Pennsylvania Organization of Nurse Leaders Annual Leadership Conference

2019 Poster Abstract Booklet

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1. Myth or Fact: Reward and Recognition of Nurses Increases Engagement – Heather Rizzo, DNP, RN-BC, CENP

Background/Significance: Employee engagement is a topic that has captured the attention of healthcare organizations for several important reasons. Research has revealed a strong link between high employee engagement and increased patient satisfaction, higher quality of care, greater productivity, better retention of nurses, and less absenteeism.

Purpose: This intent of this study was to examine specific strategies related to reward and recognition and the impact the interventions have on employee engagement. Innovative strategies were explored.

Methods: A quasi-experimental study was conducted to identify if employee engagement can be improved using specific strategies involving reward and recognition. The Utrecht Work Engagement Scale was used for the pre-surveys and post-surveys. Registered professional nurses from two medical/surgical units were recruited. Three nursing leaders were responsible for the interventions.

Results: The sample included 18 RN's with a mean age of 36.11 and 7.72 years of experience. The Wilcoxon Signed Rank Test (non-parametric version of paired t-test) was performed to test if there was a difference between Pre-scores and Post scores.

Conclusions: The finding may suggest that nurses under the age of 30 have an increase in engagement levels through reward and recognition. The subcategory of "dedication" was remarkably higher than vigor and absorption which may indicate that reward and recognition helped increase "I am proud of the work I do". It is important that nursing leaders focus on ways to increase employee engagement of their teams into their daily routine as this will help improve patient outcomes.

The finding may suggest that nurses under the age of 30 have an increase in engagement levels through.

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2. Implementing a Hospital-Wide Charge Nurse Orientation – Brittany Sheets, DNP, RN

The question was brought up asking what can be offered to nurses to help develop them professionally and how to spread it across the hospital. The charge nurse role was brought up since it is a complex and dynamic position. There has been a focus on developing nurses to become a leader in their unit and the charge nurse is the next in line leader.

Within the facility, there is no standard orientation for a charge nurse. Every unit has their own version of what a charge nurse needs to orient to and know. There was an 8hr day fellowship designed to help new charge nurses understand some concepts for them to be confident and successful in the role. Not all Unit Directors send nurses and this only occurs twice a year. A charge nurse orientation record was developed which serves as a checklist that the Unit Directors and/or clinicians will review with them. For example some of the topics included is the chain of command, their role in code response, understanding Hours per Patient Day, resources, staffing, and unit specific tasks the charge nurses do on that unit, which each unit had the opportunity to add. We also have them doing 6 Skill Builders, which are online learning modules. These discuss specific topics to enhance their personal and professional growth. The topics identified relate to a charge nurse and how they are to interact with other members of the team. In order to be signed off on orientation and to then be in the role, the nurses will need to complete their orientation record and the skill builders, attend a Charge Nurse Fellowship, and shadow a current charge nurse.

This will help hold every charge nurse to the same standards across the entire hospital.

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3. Continuous Video Monitoring Versus Traditional Patient Safety Sitter In an Acute Care Setting: An Outcome Analysis – Abigail Hebb, MSN, RN, CMSRN

To determine the usage of continuous video monitoring (CVM) in comparison to a human safety sitter identifying the incidence of falls.

Patient safety sitters pose a significant financial burden on hospital systems. AvaSys developed remote CVM systems to ensure patient safety while mitigating costs. CVM is being utilized at UPMC Shadyside when appropriate to replace human sitters for patient safety.

Data was conducted for six months to determine the usage of CVM in an acute care facility. Data was collected daily from February to July 2018 on the usage of CVMs in comparison to safety sitters. Five CVMs were available. The sample included patients who met the criteria for CVM or patient safety sitter according to policy guidelines. All falls data was analyzed for patient demographic characteristics, utilization of CVM versus human sitters, and incidence of falls within each group.

Over a six-month period 488 (33.0%) CVM were utilized in comparison to 993 (67.0%) safety sitters. A total of 259 falls occurred over the course of six months when neither type of sitter was used. Over the period of six months, a total of ten falls occurred, of which three falls were with CVM, and seven occurred with safety sitters. Among patients that were in CVM falls group, the average age was 66 years and 67.0% of the patients were female. As for the patient sitter group, the average age was 65.3 years. Of note, no serious injuries occurred in either group.

Based on the findings, the research team will design a prospective observational cohort study to evaluate outcome variables including falls, length of

stay, and seven-day readmissions. Accurate utilization of CVM may help patients, providers, payers, and health systems with decision-making and opportunities for intervention(s) early in the disease course, therefore prioritizing the public health implications associated with falls.

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4. Merging Leadership Styles to Positively Impact Nursing Satisfaction: A Reflective Analysis – Vincent Burkhimer, BSN, RN // Crystal Grone, MSN, RN

Inconsistent management and tenure on a nursing unit can lead to decreased nursing satisfaction and job enjoyment as well as a decrease in nursing staff that plan to stay in direct patient care on the same unit. When a unit-level, nurse management team of varying leadership styles, including an Authentic Leader and a Transformational Leader, are hired into the gaps where inconsistent leadership once was, a new collaboration of leadership style follows and allows opportunity for growth where detriments once were. Attributes of the authentic leader include self-awareness, relational transparency, balanced processing, and internalized moral perspective. The Transformational Leader is a model of integrity and fairness, sets clear goals, encourages others, and provides support and recognition. Strategies that have been incorporated into the nursing unit include: consistent staff recognition, increased staff autonomy, promotion of staff self-awareness, quarterly celebrations of staff culture surrounding diversity and inclusion, and maintaining a unit of complete transparency. A reflective analytical review of nursing satisfaction scores was utilized to determine the impact of newly blended management styles. The 2018 NDNQI RN Survey results showed a marked improvement, in almost every area, when compared to the previous years and have also exceeded national benchmarks. These areas include: RN-RN interactions, RN-MD interaction, RN's decision-making, RN autonomy, professional status, professional development opportunities, nursing management, nursing administration, time management, and perceived improved quality of care within the nursing unit. Additionally, results showed a significant increase in job enjoyment and a noticeable increase in nursing staff planning to stay in direct patient care on the same unit.

