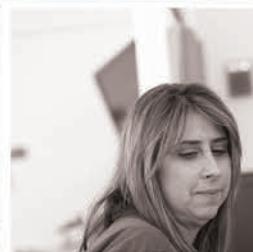




JOHNS HOPKINS NURSING  
BIENNIAL REPORT 2014



## TABLE OF CONTENTS

02	Letter from the Chief Nursing Officer
03	Strategic Priorities FY12-FY13
04	<b>Healthy Work Environment</b> Excellence Bar None Proof Positive Rise to the Occasion Nursing Profile
10	<b>Excellence and Discovery in Care</b> Urinary Tract Infections Supplying Safety Vigilance on Vaccinations
16	<b>Leadership and Integrity</b> By The Numbers <i>Patient Falls</i> <i>Pressure Ulcers</i> <i>Central Line-Associated Bloodstream Infections</i> Collaboration on an Epic Scale Consistent Voice for PED Burn Care
24	<b>Respect and Collegiality</b> Soaring to Success
28	Strategic Priorities FY14-FY15

TO DEMONSTRATE EXCELLENCE IN  
CARE, THERE MUST BE EVIDENCE.  
DURING THE PAST BIENNIAL, HOPKINS

JOHNS HOPKINS NURSING  
BIENNIAL REPORT 2014

NURSING WAS PROUD  
TO HAVE HAD AN ACTIVE ROLE IN  
ADVANCING QUALITY AND SAFETY,  
AND MEASURING THE EMPIRICAL  
OUTCOMES FROM THE WORK.



## LETTER FROM THE CHIEF NURSING OFFICER

Johns Hopkins Nursing sets a strategic plan in motion every two years. This plan focuses our attention and gives us direction. In the past two years, we invested many of our resources and much of our energy in creating a *healthy work environment* as we transitioned into our new clinical campus. The new clinical facilities—the Sheik Zayed Tower and the Charlotte R. Bloomberg Children's Center—are outstanding structures which allow us to serve our patients and families in healing facilities. But it was not all about structure.

We focused equal attention on process. We committed to making the new environments—and the environments in the historic buildings—more patient- and family-centered. As part of our strategic focus on *respect and collegiality*, we incorporated the patient's voice in our facilities planning and our program planning. We also focused on the process of *leadership*, and fostering interprofessional collaborations. But attention to both structure and process, however important, is not sufficient.

It is outcomes that matter. To demonstrate *excellence in care*, there must be evidence. During the past biennial, Hopkins Nursing was proud to have had an active role in advancing quality and safety, and measuring the empirical outcomes from the work. We are proud to have completed a triennial review by the Joint Commission, and to have received no recommendations for improvement within Nursing. We are proud to have been redesignated as a Magnet hospital—at the time of our designation, one of only 57 institutions in the country to have received three consecutive designations. We are proud to have joined with our colleagues and been recognized by the Joint Commission as a “top performer” in its *Key Quality Measures Program*.

Now we move onward. Our strategic priorities for 2014-2015 cascade from the overall priorities of Johns Hopkins Medicine (JHM). We once again focus our attention on structuring programs and processes to achieve outcomes. For example, where JHM's priority is to increase biomedical discovery, Nursing's priority is complementary: to advance translational research. Three specific projects are in play, including a nurse-driven telemetry discontinuation protocol; a study on the effectiveness of cycled lighting on patient outcomes in the Neonatal Intensive Care Unit; and a study of the effectiveness of auditory alarms and nurse call signals for improving practice. The full plan for the biennium appears on the final page of this report.

The past has been productive; the present is positive; and the future is promising.

Sincerely,

Karen Haller, PhD, RN  
Vice President for Nursing and Patient Care Services, The Johns Hopkins Hospital

## THE JOHNS HOPKINS HOSPITAL NURSING STRATEGIC PRIORITIES FY12-FY13

### HEALTHY WORK ENVIRONMENT

- Transitioning to a state-of-the-art campus
- Engaging in lifelong learning
- Assuring well-being and resiliency

### EXCELLENCE AND DISCOVERY IN CARE

- Advancing patient safety
- Translating evidence
- Measuring empirical outcomes



### LEADERSHIP AND INTEGRITY

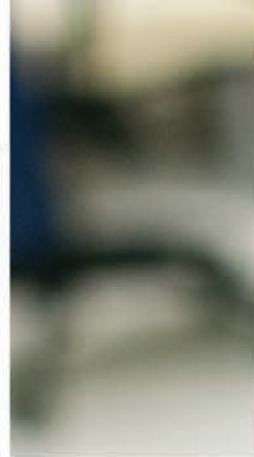
- Making performance transparent
- Leading interprofessional collaboration
- Optimizing nurses' scope

