communication and consistency of care. Through care coordination, we engage patients, talk to them about their needs, and provide them with the necessary tools to access an appropriate level of care,” says Lori Oberbroeckling, BSN, RN, CEN, ED Nurse Navigator and EBP Project Director.
Supporting Parents During a Child’s Resuscitation

In the past, it was not standard practice to allow parents to stay in the room in the event their child needed to be resuscitated. The parents were often asked to leave the room. If parents were allowed to stay, they may have been left standing in the background, wondering what was happening to their child. Spiritual or Social Services is often able to offer emotional support, but they could not answer the clinical questions; plus, they are often not available on nights and weekends.

Stephanie Stewart, MSN, RNC-NIC, Nursing Practice Leader, saw a gap in care that needed to be filled; parents need a clinical support person to answer their questions and provide support during their child’s resuscitation.

To get this practice change in place, Stewart led an interprofessional team made up of clinicians and a parent representative. The group reviewed the evidence to support parents’ presence. Drawing on formal recommendations from national and international healthcare organizations, they agreed that parents should be offered the choice to stay in the room while their child is being resuscitated.

Stewart and the group then developed a standard process for offering parents the choice to stay with the child in the event of a pediatric code blue or pediatric rapid response, and they looked at ways to best educate clinicians. The practice was implemented in the summer of 2015.

It is now recommended that a designated family advocate be assigned to stay with the parents, that person may be a nurse, respiratory therapist, nursing assistant, or other clinician from the unit. The family advocate assesses the parents’ preference for staying in the room and will tell the family that it is his or her job to be with the parents during the resuscitation. The family advocate will explain what is happening in simple terms, answer parents’ questions, and offer and provide comfort measures in coordination with a spiritual services provider or social worker. If the parents decide to stay outside of the room, the family advocate will accommodate their needs and preferences and will continually update them with information about their child.

Stewart is currently evaluating the new process to analyze if it is being done consistently and to discover more about what exactly parents and clinicians are experiencing.
INTEGRATING NUTRITION INTO CANCER CARE

THE EBP STAFF NURSE INTERNSHIP, through the Office of Nursing Research, Evidence-Based Practice and Quality, enables Staff Nurses to lead EBP projects, using the Iowa Model as the framework, that address a clinically relevant issue for their patients. Cancer care clinicians at the Holden Comprehensive Cancer Center (HCCC) have needed a useful and consistent assessment tool to evaluate the dietary needs of patients with cancer. Appropriate dietary intake is important for patients diagnosed with cancer as the disease and its treatments can alter a patient’s ability to eat.

As part of the EBP Staff Nurse Internship program, Mandy Poock, BSN, RN; Staff Nurse focused her EBP project on developing a new nutritional screening tool to be used in the ambulatory setting for adult patients. The tool identifies cancer patients that would benefit from dietary consultation.

Poock piloted the new, comprehensive tool with GI and breast cancer patients with the help of her colleagues, dietitians, and Nurse Manager Geralyn Quinn, MSN, RN, OCN. A series of questions were asked regarding changes in weight, appetite, difficulty chewing or swallowing, nausea, diarrhea stools, and the use of tube feedings or total parenteral nutrition. The tool generates a score and identifies the patient as one of the following:

- **Low risk:** The patient will be reassessed at the next visit.
- **Moderate risk:** The nurse will discuss the symptoms and provide education to the patient and family. The nurse can decide to recommend a dietary consult.
- **High risk:** A dietary consult will be recommended.

Amy Lukas, RD, LD, Dietitian, helps patients manage symptoms, such as appetite issues or taste changes, and determines the level of intake and type of nutrition needed. The care team can refer back to the dietary notes and reinforce what the dietitian has already suggested.

In reviewing charts of cancer patients seen in the HCCC clinic prior to the pilot period, none of the 619 patients received dietary consultation. During the pilot period, about 20% were referred to dietary, and 12% were identified as high risk.

“Patients are more aware of ways to manage their nutritional needs, and those needs are being addressed,” Poock says. “It has made nutrition a higher priority in the care of our patients.”

The pilot period ended in March 2016, and Poock’s next step is to modify some of the questions based on clinician feedback before it is rolled out to all adult cancer patients in the HCCC.

Around the same time that the pilot started, the HCCC hired Lukas as a full-time dietitian. Poock’s EBP project gave Lukas more consults, it let other clinicians know she was available, and most importantly, it got more patients the nutritional guidance they could use to improve their symptoms.
There were eight EBP Interns in the 2015-2016 cohort.