Another statistical demonstration of leadership effectiveness is a continuously low rate of nurse turnover. Staff retention rates, for this unit, have consistently remained high and directly contribute to the organizational retention rate, which is ranked on of the highest in the nation. Nurses, over a two year period, have left the nursing unit for two reasons: geographical relocation and professional progression (Step-down to ICU, RN to Advanced Practice RN).

- In the United States employee turnover is increasing as the economy improves following the Great Recession. Healthcare has one of the highest turnover rates among industries.
- At Temple University Hospital, employee retention is strong and turnover rates are decreasing.
- Currently, Temple University Hospital's turnover rate is 57% lower than the national average.
- RN vacancy rate on consistent decline:

July 2016	9.17%
July 2017	5.37%
July 2018	3.96%
April 2019	0.98%

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5. Impacting Health and Legislation through Collaboration and Interdisciplinary Involvement – Carol Amann, PhD, RN-BC, CDP, FNGNA // Melissa Lund, MSN, CNE, CRNP

Collaborative practice, ongoing communication and relationship building are essential skills to master to improve the health of our community. Nurses are entrusted to improve the health of our community. Through multidisciplinary collaboration across the curriculum, faculty and students addressed the vaping epidemic by providing education, focused interventions, leading the way for legislative support, and providing alternatives to vaping. Utilizing the model created as an exemplar, others can adapt interdisciplinary collaborative models of care.

Problem/Issue/Project: Nursing faculty identified a common health issue that affects our vulnerable youth populations.... Vaping. Electronic cigarettes (E-Cigs) or vaping has become prevalent in society with marketing and packaging designed to entice adolescents to engage in this risky behavior. According to the Centers for Disease Control (CDC) adolescents who partake in vaping or using other forms of electronic cigarettes are more likely to smoke cigarettes in the future (CDC, 2018).

Methods: In consideration of health promotion and improving the wellbeing of our citizenry, nurses are at the forefront to provide education and lobby legislation to improve the health of our community. Utilizing input from Respiratory therapy colleagues and faculty collaboration of two senior level nursing courses, community nursing and health policy, faculty, students, and community leaders came together to address the vaping epidemic by providing peer education, focused interventions, alternatives to vaping, and gaining legislative

support to impact accessibility and marketing of materials.

Results: Audiences impacted were vulnerable inner-city youth, middle school educators, state legislators, and the nursing students, our future leaders, who participated in one or both events (teaching and lobbying). Pre and Post tests were provided to inner city youth regarding their knowledge of vaping. These results indicated that the teaching program was effective in delivering the message to youth regarding education on the dangers of vaping. Legislators were also educated on vaping, the effects, and concerns regarding targeted marketing toward youth through the creation of a position paper and active face-to face lobbying. This approach gained support of legislators to promote legislation designed to curtail aggressive marketing techniques employed by the vaping industry.

Conclusion: The combined efforts by utilizing multidisciplinary experts and through the integration of two separate courses to promote wellness were highly successful in both the education of inner-city youth and impacting legislative changes. In looking to more than one outreach program against vaping, we brought awareness and a call to action in a myriad of ways. Working together for a common cause allows all involved to experience the full effect of seeing a project from start to fruition with the realization that we, together, can make a difference.

Adaptability: Multidisciplinary collaboration methods utilized can positively impact change from a health, wellness and legislative perspective. Bringing multiple disciplines and skill levels to the table through active mentoring can yield positive results in a multitude of projects thereby producing experts for the future growth and development of healthcare professions.

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6. Using Simulation in Behavioral De-Escalation Training – Susan Pazuchanics, MSN, RN, CCRN, RN-BC // Terry Brosche, MSN, RN, CCRN-K, CHSE

Problem: Serious workplace violence is becoming more prevalent in healthcare. In 2018, two serious events took place within our medical center that placed staff in harm's way. The two events led to the creation of a 24-7 behavioral de-escalation response team (BDRT).

This team would require training on identifying patient triggers for escalation, both verbal and non-verbal, as well as training in effective communication skills and situational awareness.

Methods: An educational plan was developed to address the unique needs of the BDRT. First, a computer-based learning module was completed on the Art and Science of De-Escalation to review effective communication skills needed for de-escalation. Second, the team members attended an eight hour crisis prevention training which included didactic material and hands on practice through case studies. Lastly, the team members participated in a live simulation where they would interact with standardized patients to diffuse an escalating realistic bedside situation. The simulation was then debriefed with the participants.

Conclusions: The simulation education was well-received. Learners appreciated the opportunity to practice and reinforce the content learned through the classroom and computer training. Since the BDRT went live in January, 2019, we have averaged about one activation call per day, and we have had zero harm towards staff members, successfully de-escalating the patients or family members in each scenario. To maintain education and expertise, ongoing education and simulation are planned so learners can continue to practice de-escalation techniques.

Evaluation: Since implementing this educational plan and activating the BDRT, we have had no negative outcomes. The planning team continues to evaluate the process and education.

Adaptability: This educational plan has great potential to be adapted into multiple healthcare settings. The first tier was a computer-based learning module on communication and verbal techniques to be used in de-escalating a situation. The second tier was an eight hour live classroom training in crisis prevention. The final tier was the simulation exercise where learners were placed into a realistic scenario and required to use their de-escalation techniques to defuse the situation. Standardized patients were used for the scenarios. The simulation scenarios can be adapted to fit the type of medical center, or an inpatient or outpatient setting, to maintain realism for the learner.