### RESPECT AND COLLEGIALLY

- Assimilating diversity
- Embracing civility
- Committing to patient- and family-centered care



To learn about our FY14-FY15 Strategic Priority Plan see p.28



**HEALTHY WORK  
ENVIRONMENT**



## EXCELLENCE BAR NONE

### Bar Code Medication Project Improves Nurse Workflow and Patient Care

The device by the patient's bed looks like something you'd see in the grocery store, but instead of price checks, what it tracks is priceless: the accuracy of medication administration. The Johns Hopkins Hospital's informatics team is following the successful use of bar codes to track laboratory specimen identification and is preparing to roll out the first phase of the Bar Code Medication Administration (BCMA) project. It starts in 2014 with approximately 400 nurses across several units within the Departments of Medicine and Neurosciences.

With the implementation, there will be a Bluetooth scanner in every patient room. Rather than giving medication in the room and documenting it later, nurses will be able to scan the bar code on the dose as they administer it. It's more efficient for the nurse and provides more accurate documentation of administration.

Project leader Barbara Bryant, RN, a critical-care nurse expert for clinical informatics, led the implementation for specimen identification and brings her experience to BCMA to ensure a smooth transition. "It was always the hospital's intention to use bar codes

widely for safety and efficiency," she says, "so we started with specimen collection to learn how to train users and get used to the equipment. Now we're ready to expand."

Bryant and the BCMA team draw on those lessons learned as they make decisions like tethering the scanners to each room's workstation to ensure equipment is always at hand, and to inform their failure mode and effects analysis—examining details like the clarity of ink used to print patient ID bands. That experience will also help to shape both the classroom work and the custom e-learning module that will train the roughly 70 selected super-users at the start of implementation.

"Giving medication is one of the most potentially dangerous things a nurse does," says Bryant. "Our goal is to provide better tools to support them in delivering safe patient care."

### MEANINGFUL USE

The bar code system at JHH uses certified electronic health record (EHR) technology, provided by CareFusion, as part of compliance with federal meaningful use requirements. "Meaningful Use" originated within the HITECH Act in the American Recovery and Reinvestment Act of 2009 and, simply put, offers health care providers incentives to use certified EHR technology that allows both patients and providers to access a thorough and complete medical history at any time, using a number of criteria to ensure that those records are high-quality and improve patient care. Provisions of the Affordable Care Act reinforce or expand on HITECH's requirements by providing incentives for increased quality measures, improving reporting requirements, and funding research for the evolution of the concept of meaningful use.

## PROOF POSITIVE

### Science- and Psychology-based Program PROPELs Staff Past Stress

It all boils down to trust for gynecologic oncology nurse Amy Brown, BSN, RN. "It's the most essential element of having a successful unit, department, and hospital," she says. "When the staff trusts each other and works as a team, patient care and safety improve on all levels."

That is the heart of the year-long PROPEL® program, rolled out in January 2011. Based on research from positive psychology, leadership development, and organizational science, PROPEL® applies six principles—Passion, Relationships, Optimism, Proactive, Energy, and Legacy—to reshape how staff address unit challenges. So far, 29 units have participated in PROPEL®, funded by a grant from the Maryland Health Services Cost Review Commission.

PROPEL® helped Brown's unit strengthen communication and weather stressful times, such as bed count fluctuations. "I try to be the kind of nurse I would want to work with," Brown says. "The pace of the leader is the pace of the shift."

Nurses learn how to apply the six principles through coaching sessions where they work on "real time" challenges. Staff have come to appreciate and draw on each other's strengths and develop shared values, improving collaboration. "It's amazing how such seemingly simple concepts can elevate the way we care for our patients, our coworkers, and ourselves," says Francesca Brown, BSN, RN, from Weinberg 5A in Oncology.

Identified staff for PROPEL® serve as team leaders to create unit-specific initiatives to further the concepts. Oncology nurse Halley Friedeman, RN, BSN, NCIM, on Weinberg 5A, grew a "garden" on her unit. She created a tree for the bulletin board and encouraged staff to decorate it. Soon after, photos, paper flowers, drawings, quotations, and nice notes filled its branches, signifying the growth of the nursing team. "PROPEL has changed the way I approach my job and shaped the rest of my career and leadership role," Friedeman says.