<table>
<thead>
<tr>
<th>PROJECT TITLE</th>
<th>INTERN</th>
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<td>Superman Initiative: Prone Therapy for Severe ARDS in the Medical Intensive Care Unit (MICU)</td>
<td>Kristina Ehret, MSN, RN, CCRN</td>
<td>Amy Bowman, BSN, RN, CCRN</td>
<td>Joseph Greiner, MSN, RN, CPHQ; Lynn Comried, MA, RN, CCRN; Melissa Forsythe, RRT; Dana Fowler, ARNP; Rhonda Barr, DPT, Sue Little, RD; Gregory Schmidt, MD; Kevin Doerschug, MD; Michele Farrington, BSN, RN, CPHON; *Laura Cullen, DNP, RN, FAAN</td>
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<td>Defining an Evidence-Based Practice for Seizure Recognition and Management</td>
<td>Robin Enfield, BSN, RN, CNRN</td>
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<td>Dan Lose, DNP, RN, CNML; Michele Wagner, MSN, RN, CCRN; Kelly Petrulevich, BSN, RN, OCN; Gloria Dorr, MA, RN-BC; *Laura Cullen, DNP, RN, FAAN</td>
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<td>Lymphedema Patient Education</td>
<td>Shannon Greene, BSN, RN</td>
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<td>Carmen Kealey, MA, RN; Linda Abbott, DNP, RN, CWON, ACCN; Stephanie Cummings, BSN, RN; Wei Chen, MD, FACS; Angela Williams, MA; Megan Zarrifis, CMA; Karina Schnieders, BSN, RN, CMSRN; Ericka Larson, BSN, RN; Jean Arndt, MA, RN, CBCN, ACCN; Becca Miner, DNP, RN-BC; Jody Martin, OTR/L, CLT; Trudy Laffoon, MA, RN-BC; *Michele Farrington, BSN, RN, CPHON</td>
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<td>Clostridium Difficile Associated Diarrhea in Medical ICU Patients</td>
<td>Seth Jackson, BSN, RN</td>
<td>Amy Bowman, BSN, RN, CCRN</td>
<td>Cheryl Bombei, MSN, RN, CCRN; Karen Stenger, MA, RN, CCRN; *Laura Cullen, DNP, RN, FAAN</td>
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<tr>
<td>Improving Critical Thinking Skills in Newer Nursing Staff with Preceptor Led Strategies</td>
<td>Amy Lage, BSN, RN, C-NPT</td>
<td></td>
<td>Jeanna Humpton, RN, MBA, RNC-NIC; Stephanie Stewart, MSN, RNC-NIC; Emily Spellman, MSN, RNC-NIC; *Michele Farrington, BSN, RN, CPHON</td>
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<td>Multidisciplinary Approach to Reduce Unnecessary Return Visits to the Emergency Department</td>
<td>Lori Oberbroeckling, BSN, RN, CEN</td>
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<td>Laura Yahnke, MSN, RN, CCRN; Greg Bell, MD; Alycia Karsjens, LMSW, Katy Demeueneabe, BSW; Melanie Berry, LMSW; Peggy O’Neill, MSN, RN, ACM; Sharon Tucker, PhD, RN, PMHCMS-BC, FAAN; Stacy Davis, BSN, RN; Joanne Grey, MSN, MA, RN; Macy Hall, BSN, RN; Vivian Ochola, MBA, MSN, RN; Lavon Yeggy, BSN, RN; Ryan Foulkes, MSN, RN, NREMT-P, CCP, BA; Cassaundra Ellis, BSN, RN, CEN; *Michele Farrington, BSN, RN, CPHON</td>
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<tr>
<td>Nutritional Screening Tool for Outpatient Adult Oncology Patients</td>
<td>Amanda Poock, BSN, RN</td>
<td></td>
<td>Geralyn Quinn, MSN, RN, OCN; Linda Abbott, DNP, RN, CWON, ACCN; Doug Robertson, RDN, LD; Bridget Drapeaux, MA, RDN, LD; Amy Lukas, RD, LD; Gloria Dorr, MA, RN-BC; Brack Bingham; Keith Burrell; Kenneth Nepple, MD; *Michele Farrington, BSN, RN, CPHON</td>
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<tr>
<td>Intrapartum Bladder Care</td>
<td>Abby Salton, BSN, RNC-OB</td>
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<td>Amy Sanborn, DNP, RN, C-EFM; Jeana Forman, MSN, RN, RNC-OB; Haley McNulty, BSN, RN; Lynne Himmelreich, MPH, ARNP, CNM; Jenny Driscoll, BSN, RN; Tracy Finke, NA; Kelly Ward, MD; *Michele Farrington, BSN, RN, CPHON</td>
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* Office of Nursing Research, Evidence-Based Practice and Quality EBP Mentor
EXPERIENCED NURSE FELLOWSHIP CREATES SMOOTH TRANSITIONS