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7. Optimizing Care Transitions: Re-imagining Case Management – Mary Pat Winterhalter, MS, BSN, RN, NE-BC

An opportunity was identified to create efficiencies, reduce readmission rates and improve patient satisfaction by redefining roles and responsibilities related to discharge planning and care transitions. Historically, nurse case managers were attempting to complete utilization review, obtain authorizations for continued stay, work with providers regarding insurance denials, adhere to regulatory standards and establish a patient centric discharge plan. Social Services and Case Management were referring patients to post acute care services. This traditional structure was dissatisfying to nurse case managers, confusing to patients and staff and was no longer producing desirable results or favorable hospital metrics.

Project goals and deliverables included: developing current and future roles and responsibly matrix and budget analysis, restructure case management department, Transitional Care Nurse Navigator (TCNN) as single point of contact for patient, implement software solution to support new workflows, reduce 30 day readmission by bridging the care continuum and navigating patients through the acute care visit, post

acute period and back into the ambulatory care setting.

To fully implement this process improvement project a phased approach would be necessary. Six full time Transitional Care Nurse Navigators would be recruited, hired, and fully oriented. In order to be budget neutral there was a need for FTE redistribution. It was decided to split out the two roles of the Case Management staff. The task of utilization review would be given to a small group of nurses called Case Managers and their leadership hierarchy would roll up through the CMO. The function of discharge planning would be assigned to the TCNN and their reporting structure would roll up through the CNO. Leveraging technology was also accomplished by replacing pages with smart phones and implementing two web based patient transition software solutions.

Along with discharge planning activities, the TCNN assumed the primary responsibility of collaborating with the care team to ensure patients were discharged with follow up appointments in hand. Post discharge phone calls were also added the TCNN responsibilities. A templated telephone encounter was created in the EHR to capture a brief head to toe assessment in addition to questions about medication adherence and anything specific to the discharge that the TCNN needed to act upon.

A TCNN dashboard was created with key performance indicators to monitor process and outcome measures. This dashboard is shared regularly with leadership and staff and is a source for reassessment with focused intervention to continually refine and improve the discharge care transition.

The restructure of the traditional case management model is certainly something that could be replicated in an acute care setting. Customizations that support the delineation of roles and responsibilities of front line staff and efforts to adopt a single point of contact for patients is worth investigation by hospital leaders.

Upward trends have been seen in the Press Ganey HCAHPS discharge and care transition domains. Downward trends have been seen in 30 day readmissions. The Hospital & Healthcare Association of PA awarded this project it's 2019 Optimizing Operations Award at their May 2019 Leadership Summit in Harrisburg, PA.

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8. Nurse-Driven Practices for Reducing Unnecessary Oncology Admissions and Improving Patient Care Across the Continuum: Changes to Reflect the Changing Healthcare Environment – Abbey Walsh, RN, MSN, OCN // Lauren Cullen, RN, BSN, OCN, ASQ-CSSGB

Nurse leaders at all levels at an 800-bed academic medical center recognized the need to improve communication and develop a partnership between a same-day oncology evaluation center (OEC) and an emergency department (ED). Oncology patients are a high-risk patient population for their specialized care needs that often require immediate assessment and intervention that can otherwise lead to unnecessary ED visits and preventable inpatient admissions. Establishing a nurse-driven partnership between the OEC and ED with shared-decision making and collaboration is needed to improve clinical practice, care across the continuum, prevent delays in care delivery, and reduce unnecessary admissions for oncology patients.

Nurse leaders supported clinical nurse greenbelts to use six sigma methodology to: improve care transitions by developing innovative nurse and APRN driven practices; establish criteria for varying levels of care; and improve OEC-ED communication to ensure high-quality, patient-centered care. Nurse greenbelts mentored by blackbelts and executive leadership performed a gap analysis to identify best practices in reducing avoidable readmissions through understanding barriers to maximizing OEC utilization and inefficient oncology-specific interventions in the ED. This included qualitative data from interprofessional surveys, focus groups, and benchmarking. Retrospective chart reviews identified opportunity to shift care from the ED to OEC, and develop pathways for ED observation utilization for oncology patients requiring care beyond the capacity of the OEC, but not an inpatient admission. Shared decision-making between frontline nurses and APRNs leveraged collaboration among nursing teams nurturing the development of: standard EMR documentation to provide a snapshot of a patient's status; a communication pathway ensuring efficient transfer of patient information; education for oncology providers, and development of evidence-based treatment pathways for prompt, individualized care from the OEC to the ED observation unit (OU). Recognizing the value of this initiative, executive leadership sponsored the addition of 24-7 on-call oncologists to provide progressive recommendations to APRNs outside of established care pathways.

After 4 months of these nurse-driven strategies, 11 oncology patients beginning care in the OEC were appropriately transitioned to the EDOU with a disposition to home. Oncology readmission rates decreased by 8.3% within six months. Educational in-services across disciplines assisted with improving communication and knowledge across the health care system. Provider buy-in was achieved by establishing an accelerated transition pathway for OEC patients needing additional care in the ED. The impact of these efforts resulted in an increase in OEC utilization by 302%, and 94% of patients satisfied with OEC care.

These nurse-led practice changes align with national trends to move care to the ambulatory setting while preventing unnecessary admissions. Nurse Leaders investment in nursing practice, interprofessional relationships, and patient-centered care improved the knowledge, skills and abilities required for successful nursing leadership at all levels. The need for same-day evaluation and symptom management has expanded beyond the oncology patient population to other specialties in an effort to address the acute needs of all patient populations and reduce

readmissions. Organizations with large ambulatory practices facing the same pressures can adapt this care model to enhance the continuum of care between departments and prevent avoidable admissions.

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9. Transformational Leadershp and Strategic Staff Allocation – Mpande Mwape, MSN, RN // Carrie Jeffrey, MSN, RN

Purpose: Predicting staffing needs based on accurate unit census projections and resource adequacy requires transparency and collaboration between nursing leaders and nursing staff. Increasing Administrator on Duty (AOD) autonomy and role utilization is essential.

Relevance: Staffing decisions were made by unit leadership and the staffing coordinator during daylight bed meetings. A spreadsheet was used to input scheduled nursing unit staff. This process lacked analytical capabilities, transparency, effective collaborative efforts, consistent resource allocation, and a reliable predictive staffing tool. The absence of AOD involvement in staffing decisions on daylight had a negative impact on relationships, communication, and nursing morale.