**"It's amazing how such seemingly simple concepts can elevate the way we care for our patients, our coworkers, and ourselves."**



## RISE TO THE OCCASION

### Peer Responder Program Offers Nurses Support Through Grief or Self-Blame

Pediatric nurse Bonnie Fisher, BSN, RN, discovered that the extensive IV infiltrate incurred by one of her patients was likely due to a problem with the pump and that the incident was reported to the manufacturer. This a little more than a week after she'd blamed herself and been so consumed with shame over the incident that Fisher had considered leaving nursing altogether. What changed her perspective was a talk-through with Joyce Parks, MSN, RN, the RISE peer responder who assured the new nurse that she wasn't alone or in the wrong profession.

The Resiliency in Stressful Events (RISE) program was spearheaded by Cheryl Connors, MS, RN, then-Nurse Manager for the Pediatric Clinical Research Unit at the Johns Hopkins Children's Center, beginning with a pilot in 2011. Connors, who had been a nurse in the unit when a little girl named Josie King died of dehydration, was driven to create a peer support network to help nurses and other care providers through the emotional aftermath of medical error or patient death.

The program rotates small groups of formally-selected, experienced nurses with RISE training through volunteer on-call weeks, during which those responders are available to any Hopkins employee who calls the RISE pager. "This is not about investigation or finding root cause," stresses Connors, "but to provide compassion and someone within the field to turn to for support."

"Often, callers just want to have their feelings recognized," says Nancy Pragliowski, MSN, RN, Nurse Manager in Pediatric Psychiatric Services and one of the most experienced re-



sponders. "We also provide a list of resources that Hopkins offers, from wellness through therapy." Since its inception, the RISE Team has performed 30 peer consultations.

Using RISE empowered Fisher to weather a stressful situation and come out stronger for it. She's become an unofficial ambassador for the program, putting brochures in break rooms and recommending it as widely as she can. "I can't speak highly enough about it," she says. "RISE helped me develop into a better nurse."

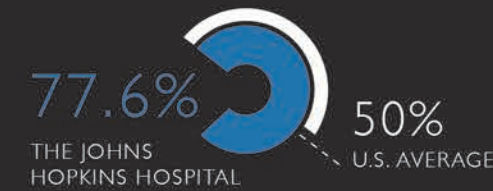
**To reach a RISE responder for yourself or a colleague, call 410-283-3953 and leave your phone number followed by the # sign.**

## THE JOHNS HOPKINS HOSPITAL NURSING PROFILE

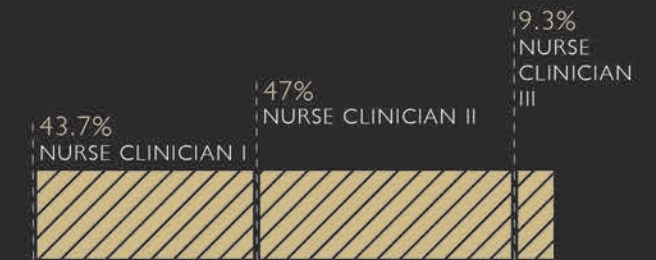
**2,795** DIRECT CARE NURSES

### EDUCATION

Baccalaureate or Higher Degree



### CLINICAL LADDER



### LENGTH OF SERVICE

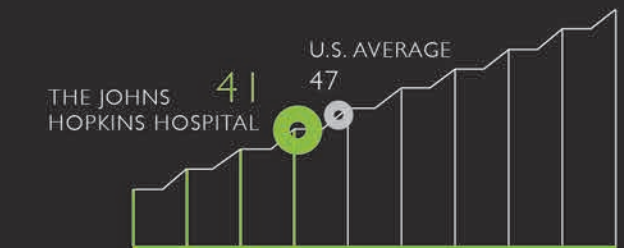
**72%** OF THE JOHNS HOPKINS HOSPITAL staff have been employed for two or more years

### DIVERSITY

Diverse Racial and Ethnic Backgrounds



### AVERAGE AGE



### GENDER

THE JOHNS HOPKINS HOSPITAL



U.S. AVERAGE





## EXCELLENCE AND DISCOVERY IN CARE



## URINARY TRACT INFECTIONS

### Bundle Approach on Catheters Gives Care Team a Leg Up on CAUTI

"Sometimes" doesn't work in fighting catheter-associated urinary tract infections (CAUTI), says Judy Ascenzi, DNP, RN, a nurse member of an interdisciplinary group adapting a successful prevention program from pediatrics for use in adults across the hospital. Ascenzi is helping the team to implement a protocol that, when followed "100 percent, 100 percent of the time" has been shown to reduce urinary tract infections among pediatric intensive care patients by 52 percent.