PROFESSIONAL TRANSITIONS can be stressful for nurses. The American Nurses Credentialing Center has established guidelines for the accreditation of RN fellowship programs to transition experienced nurses into a new practice environment. In response to these guidelines, the Department of Nursing implemented an Experienced Nurse Fellowship for newly hired, experienced nurses. Janet Hosking, MSN, RN-BC, CHSE, Nursing Practice Leader and Sarah Schneider, MSN, RN, PCCN, Nursing Practice Leader developed the proposal.

The fellowship was designed to:
- support the transition of an acute care experienced nurse to a new clinical practice
- foster clinical nursing leadership at the point of care
- promote clinical decision making
- improve patient outcomes through integration of research, EBP, and quality improvement initiatives
- explore opportunities for nursing professional development
- increase nurse satisfaction
- reduce turnover of experienced nurses

Participation in the Experienced Nurse Fellowship is required for newly hired, acute care experienced nurses appointed for a 50% or greater budgeted position. Experienced nurses who have once worked at UI Hospitals and Clinics and then returned are exempt from the program. Hourly per diem nurses may participate at the discretion of their Nurse Manager. The program is introduced during central orientation and a rolling enrollment approach allows nurses to get started as quickly as possible at the next available session. The goal is to have each experienced nurse complete the full program within her/his first year of employment.

There are three, 4-hour sessions, provided over a six-month period:
- Session 1 - promoting a healthy work environment and working with the interprofessional team
- Session 2 - nursing quality improvement and EBP
- Session 3 - patient and family-centered care, including attention to ethical decision-making, patient/family education, and professional development opportunities for nurses

Each session includes a small group discussion entitled “Reflection: past, present, and future.” This reflection allows the nurses to connect, share experiences, successes, and challenges, and to continue discussion of a topic.

At completion of the program, each nurse provides an evaluation on the impact of the overall program related to each goal. In the future, there is a plan to add nurse satisfaction and retention metrics to the program evaluation.

Feedback data indicates this program has been a source of support for new employees. A recurring theme in participants’ comments, even those who entered the program with skepticism, is that they found it valuable and appreciated the opportunity to interact with others who were having the same “new employee” experience.

RN-TO-BSN TUITION SUPPORT IMPROVES CLINICIAN EDUCATION

At UI HOSPITALS AND CLINICS, the Department of Nursing prioritizes the development of the nursing workforce at the baccalaureate level or higher to ensure best practices for patient safety and outcomes, to meet the Institute of Medicine Future of Nursing report recommendation for an 80% BSN workforce by 2020, to assure nurses are practicing at the top of their license, and to continue to stay aligned with Magnet Recognition Program® expectations for clinician education levels.

In the fall of 2016, the Department of Nursing, with the endorsement of UI Heath Care executive leadership, completed a successful three-year RN-to-BSN support campaign. During this period, 227 RNs participated in the program for at least one semester. Ninety-seven obtained a BSN degree and 23 are still actively seeking a graduate bridge degree or remain enrolled in the program.

RN-to-BSN tuition was reimbursed at $3,000 per semester and allowed clinicians to apply for funding up to a maximum of $9,000 over three semesters or an equivalent timeframe.

Lou Ann Montgomery, PhD, RN-BC, Director, Nursing Professional Development and Advanced Practice/Nursing Informatics
Liaison, oversaw this program. “I have several notes of appreciation from participants in the RN-to-BSN tuition support program who said they probably never would have taken this next step without the support they received,” says Montgomery.

The Department of Nursing is currently at a 76% BSN-prepared RN staff and hopes to continue to grow that number. A modified version of the program is in development for 2017.

IMPROVING THE PROCESS FOR ARNP TRAINING

UI HOSPITALS AND CLINICS utilizes Advanced Registered Nurse Practitioners (ARNPs) in virtually every department and clinic, and the need for them continues to grow. Maria Lofgren, DNP, ARNP, NNP, PNP, FAANP, Director, Advanced Practice Providers and Lou Ann Montgomery, PhD, RN-BC, Director, Nursing Professional Development and Advanced Practice/Nursing Informatics Liaison have developed a process to assist ARNP students needing clinical experiences with credentialed, licensed preceptors.