Strategy/Implementation: This three-phased leadership strategy involved the development of a predictive staffing tool, the placement of a daylight AOD, and an expedited process for placement of staff where needed. Information technology helped design and implement a predictive tool that utilized real time census, departmental discharges, transfers and surgical admissions to project volume. Utilization of the tool occurs in the daily bed meetings thus increasing transparency in census and subsequent staffing needs for inpatient units. A presurvey was administered to inpatient nursing department unit directors, clinicians, and charge nurses, with a focus on AOD communication, visibility, and collaborative relationships. Seventy five percent of respondents desired more AOD visibility during daylight shifts, while 65% stated that collaboration was ineffective. Scheduling changes enabled the AOD to lead the bed meetings, adding to a more active role in daily staffing decisions.

Outcome: The projected census was calculated within 99.5% accuracy by using a predictive tool. Based on accurate data, AODs were able to efficiently allocate staff while decreasing bed meeting time by 60%. To increase visibility, AODs are scheduled seven days a week, instead of two weekend days. A post implementation survey regarding AOD leadership will be conducted at the six-month mark.

Implications: A transformational nursing leadership approach met the needs of staffing using innovative methods and an empowered AOD to allocate resources effectively and transparently. This leadership formula provides a reliable foundation for trust, nursing engagement and decreased turnover.

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10. Data on the Fly – David Moore, RN, MSN, MBA // Sandy Hlipala, RNC, MSN

Washington Health System (WHS) has developed a process to allow staff to access "Data on the Fly" which has resulted in improved patient satisfaction, safety and delivery of more targeted care. Empowering staff is a goal of most organizations, but doing so requires transparency and access to timely data. To achieve this goal, WHS expanded their nurse call system to include a real-time data reporting system. The dashboard includes metrics and data on hourly rounding, exit alarms, patient calls, response times and interventions. This format provides tailored views of data by role, allowing each stakeholder to see what matters to them. Each view allows a deeper dive into the data, offering a clear path to answers that can drive change, and identify what's working and what's not.

Real-time data has traditionally not been available to staff and therefore, impacts the staff's ability to appropriately plan care for their patients. Historically data is often presented to staff days, weeks or even months later while staff is expected to answer the question of, "Why?" Nurse Leaders at WHS have empowered their staff to use this data during shift change huddles to make decisions about how to alter care to impact patient outcomes. The data allows staff to make timely decisions regarding adjustments in workloads, validation of effective rounding, pain control and fall prevention strategies. Staff can see a real-time connection between the work being delivered and the partnership with our patients to create a safer, more effective means of providing care. The data provided by the tool promotes conversations between care providers to evaluate the effectiveness of care delivered. The staff owns the data and uses it for the benefit of the patient. For example, if a patient is calling for assistance frequently during a shift, the on-coming staff may adjust workloads accordingly or make plans to for additional interventions to meet patient needs.

WHS had a very clearly defined goal to use this data to improve two key clinical areas; Patient Safety (fall reduction) and Patient Experience (staff responsiveness). By empowering the staff to use the data, falls were reduced by 38% on the units utilizing the real-time dashboards in the initial 6 months following implementation. The top box scores in responsiveness of hospital staff for HCAHPS (Press Ganey) rose from the 28th percentile to the 90th percentile within five months of implementation. The information displayed on the dashboards is continually reviewed for improvement opportunities to better drive outcomes. Dashboards are updated with process changes and the roll out of new practices.

The creation of a means to present aggregated data, in near real-time to the frontline clinical staff, has proven to be a very effective tool in impacting patient safety and patient experience.

11. Using a Discharge Checklist in the Inpatient Population – Christina Harker, BSN, RN OCN

Discharges within the inpatient medical oncology population were frequently occurring late in the day and delayed due to preventable reasons. Late discharges lead to issues with patient flow into the inpatient unit, delaying admission or transfer of new patients. A lean Six Sigma methodology was used to address the issue of discharges occurring late in the day, and the implementation of an interdisciplinary discharge checklist was the intervention decided on by the project team. Use of the discharge checklist by house-staff resulted in earlier discharge times by 1 hour on average which were statistically significant (p value -0.04), compared to those who did not have the discharge checklist used during this time frame. The project led the providers to work as an interdisciplinary team to improve the discharge process, and address possible issues that delay discharges proactively, leading to increased communication and relationship building. The checklist allowed for discharge planning to begin upon patient admission to the hospital. Oncology specific task descriptions were included within the checklist; however, the checklist could be adapted to include population specific tasks for a variety of disciplines. This attention to special characteristics within a disease population and interdisciplinary responsibility demonstrates the attention to knowledge of the healthcare environment and professionalism.

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12. 500+ Days Without a Newborn Fall – A Newborn Fall Prevention Program – Donna Martin, MSN, RN, IBCLC

Newborn falls are the most common event affecting newborn safety on inpatient Mother/Baby units (MBU), with approximately 600 to 1,600 newborns in the United States experiencing an in-hospital fall each year. Newborn falls are defined as an unintended sudden descent, with or without injury that results from the newborn coming in contact with the floor, another surface, person, or object. Falls often occur when a parent or other support person falls asleep while holding the infant, when transferring the newborn, or when an individual falls or trips while holding the newborn. The fall may result in physical harm to the newborn and emotional distress to all involved, including the parents and health care team.

There is little research about newborn fall prevention. The challenge faced by the healthcare team is how to balance safety with promoting family bonding. Exhausted parents may not consider the possibility of a fall while caring for their newborn.

While newborn falls have been a safety initiative at Abington Jefferson Health since 2012, the team had not achieved their goal of zero falls as of 2017. After an incident in the fall of 2017, nursing leadership became even more determined to address this problem. In addition to evaluating the events surrounding the falls, which occurred on the unit, literature was reviewed to incorporate the latest evidence based practices. The team of nursing leadership and bedside nurses developed and implemented the fall prevention program.

Components of the Newborn Fall Prevention Program include the following:

- Staff awareness and education. The # of days since our last fall is reported at each patient safety briefing in addition to the posting of the # on the unit. Staff completed the Cribs for Kids Safe Sleep education, which includes fall prevention recommendations. In addition, the unit provided education to other members of the healthcare team who provide services on the unit. MBU collaborated with Environmental Services, Venipuncture, and Dietary to assist the team in keeping the newborns safe. When the team member identifies an unsafe sleep environment, the individual notifies the nurse to address the situation. Members who have found parents sleeping with the newborn in their arms have prevented many newborn falls.
- Parent education. A flyer was created in English and Spanish and posted in each patient's room reminding parents to place the newborn in the crib when the parent is sleepy. This information is reviewed with parents.
- Purposeful Rounding. Hourly rounding by the team includes confirming that the newborn is in a safe position.
- Promoting Maternal Rest. The unit developed "Quiet Time" from 1:30pm -3pm daily to encourage the mothers to nap/rest and limit visitors during that period. Nursing staff limits interruptions during Quiet Time. Parents comment how they are able to rest due to the clustered nursing care.

This program's components can be implemented in other hospital settings to prevent newborn falls.

This process included the AONE competency domain of knowledge of the healthcare environment.

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13. Changing the Climate from Worst to Best: A Unit's Voyage to Success – Lauren Christy, PhD, MSN, RN, NEA-BC // Vittoria Dowds, BSN, RN, CPN

Decreased patient satisfaction is the utmost of importance for hospitals. It is even more imperative for the nurses who care for these patients are satisfied. If the employee is satisfied with their job, they will provide better patient care. Ultimately, RN satisfaction effects the patient's experience and ultimately the outcome. Over three years, an innovative leadership technique to decrease nurse turnover, while increasing patient satisfaction was implemented. Five phases of implementation concerning leadership were executed.

Phase I included listening to staff and dissection of areas of opportunity for patients. Not only was patient satisfaction an area of improvement, but RN satisfaction and turnover were areas of development. Phase II was tasked with building a leadership team. This leadership team would be the 24/7 driver of our mission and vision to create an environment of trust and caring, not only for patients, but for staff as well. Phase III was creating leadership responsibilities to ensure patient and RN satisfaction. Phase IV included quality conversations with patients, patient families and all the staff members on a continuous basis. Finally, Phase V included the repeating of the previous phases to ensure sustainability within the unit.

Constant communication with patients and nursing staff, leadership, autonomy and a multi-disciplinary team approach deemed to be successful. In 2016, the rolling 12-month RN turnover was 25%, patient satisfaction scores in the 30th percentile and leadership scores in the 56th percent. Within 3 years, the climate had changed, and the numbers inversed in a positive way. In 2019, by implementing this leadership process, RN turnover has decreased to 3%, patient satisfaction scores are in the 90th percentile and leadership scores in the 92nd percentile.

The leadership phase implementation is a way to make staff engagement a priority without compromising quality of care. Instead, this implementation has shown to do the opposite and illuminate patient needs. The patients were happier, the staff was satisfied with work environment and leadership was thriving. It can be implemented in any healthcare arena. But the real test of time was the sustainability of the implementation. Leadership completed several phases to incorporate the change, but also continuously re-directing staff and patients to phase I, II and III. The phases were constantly repeated for the sustainment of success.

As hospital leaders, we are tasked with competing priorities on a daily basis. However, it has been shown through this leadership implementation, that patient and employee satisfaction are the drivers to quality care, better outcomes and less RN turnover.

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14. Igniting a Culture of Inquiry in Research and Evidence-Based Practice – Cheryl Monturo, PhD, MBE, ACNP-BC // Cindy Brockway, MSN, RN, CCRP

Problem/Issue/Project: Some clinicians rarely question clinical practice or the status quo. Question asking may not be 'normalized' within their organizations and those in leadership positions may not actively model the practice in a professional manner. Often, organizational climate affects the comfort with which nurses question their practice. Without the freedom to question practice it is difficult to support and grow a research and evidence-based practice environment. Additionally, clinical inquiry and learning is sometimes limited due to the time crunch for most nurses. Micro-learning or manageable bites would address this barrier and delivering this bite on-demand is also critical. We would address this issue through a simple but innovative strategy; the use of QR codes via a mobile device to access this micro-learning opportunity. The code is easily read by a mobile device's camera, redirecting the viewer to documents, videos or photos. Therefore, the purpose of this initiative was to ignite a spirit of inquiry through mobile and micro-learning using an innovative approach.

Method: Three QR codes were created sequentially to introduce the use of this technology. The first linked the viewer to a poster discussion on the hospital's intranet Nursing Journal Club site. Fliers including the code and poster were distributed throughout the institution and read, "scan me for more information." Directions about QR codes were disseminated through the hospital's intranet team page. The remaining two codes of 3 were developed to link the viewer to 2 videos of nurses discussing their posters. This promoted the concept of "virtual poster presentations" and communicating through more than medium. The full posters were on display, and fliers were posted similarly throughout the hospital. These two QR codes were trackable and data were collected over 4 months to determine the number of times someone scanned them to view the videos.

Findings/Conclusions/Solutions: The first code was not trackable, therefore a 2nd code was created and made trackable; eighty-one clicks were recorded. The third code was produced similarly and resulted in a total of 44 clicks.

Evaluation/Outcomes: The overall response to micro-learning through QR codes has been positively received. In addition, ongoing communication with nurses has begun to build relationships in which they are energized to present their work and mentor peers. More needs to be done to encourage sustained interest such as the addition of continuing nursing education credits.

Adaptability: Mobile micro-learning is easily adapted to another hospital, outpatient setting, or even a School of Nursing through the use of QR codes. They are easily recognizable and simple to create and use. Additionally, the small bite of information fits the busy schedule of most nurses.