This system is designed to help ARNP program faculty, students, and UI Hospitals and Clinics departments navigate through the placement process and create a centralized point of contact for ARNP students to explore placement for clinical training at UI Hospitals and Clinics. Dr. Montgomery assists prospective students to determine if an affiliation program exists between their academic institution and UI Hospitals and Clinics. Once that affiliation has been established, Dr. Lofgren helps recommend options for potential preceptors.

Currently, UI Hospitals and Clinics has affiliation agreements with 25 nurse practitioner programs in 11 states. There has been a significant increase in the number of ARNP students placed at UI Hospitals and Clinics since the Department of Nursing assumed coordination of this process.

PREPARE TO CARE IMPROVES TRAINING FOR DIRECT CARE PROFESSIONALS

DIRECT CARE PROFESSIONALS constitute the single largest profession in Iowa, estimated at approximately 78,000 workers. There is a projected need for more than 20,000 additional direct care professionals by 2020.

The UI College of Nursing partnered with the Iowa Department of Public Health to develop Prepare to Care, a statewide curriculum to improve and standardize training for direct care workers. The Department of Nursing worked with both entities and was the first acute care organization in Iowa to adopt this curriculum for orientation of nursing assistants. The Prepare to Care curriculum includes core training, plus five additional advanced training modules. These modules meet current federal requirements for home health aide and hospice aide training.

The core training module is available online and can lead to a Direct Care Associate Certificate. The module provides basic foundational knowledge and stresses Professionalism, Person-Centered Approach, Communication and Interpersonal Skills, Infection Control, Documentation, and Mobility Assistance and Worker Safety.

Advanced training modules address specific areas designed to help people with daily living and health monitoring and maintenance. Completion of a combination of these advanced training modules, with a required exam, results in an Advanced Training Certificate in Community Living, Personal Support, or Health Support.
GLOBAL REACH OF UI HOSPITALS AND CLINICS NURSES

The Department of Nursing places a high priority on sharing knowledge and best practices developed at UI Hospitals and Clinics with clinicians and hospitals around the world. In the past year, we have participated in several exchanges.

At the Sigma Theta Tau International Research Congress held July 2015 in SAN JUAN, PUERTO RICO, UI nurses presented two symposiums and a podium presentation to an international audience of nurses. The symposiums were: Evidence-Based Practice Journey to Excellence: Impacting Local, Regional and Global Nursing Practice, presented by Cindy Dawson, MSN, RN, CORLN; Director, Ambulatory Nursing, Michele Farrington, BSN, RN, CPHON; Clinical Healthcare Research Associate, and Kirsten Hanrahan, DNP, ARNP, CPNP-PC; Nurse Scientist and The 2015 Revised Iowa Model of Evidence-Based Practice to Promote Excellence in Health Care presented by Farrington, Hanrahan, and Victoria Steelman, PhD, RN, CNOR, FAAN, Associate Professor, from the UI College of Nursing. Farrington also presented: Staff Nurse Role Questioning Practice Locally and Providing a Guide for Nurses Globally.

In November 2015 and May 2016, visiting healthcare clinicians from NIGERIA spent a month at UI Hospitals and Clinics to observe how we deliver healthcare in the Neonatal Intensive Care Unit. UI Hospitals and Clinics has one of the lowest infant mortality rates in the world. Emily Spellman, MSN, RNC-NIC, Nursing Practice Leader, designed an itinerary to help the visitors learn about many of the standards of practice employed here in areas such as intravenous nutrition, central line insertion, neonatal resuscitation, and safe sleeping practices.

In January 2016, Sharon Tucker, PhD, RN, PMHCNS-BC, FAAN; Director, Nursing Research, Evidence-Based Practice and Quality, Laura Cullen, DNP, RN, FAAN, EBP Scientist, and Michele Farrington, BSN, RN, CPHON, Clinical Healthcare Research Associate traveled to ABU DHABI, UNITED ARAB EMIRATES to conduct an Evidence-Based Practice Workshop with nurse leaders at the new Cleveland Clinic there.