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15. A Tale of Two Hospitals – MaryBeth Foy, RN, MSN // Elizabeth Avis, RN, MSN, CCRN

A nursing initiative created the role of the independent Rapid Response Nurse (RRTRN)at a Magnet University Hospital. This innovative nurse driven model created an independent role that not only responded to rapid response team (RRT) activations but focused on: proactive rounding, data collection, education, performance improvement activities and leadership in hospital initiatives. After 5 years of proven success, the RRTRN team was charged to replicate this role in the 168-bed community hospital within the health system.

Initially, this task was met with unknown fears and the challenge of change. Fear was turned into action. A multidisciplinary task force was formed and policies were revised and personalized. Traversing the goal of standardizing a model, while preserving the hospital's unique identity was challenging. There were many hurdles in trying to take a successful process at one institution and implement it at another. Clinical nurse champions were recruited from each nursing unit to help this process. Each clinical area received education regarding the new RRT process, while the RRTRNs received education from the staff on their respective specialties. A synergistic relationship formed. Each hospital department received education, rapport had to be established along with their commitment to the process. The RRTRNs would work between the sister hospitals providing consistency, and financial viability.

Replication of the nurse driven model was successful. The adapting culture of the clinical nurses has shifted towards a comfort level with proactive rounding, as well as, the RRTRNs becoming comfortable with rotating between the hospitals and new practice changes. An increase in RRT activations was noted. RRT rates, as calculated by number of events/1000 patient days, rose from 3.61 in January 2017 to 10.09 in July, 2018. Proactive rounding resulted in a decreasing trend in transferring patients to the intensive care unit. June 2017 rates were 2.30 decreasing to 1.89 in June, 2018. There has been positive anecdotal evidence expressed by nursing and physician staff in support of the RRTRNs.

The RRTRN model can be successfully replicated in the community hospital setting with modifications. Particular attention is needed to preserve their community identity. This requires a collaborative effort between the clinical nurses, the RRTRNs and nursing leadership.

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16. SOS: Stamp Out Sepsis, Two-Person Sterile IV Tubing Changes to Prevent Central Line-Associated Blood Stream Infections – Mary Wilson, MSN, RNC-NIC

Central line-associated blood stream infections (CLABSIs) can be lethal for infants, especially those that are extremely premature and compromised. In 2016, four infants had CLABSIs, the highest incidence since 2011. In 2011, there were seven cases which led to the initial launch of the Stamp Out Sepsis (SOS) group - where central line placement and management practices were first evaluated and changed. From 2012-2015, there was an average of one to two CLABSIs per year. The increase in 2016 showed process and practice drift and another SOS group was relaunched. Data revealed that CLABSIs were occurring during the maintenance phase rather than during insertion. The team recognized great variation in practice concerning tubing changes for central lines and identified a need for a specific standard of practice.

Once it was determined that line maintenance was where this SOS initiative needed to focus, the group did a literature review for best practices. The topic was put out on ListServs as well as discussed with epidemiology. CDC and INS guidelines left room for variations. Other hospitals across the country responded with different practices and voiced that they were also looking for guidance on this as well. The team went to an affiliated hospital that has not had a CLABSI in years to learn their practices.

It was then determined that a two-person sterile IV tubing change process would be adopted.

- A step-by-step process was developed
- Special supply carts were purchased to all supplies were readily available to staff
- Staff education was performed
- Maintenance audits on compliance are performed using "secret shoppers"
- Infection data continues to be collected
- If CLABSI occurs, debriefing is performed with involved medical and nursing teams, as well as with epidemiology

Staff training was completed in April and May 2017. Staff was highly resistant to change in practice, as it was time consuming at the start until proficiency was achieved. Process reinforcement was needed, as well as support that this process is what we believe is truly best practice. Many felt that this process was "overkill", and many conversations were had with staff that we were not 100% confident that this would eliminate all CLABSIs indefinitely, but that there was so much practice variation in drift, that it was necessary to essentially start from scratch. Physician buy-in and support was integral to this process change, but most importantly was participation and dedication of bedside nursing champions who helped coach and support fellow staff members. Staff involved voiced feeling empowered and that they had a direct impact on the infant's outcome.

As of this submission, since November 2016 there have been two CLABSIs – one of which was borderline ruled a congenital infection. Staff members are informed of data outcomes and project update through learning boards on the unit.

Standard practice eliminates variations and allows for truly determining point of cause for infection. We continue to collect real-time data and identify further areas for improvement.

17. In-Situ Simulation in the Medical Intensive Care Unit (MICU): Engaging the Millennial Learner – Janet L. Limone, RN, MSN, CCRN, CCCTM // Kathleen Boyle, RN, BSN, CCTM

Problem: The health care environment is changing and the way front line staff are educated needs to change as well. Previously education was brought to staff members in an impromptu manner throughout their workday. Educational feedback included difficulty-retaining information with work distractions, and feelings of being 'nagged'. Evaluations of current educational methods motivated our move toward an innovative approach to addressing staff needs. We noted; for the first time on our unit, there are three generational cohorts in the workplace. Of the eighty-six nurses who comprise the MICU staff, fifty-six (65%) are of the millennial generation. Their learning needs contrast with past education presentations. Millennial learners prefer to work in teams, utilize technology, and acquire new information through active hands on participation (Montenery et al., 2013). The utilization of scenario-based simulation supports the understanding of evidence-based practice in the healthcare environment through the improvement of clinical practice knowledge and dedication to patient safety.

Method: The IRB supported project launched in 2018. The MICU education team created two patient-based scenarios incorporating 12 high-risk/low frequency skills. A low fidelity mannequin bridged the generational gaps. Using a simulation design, presented the opportunity to blend millennial preferences with learning styles preferred by other generations. There were fourteen sessions presented over a six-month period with each two-hour class limited to ten nurses. A modified National League for Nursing (NLN) educational evaluation was completed after each session. The evaluations consisted of ten questions with a 5-point Likert scale of 1 (Strongly disagree) to 5 (strongly agree). A description of the

Findings: The learning content and method of the educational sessions were well received. Greater than 90% Strongly Agree responses were noted on all questions. Due to the success of the project, administration is supportive of future sessions and new scenarios. The project has continued with more staff input. A brief educational needs assessment incorporated into the evaluation tool promoted staff empowerment.

Evaluation: Our new approach to education revealed that scenario-based simulation was effective for all learners, but particularly engaging for our millennial staff. Clinical practice knowledge has been strengthened through scenario-based competency skill review. Evidence-based practice simulation is now the foundation for staff education in the MICU.

Adapability: This project is adaptable to other clinical settings along the continuum of care. The ability to practice high acuity /low frequency skills with simulation builds confidence, competency and promotes safer patient care at the bedside.

AONE competency domain(s): The utilization of scenario-based simulation supports the understanding of evidence-based practice in the healthcare environment through the improvement of clinical practice knowledge and dedication to patient safety.

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18. Utilizing the Aggressive Behavior Risk Assessment Tool to Prevent Workplace Violence Events
– Katharine Gambill, MSN, CMSRN

Problem: In April 2018 the Joint Commission released a Sentinel Event Alert focusing on physical and verbal violence against healthcare workers. Nursing is identified as the profession most vulnerable to patient-related violence and nurses are exposed to high levels of physical and verbal violence. Nurses new to the profession are at especially high risk for experiencing workplace violence as they may not recognize cues and warning signs of an escalating patient. One hospital unit noted 14 documented instances of workplace violence (WPV) between November 2017 and November 2018. In January 2019 the nursing unit is noted to have 52% of its nurses in their first year of practice. The effects of workplace violence may cause higher organization costs and lower quality of care for patients.

Methods: A prospective cohort study was carried out comparing the prevalence of WPV on an inpatient medical-surgical unit before and after utilizing the Aggressive Behavior Risk Assessment Tool (ABRAT), a 10-point questionnaire shown to predict violent events. Patients at high risk for violence were identified using ABRAT and a special magnet was placed on their doorframe so all caregivers were aware of potential violent behavior. Nurses were educated on the use of ABRAT and all staff were educated on the meaning of the magnet.

Findings/Conclusions/Solutions: The ABRAT has been implemented on a 29 bed medical surgical unit that frequently cares for patients at risk for aggressive behavior. Registered Nurses were given a survey utilizing the Likert Scale that assessed their confidence level for assessing patients at risk for aggressive behavior. Fisher's exact test was used to determine a P=0.111 which showed the results were statistically insignificant, this could have been attributed to the extremely small sample size of registered nurses that completed the pre and post survey (n=9). When looking at events of workplace violence there was a statistically significant decrease (p=0.0276) after implementation of the ABRAT tool.

Evaluation: The effects of workplace violence have profound effects on organizational costs and quality of care for our patients. This study provides an innovative strategy that nursing leaders can use to proactively identify patients at risk for aggressive behavior thus lowering organization costs and increasing quality of care.

Adaptability: An identification tool, such as the ABRAT, can be utilized in any healthcare setting to proactively identify patients at risk for aggressive behavior.

AONE competency domains: Knowledge of healthcare environment.

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19. Quick Triage: An Efficient and Effective Tool to Improve Quality Metrics in an Emergency Department – Frances Cusick, MSN, RN, NEA-BC // Marla Pellegrini, MSN, RN, CEN // Joanna Dixon, MSN, RN, CEN

In an era of value-based customer driven care, coupled with the ease and efficiency of electronic health record data, the nursing leadership team at a suburban Philadelphia hospital prioritized daily review of emergency department flow metrics such as door-to-triage, left without treatment (LWOT), door-to-provider, overall length of stay, and disposition to departure times. Metrics perceived to have the most potential for nurse-led improvements were door-to-triage times and LWOT rates. After conducting a literature review, quick triage was determined to be an effective tool to assess patient priorities, decide on appropriate and safe next steps in patient care, and reduce the time from patient arrival to a registered nurses' triage evaluation with an anticipated decrease in LWOT rates.

A nurse-led interprofessional team was convened to establish priority assessments and screenings at the time of quick triage to ensure regulatory screenings would be fulfilled and essential information pertaining to the patient's visit would be collected to promote safe and expedient care. Emergency department nurses were critical in the formulation of the quick triage roll-out plan to ensure bedside expertise and staff buy-in. Part of the planning process included a team of nurses visiting and consulting with other hospitals that had implemented similar processes. Prior to implementation, all staff were educated on the process change, which would be implemented during a time of transition into a newly constructed building.

The nursing team was involved in all aspects of development, including building design and patient flow processes based on best practice nursing care models. The design of the new lobby allowed for a visual across-the-room assessment by nurses of all walk-in patients. After being registered into the department census, a quick look triage nurse was assigned to conduct a review of the present illness, assign an Emergency Severity Index (ESI) triage classification, and determine the most appropriate plan in caring for the patient, including bed assignment when available and entering appropriate protocol nursing orders.

After the quick triage process was implemented, there was open and frequent communication with the nursing team members who were assigned to the triage position to determine strengths and opportunities for improvement with the goal of standardizing practices and refining the process to meet the needs of both the patients and care team members. In response to staff feedback, additional screening measures were added to the triage set to minimize risk and maximize timely and safe patient care.

Ultimately, the time from "door-to-triage" decreased from an average of 16 minutes to 2 minutes. LWOTs decreased from 1.4% to 0.6%. By allowing for a more timely assessment and evaluation by a nurse at time of presentation to the emergency department, there is opportunity to improve efficiency of care in time-sensitive conditions such as stroke, sepsis, and ST-elevation myocardial infarction to positively impact quality of care and ultimately patient outcomes. Through a daily focus on quality metrics, this data-driven initiative provided a tangible triumph in nurse-led care that can be easily translatable to other institutions' emergency departments.