Beginning in March 2016, a nursing student from TURKEY spent six months at UI Hospitals and Clinics conducting research on how to help families adjust to having a child with a gastrostomy tube. Lou Ann Montgomery, PhD, RN-BC; Director, Nursing Professional Development and Advanced Practice/Nursing Informatics Liaison and Laura Phearman, BSN, RN, CPNP, Nurse Clinician, worked out the logistics to make this experience possible and helped expose her to evidence-based processes that she was able to apply to her work with gastrointestinal patients in Turkey.
In May 2016, Gloria Dorr, MA, RN-BC, Nursing Practice Leader and Pamela Kunert, MSN, RN-BC, Nursing Practice Leader, were invited by the UI College of Nursing to present work they have done to integrate “NNN” (NANDA, NIC, NOC) language into care plans and nursing documentation in the electronic health record at the NANDA Conference in MEXICO. The UI Hospitals and Clinics Department of Nursing has partnered with the UI College of Nursing for nearly four decades in the development and use of standardized nursing languages. “Because we have been using NANDA, NIC, and NOC for so long, it helped us when we implemented standardized language into the electronic health record,” explains Dorr: “We have touched many nations over the years with the work we’ve done.”

The UI Department of Nursing continued to demonstrate worldwide reach through its EBP programs and resources. The Advanced Practice Institute: Promoting Adoption of EBP in October 2015, was attended by visitors from TOKYO, JAPAN, CHIBA, JAPAN, and ABU DHABI, UNITED ARAB EMIRATES.

In April 2016, the UI Hospitals and Clinics 23rd National Evidence-Based Practice Conference was attended by participants from THAILAND, JORDAN, and CANADA.

In addition, between July 1, 2015–June 30, 2016 there were 49 international requests to use the Iowa Model from countries including: AUSTRALIA, BRAZIL, CANADA, CHINA, COLOMBIA, CZECH REPUBLIC, INDIA, INDONESIA, JAMAICA, JAPAN, KENYA, KOREA, NETHERLANDS, OMAN, PHILIPPINES, PORTUGAL, SINGAPORE, SOUTH KOREA, SWITZERLAND, TAIWAN, THAILAND, TURKEY, UNITED ARAB EMIRATES, and UNITED KINGDOM.
**UI HOSPITALS AND CLINICS** is the first and only hospital in the state of Iowa to have a Gold Beacon Award unit designation from the American Association of Critical-Care Nurses (AACN). Additionally, four units have earned Silver Beacon Awards.

The Gold Beacon Award went to the Intermediate Medical-Surgical Cardiology Unit. Of the eight Silver Beacon Awards given in Iowa, four of them were awarded to units at UI Hospitals and Clinics: MICU, Surgical and Neuroscience Intensive Care Unit (SNICU), Adult Blood and Marrow Transplant, and Cardiovascular Intensive Care Unit (CVICU).

The AACN Beacon Award designates three levels – gold, silver, and bronze – recognizing significant milestones along a unit’s journey. For patients and families, the Beacon Award signifies exceptional care through improved outcomes and greater overall satisfaction. For nurses, a Beacon Award signals a positive and supportive work environment with greater collaboration between colleagues and leaders, higher morale, and lower turnover. The Beacon Award designation is active for three years. Award recipients show exceptional performance in five categories: Leadership Structures and Systems; Appropriate Staffing and Staff Engagement; Effective Communication, Knowledge Management, Learning and Development and Best Practices; Evidence-Based Practice and Processes; and Outcome Measurement.

“Our number one goal is to provide excellent patient care,” says Toni Mueller, DNP, RN, CCRN, Director, Intensive and Specialty Services, who counts four of UI Hospitals and Clinics’ five Beacon Award winners in her group. “Our units value evidence-based practice, as well as advocating for our patients and making a difference in their lives.”
THE ED AT UI HOSPITALS AND CLINICS was one of only 11 EDs in the country selected to receive a 2016 Lantern Award. This award recognizes a select group of EDs that exemplify exceptional practice and innovative performance in the core areas of leadership, practice, education, advocacy, and research. This was the first time UI Hospitals and Clinics’ ED has applied for the Lantern Award.

ED patients and their families seek quick access, meaningful interactions with the healthcare team, and a coordinated plan. The Lantern Award recognition is valid for three years and is a visible symbol of an ED’s commitment to quality, presence of a healthy work environment, and accomplishment in incorporating EBP and innovation into emergency care. Successful applications demonstrate a variety of diverse initiatives with quantifiable outcomes, sustained improvements, and innovative processes. Submissions are evaluated by a team of reviewers via a blinded review process. The ED team received the award at the Emergency Nursing 2016 conference in Los Angeles, CA in September 2016.
THE 100 GREAT IOWA NURSES PROGRAM annually honors 100 outstanding nurses selected from the 99 counties in Iowa and funds financial awards to support the education of Iowa nurses. Established in 2004, the program recognizes qualities that demonstrate efforts beyond those expected of a nurse within his/her normal duties, such as concern for humanity, significant contribution to the profession, and mentoring.

A pair of mother/daughter honorees was selected for the first time in the 12 years of the program. Elizabeth Faine from UI Hospitals and Clinics was honored as well as her mother, Colette Rossiter, from Spencer Hospital in Spencer, IA.

The UI Hospitals and Clinics Department of Nursing was pleased to have 13 of the 100 Great Iowa Nurses honorees for 2016:

- Anne Bye, BSN, RN, CPN, Staff Nurse, 3JCP
- Elizabeth Faine, MSN, ARNP, PNP, Nurse Practitioner, Department of Orthopedics
- Lisa Gerard, RN, Staff Nurse, Pediatric Specialty Clinic
- Brenda Haag, BSN, RN-BC, Nurse Clinician, Fetal Heart Program
- Trudy Laffoon, MA, RN-BC, Nurse Manager, Dermatology Clinic/Surgery Specialty Clinic
- Michelle Mathias, BSN, RN, Clinical Coordinator, Perioperative Nursing Services
- Judy A. Miller, ARNP, Nurse Practitioner, Department of Pediatrics
- Geralyn Quinn, MSN, RN, OCN, Nurse Manager, Holden Comprehensive Cancer Center
- Kenneth J. Rempher, PhD, RN, MBA, CENP, Chief Nursing Officer
- Stephanie Stewart, MSN, RNC-NIC, Nursing Practice Leader, Children’s and Women’s Services
- Christina Trout, MSN, RN, Clinical Service Specialist, Department of Pediatrics – Neuromuscular Program
- Stephany Walk, BSN, RN, Staff Nurse, Pediatric Intensive Care Unit (PICU)
- Laramie Wall, BSN, RN, Staff Nurse, Extracorporeal Membrane Oxygenation

THE DAISY FOUNDATION provides grants, encouragement, and awards for exceptional nurses across the country. Developed as a way to give back to nurses who give so much to their patients, the DAISY Award recognizes one of our nurses each month with a bouquet of daisies (of course), a unique sculpture, cinnamon rolls, and a banner displayed on her/his suite.

July 2015: Caitlin Davis, BSN, RN, 3 John Pappajohn Pavilion West (3JPW)
August 2015: Kelsey Rasmussen, BSN, RN, 3 JCP September 2015: Allison Banwart, BSN, RN, SNICU
October 2015: Jennifer Off, BSN, RN, OCN, Holden Comprehensive Cancer Center Infusion Service
November 2015: Kristi Durbin, BSN, RN, 6 Roy Carver Pavilion West (6RCW)
December 2015: Michelle Greve, BSN, RN, Clinical Research Unit Team 4
January 2016: Holly Olson, MSN, RN, ED
February 2016: Shelly Lacy, RN, 4 Roy Carver Pavilion (4RCP)
March 2016: Patrick Doser, BSN, RN, CFRN,CEN, CPEN, AirCare
April 2016: Brittany Mozerka, RN, 6 John Colloton Pavilion (6JCP)
May 2016: Heidi Haustein, BAN, RN, CMSRN, 6 Roy Carver Pavilion (6RCP)
June 2016: Laura Super, MSN, RN, CCRN, SNICU
THE FELLOWS OF THE ASSOCIATION OF NURSE PRACTITIONERS (FAANP) program was established in 2000 to recognize nurse practitioner leaders who have made outstanding contributions to healthcare through clinical practice, research, education, or policy. Invitation to the fellowship is one of the highest honors a nurse practitioner can receive for accomplishments in the Nursing profession. The 2016 Fellows from UI Hospitals and Clinics are:

- Maria Lofgren, DNP, ARNP, NNP, PNP, FAANP, Director of Advanced Practice Providers, Nursing Administration
- Cheryll Jones, ARNP, CPNP, FAANP, PA/ARNP/NNP Supervisor, Pediatrics

NURSING EXCELLENCE IN CLINICAL EDUCATION AWARD is given jointly by the UI Hospitals and Clinics Department of Nursing and the UI College of Nursing to recognize a BSN-prepared Staff Nurse for excellence in learning, educational leadership, advocacy, professional role model, and innovative spirit.