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20. Alternative Work Arrangements for Nurse Managers – Dominique Ferrier, MSN, RN

Problem: Nurse managers often work hours beyond the standard 40 work week. They are available to staff as needed, resulting in frequently answering emails, texts, phone calls beyond standard business hours. During business hours, nurse managers have an increased demand to be visible by allowing an open-door policy. With open door policies, nurse managers can often be prevented from doing meaningful work with can lead to decrease engagement and job satisfaction. 24/7 availability can lead to decrease work life integration. In January 2018, an opportunity was presented by a new policy for working offsite. The policy was implemented with guidelines and started in March 2018. Will my patient, employee, or operational metrics be negativity effected by working from home?

Intervention: Our new DON started in 2017 with a commitment to work life integration for nurse managers. In 2018 a policy was implemented with input from nurse managers and senior leaders to allow nurse managers to work offsite for productive work in an uninterrupted setting. This Nurse Manager evaluated the impact of nurse manager working off site.

Findings:

- Patient satisfaction - Top box: May 2018 – 48th percentile to April 2019 - 81st percentile
- Employee rounding: Maintained visibility with monthly employee rounding
- Employee Turnover: May 2018 - 36.92% to April 2019 – 13.82%
- Did your nurse leader round during your stay: June 2018 - 50% to April 2019 – 94%
- NDNQI 2016/Press Ganey 2018 Survey results

- Leadership access and responsiveness: from 2.51 to 3.81
- Adequacy of Resources and Staffing: from 2.66 to 3.86
- Fundamentals of Quality Nursing Care: from 3.03 to 4.03

Implications: Effective leadership and influence over outcomes may not be diminished; Resilience and integration are an important factor in job satisfaction; Generational leaders prioritize scheduling flexibility and work life integration as a job satisfier.

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21. Caring For Our Caregivers: A Hands-on Culture of Caring Intiative – Patricia Blaney, BSN, RN-BC // Donna Rugh, MSN, RN-BC, CPHN

Problem: The health care system was experiencing increased turn over rate. Nurses and other staff members were informally reporting symptoms of stress and or burnout. Employee engagement surveys reflected this anecdotal report as well.

Methods: Two staff nurses approached the CNO to share concerns about staff morale, turnover and engagement. These nurses obtained approval from the CNO to start a "Caring Cart". A total of 35 bedside nurses (trained in aromatherapy and or Reiki) staffed a schedule for 2 weeks to bring hands on care to our caregivers in 5 hospital settings. The Caring Cart offered aromatherapy hand massages, calm music, therapeutic listening and tasty treats to staff at each hospital during day, night and weekend shifts. While rounding on each unit with the Caring Carts, the teams encouraged the importance of taking a few minutes to relax during a busy shift and communicated a message of gratitude. Staff who participated in the caring cart experience completed a brief paper survey.

Findings: Via collected survey results after two rounds of caring carts (February 2019, May 2019) 97% of employees reported their experience with the caring cart made them feel valued and 94 % reported the caring cart provided an excellent or very good healing environment. The consistent results encourage our plan to utilize the caring cart three times a year as well as to work toward embedding a culture that focuses on caring for staff. An unintended benefit was discovered as the caring cart team reported a sense of pride and appreciated for being able to be a part of caring for their colleagues in such a meaningful way.

Evaluation: This innovative intervention provided an avenue for staff to feel heard and receive a hands on "thank you for the important work you are doing today" from fellow staff members. The leadership team received over 100 emails of gratitude reflecting that little actions may have the biggest impact. Nearly 1,000 response cards were tallied between the two caring cart sessions where messages of thanks and sincere appreciation were also captured. Additionally, the team noted an overall increase in communication with the added benefit of promoting a reduction in power gradient.

Adaptability: This project is easily adaptable to many healthcare settings. The cart itself is the physical vessel and the treats and personal touches can be tailored to match the culture of any healthcare institution. Costs can easily be contained to accommodate budgetary restrictions. The message is in the intentional offering of gratitude to staff and personally acknowledging the important work they do each day through holistic communication.

AONE Competency Domain: (Communication/Relationship Building and Leadership) The nurse leaders acknowledged the issue of turnover and burnout within the organization and worked to provide creative solutions.

By focusing on a culture of caring for caregivers, the leadership team strengthened relationships and communication with staff while providing an environment that promoted self-care, minimizing stress and burnout factors.

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22. Leading Change: A Collaborative Approach to Patient Education – Lisa Figueroa, BSN, RN, OCN

High -quality patient education is associated with adherence to treatment plans, patient satisfaction, and patient outcomes. As ambulatory oncology infusion centers are expanding to serve an increasing volume of complex patients, educational support should be evaluated. Oncology infusion nurses deliver concise, valuable patient education that improves patient satisfaction and understanding of teaching, while decreasing patient wait times and preventing inpatient admissions.

Hospital executives and nurse leaders identified a need to enhance the clinical practice environment through expanding patient education. Clinical nurses at all levels developed a New Treatment Teaching Session to meet individually with patients to provide education on treatment courses, common side effects, conduct a tour of the facility and introduce staff. Written materials, enhanced and updated to include current evidence-based practice, were provided to patients before their visit and reviewed during the session. Follow-up calls 24-72 hours after first treatments provided additional opportunities to reinforce learning, intervene with symptom management, and answer questions. To further educate patients on the infusion environment, a guide to infusion video was adapted to be shown in advance of first treatment appointment. In preparation, nurses attended a course covering various teaching methods, allowing for role play and strategies to integrate these methods into

the New Treatment Teaching Sessions.

Patient satisfaction data before and after expansion of the infusion center increased for Education Material Provided by 6%, and What to Expect During Chemo by 3%. Nursing satisfaction data showed 11% increase in Nursing Foundations for Quality of Care, 21% increase in Professional Development Opportunity and 29% increase in Professional Development Access.

Investing time and resources for new patient education and support is paramount to improving the patient experience and increasing their knowledge of the healthcare environment while improving patient flow and avoiding hospital admissions. The easily replicable program has shown significant return on investment and is a valuable addition to outpatient care.