**2016 Staff Nurse Recipient:**
- Kari Bornong, BSN, RN, 3JCP

**2016 Staff Nurse Semi-Finalists:**
- Amy Conklin, BSN, RN, Radiology
- Jackie English, RN, CORLN, 3JPW/Otolaryngology Clinic
- Lindsay Fayram, BSN, RN, CCRN, PICU
- Erica Gooding, BSN, RN, 4 John Pappajohn Pavilion (4JP)
- Allison Hanson, BSN, RN, Acute Pain Service
- Rachel Krueger, BSN, RN, 6JCP
- Katherine Schroeder, BS, RN, PCCN, Heart and Vascular Center
- Jill Swartz, BSN, RN-BC, 4JP
- Brittany Wicks, BSN, RN, 4JP

THE SALLY MATHIS HARTWIG SCHOLARSHIP is awarded annually to a nurse currently employed by UI Hospitals and Clinics who demonstrates excellent clinical skills and leadership potential and is seeking an advanced degree through the UI College of Nursing. The 2016 recipients were:

- Katie Hepfer, BSN, RN, CPHON, CPNP-PC, Staff Nurse, 3JCP
- Trudy Laffoon, MA, RN-BC, Nurse Manager, Dermatology Clinic/Surgery Specialty Clinic
THE PROFESSIONAL RECOGNITION PROGRAM (PRP) recognizes and rewards the accomplishments of direct care Staff Nurses for their engagement in direct patient care as they support safety, quality, and research. These RNs consistently go ‘above and beyond’ in such areas as precepting new nurses and nursing students, engaging in quality improvement and/or EBP projects, participating in committees and councils, promoting service excellence, and demonstrating involvement in professional activities.

There are two levels of accomplishment: Level 1 (Silver) for meeting 10 of 17 professional achievement and contribution requirements and Level 2 (Gold) for meeting 15 of 23 professional achievement and contribution requirements.

The cohorts named in July 2015 (Cohort 4) and March 2016 (Cohort 5) form a combined total of 45 nurses recognized at Level 1, and one nurse recognized at Level 2.

Cohort 4 — July 2015
Level 1 Recipients
- Julie Barrett, BSN, RN-BC, SNU
- Melissa Bodecker, BSN, RN, 7 Roy Carver Pavilion (7RCP)
- Deniece Carlson, BSN, RN, OCN, 4 John Pappajohn Pavilion (4JPP)
- Robin Enfield, BSN, RN, CNRN, 2 Boyd Tower (2BT)
- Lindsay Fayram, BSN, RN, CCRN, PICU
- Emily Gage, MSN, RN, CNOR, Main OR Team 3
- Nancy Hanson, BSN, RN, CNOR, Ambulatory Surgery Center
- Ashley Hinman, MSN, RN, University Employee Health Clinic
- Jennifer Lewis, BSN, RN, CCRN, PICU
- Sheri McSwain, BSN, RNC-OB, Resource Unit
- Jennifer Off, BSN, RN, OCN, Holden Comprehensive Cancer Center Infusion Suite
- Stephanie Palmer, BSN, RN, 7 Roy Carver Pavilion (7RCP)
- Abby Salton, BSN, RNC-OB, Labor and Delivery
- Deborah Sheikholeslami, BSN, RN-BC, OCN, 4JPP
- Colleen Shipley, BSN, RN-BC, Pediatric Cardiac Catheterization Lab
- Katie Steele, BSN, RN-BC, 4JPP
- Stacy Steffens, MSN, RN, Digestive Disease Center
- Jill Swartz, BSN, RN, 4JPP
- Ashley Switzer, MSN, RN, 2BT
- Jennifer Szymanowski, BSN, RN, CCRN, PICU
- Kimberly Taylor, BSN, RNC-MNN, Childbirth Educator
- Nancy Vincent, BSN, RN, CNOR, Ambulatory Surgery Center
- Tyeisha Washington, BSN, RN, SNICU

Cohort 5 — March 2016
Level 1 Recipients
- Chelsea Amelon, BSN, RN, 4RCP
- Anne Bye, BSN, RN, CPN, 3JCP
- Chelsea Dvorak, BSN, RN, CCRN, PICU
- Emily Lu Hast, BSN, RN, 4 John Pappajohn Pavilion West (4JPW)
- Andrea Haynes, BSN, RN, CCNR, PICU
- Mary (Lisa) Hill, BSN, RN, CNOR, Ambulatory Surgery Center
- Teresa Julich, MSN, RN, CCRN, Extracorporeal Membrane Oxygenation/CVICU
- Jessica Karr, BSN, RN, CCRN, SNICU
- Gracie Laughton, BSN, RN, CPHON, 3JCP
- Keri L. Nace Mercer, MPH, BSN, RN, CMSRN, 4JPW
- Gail O’Donnell, BSN, RN, CPAN, Ambulatory Surgery Center
- Mary Ohm, BSN, RN, CV-BC, 4RCP
- Deborah Schloss, BSN, RN, 2BT
- Kelsey Striegel, BSN, RN, CPEN, CEN, ED
- Carrie Swenka, BSN, RN, Neonatal Intensive Care Unit (NICU) Bay 1
- Deborah Strike, BSN, RN, Neonatal Intensive Care Unit (NICU) Bay 1
- Melissa Vrban, BSN, RN, CNOR, Ambulatory Surgery Center
• Jackline Wangui-Verry, MSN, RN-BC; Roy Carver Pavilion (2RCP)
• Jenny Weber, BSN, RN, CPN; John Colloton Pavilion (2JCP)
• Connie Witte, BSN, RN-BC; Women’s Health Center
• Paula Woods, BSN, RN, CNOR; Ambulatory Surgery Center
• Malika Ziebarth, MSN, RN, CCRN, CVICU

Level 2 Recipient
• Lisa Kongable, MA, ARNP, PMHCNS-BC, CNE, John Pappajohn Pavilion West (1 JPW)

CORRIDOR BUSINESS JOURNAL
WOMEN OF INFLUENCE

The Corridor Business Journal, a weekly publication focusing on the Cedar Rapids-Iowa City area business community, annually recognizes a select group of talented and inspiring women who have made the region a better place to live. Karen Stenger, MA, RN, CCRN, Nursing Practice Leader, was selected to be among the 2016 Women of Influence because of her leadership, knowledge, and dedication to exceptional patient care.

QUALITY FELLOWS IN IOWA, INAUGURAL QUALITY FELLOWS PROGRAM
Renee Gould, MS, RN-BC, Nursing Practice Leader, was one of 21 participants accepted from across the state to participate in the Iowa Hospital Association’s first Iowa Quality Residency Program, which was held from November 2015 to December 2016.

HELPING HANDS: RECOGNIZING OUTSTANDING MERIT STAFF
Assistants, technologists, and clerks have an enormous impact on the patient experience. Yet, even though these colleagues are essential members of our care team, clinician surveys showed that many of them did not receive the recognition and appreciation they deserve.

The Nursing Assistant Workgroup has created a program focused on positive reinforcement and public recognition to not only reward individuals for outstanding work but to also remind the entire hospital of the importance of support staff.

The new “Helping Hands” program combines individual acknowledgement with group appreciation. Helping Hands nomination forms are displayed in each unit and are always available on the intranet. Patients, visitors, volunteers, and co-workers are all welcome to nominate any outstanding merit clinician that performs direct patient care.

Helping Hands Award Recipients:
December 2015: Diane Kohl, Nursing Unit Clerk, 6RCP
February 2016: Carolyn Smith, Psychiatric Nursing Assistant, John Pappajohn Pavilion West (1JPW)
March 2016: Joyce Rogers, Nursing Unit Clerk, Digestive Diseases Clinic
May 2016: Jean Burr, LPN, 3JPW
June 2016: Christina Kelly, Nursing Assistant, MICU
Abbott, L., Quinn, G., & Cullen, L. (2016). Energy Through Motion©. In M. Farrington (Series Ed.), EBP to Go©: Accelerating evidence-based practice. Iowa City, IA: Office of Nursing Research, Evidence-Based Practice and Quality, Department of Nursing Services and Patient Care, University of Iowa Hospitals and Clinics.


Block, J., Lilienthal, M., & Cullen, L. (2015). Thermoregulation for adult trauma patients. In M. Farrington (Series Ed.), EBP to Go©: Accelerating evidence-based practice. Iowa City, IA: Office of Nursing Research, Evidence-Based Practice and Quality, Department of Nursing Services and Patient Care, University of Iowa Hospitals and Clinics.


Iowa Model Collaborative. (in press). Iowa Model of Evidence-Based Practice: Development and validation of revisions. *Worldviews on Evidence-Based Nursing.*


Shalla, A. (2016). Nurse work hours and fatigue mitigation. In M. Farrington (Series Ed.), *EBP to Go®: Accelerating evidence-based practice.* Iowa City, IA: Office of Nursing Research, Evidence-Based Practice and Quality, Department of Nursing Services and Patient Care, University of Iowa Hospitals and Clinics.