The protocol includes a bundle of care processes that are individually grounded by research and, when consistently implemented together, improve care. Ascenzi, with Dana Moore, MS, RN, and Patricia Lawson, MPH,

MS, RN, co-chairs the CAUTI Quality Work Group, an interdisciplinary team working to disseminate the bundle of evidence-based practices that includes preventing unnecessary catheter use, maintaining catheters according to care guidelines, and exploring ways to ensure prompt catheter removal.

In addition to developing and implementing the protocol, the work group has evaluated products and sponsored a kick-off event to help spread the word. "Ongoing education is just as important as what you get at the kick-off," Ascenzi says. "You must review your practice and talk with the staff." Take the daily care of the Foley catheter itself. The bundle calls for the catheter to be attached firmly at a certain level on the patient's leg, the bag at a similar height. If it's not currently done that way, "that's a fairly easy thing to fix," Ascenzi says. With shift changes, normal staff turnover, and the like, what's tougher is making sure every single staffer understands each aspect of the bundle in the same way. Recognizing that everybody wants to "do the right thing," the challenge is helping them "carry out what's written on the paper" 100 percent of the time.

## SUPPLYING SAFETY

### Perioperative Staff Recommendations Lead to Dramatic Improvement in Infection Control

When it comes to an issue as serious as preventing health care-associated infections in the perioperative setting, there are so many factors in play that there's no one easy solution. But whether it's color-coding scrubs worn within the operating room or implementing a five-step checklist for catheterization, time and again Hopkins staff have drawn from on-the-job experience to identify simple yet powerful changes that lead to safer care. This year, the perioperative nursing staff raised the bar with a single word: inventory.

Patti Wieczorek, RN, leads the perioperative nursing team that has been working with nursing leadership, the infection control team, and consultants in a review of operating room procedures over the past year and a half. Her team was tasked with providing data and recommendations related to the rate of immediate use sterilization cycles in the operating room. The steam-cleaning process is intended as an emergency measure only, and improving best practices for infection control requires finding ways to reduce the need for those cycles.

**"The nursing staff was vital in identifying what instruments we used the most, which ones we needed more of, and how to better manage their use."**

By reviewing cycle logs and talking with nurses about day-to-day experiences, Wieczorek's team realized that the best way to reduce those rates was to improve supply management. "The nursing staff was vital in identifying what instruments we used the most, which ones we needed more of, and how to better manage their use," says Wieczorek. Acting on those recommendations, the rate of immediate use cycles went from 30 percent of OR procedures to 5 percent.

"The goal has always been to get as close to zero percent as possible," Wieczorek points out, adding, "The nursing staff were completely on board with this review from the start. Everyone understands its importance, and they welcomed the chance to improve our process and make our cycle data more meaningful."



## VIGILANCE ON VACCINATIONS

### Task Force Points the Way on Core Measures, Achieving Compliance and Saving Lives

Doing the difficult, but right thing was the only call for Terry Nelson, MSN, RN, Assistant Director of Nursing in Medicine. In 2006, the Joint Commission established a set of care processes, or core measures, requiring hospitals to screen and vaccinate selected patient populations, regardless of diagnosis, for the influenza and pneumococcal viruses. To create a hospital-wide plan to carry out this complex but critical public health measure, The Johns Hopkins Hospital (JHH) formed a Vaccine Task Force, of which Nelson is a founding member. "Putting this policy in place was the right thing to do, morally and ethically," she explains. "We are saving lives and preventing illness."

But it wasn't easy. The interdisciplinary group of nurses, doctors, and pharmacists began by developing a paper screening mechanism and educating broadly about the vaccination core measures. Later plan revisions included adding Sunrise informatics staff to the task force to develop a digital screening system and increase the availability of vaccinations to units.

Achieving compliance with core measures requires ongoing vigilance, interdisciplinary collaboration across various care settings, twice-monthly task force meetings, and nurse champions in every department who educate new or temporary nurses on the vaccination screening initiative. The hard work is paying off.

As of August, Hopkins was 98 percent compliant for influenza and 96 percent for pneumococcal vaccination screening.

"JHH could not have achieved this improvement if it had not been for the involvement of our nursing champions, both on the units and in the Quality Improvement department

**"Putting this policy in place was the right thing to do, morally and ethically. We are saving lives and preventing illness."**

with Sunrise informatics staff," says Denise Duda, RN, MHA, Quality Improvement Team Leader, Medicine, Emergency Department, and Pharmacy.

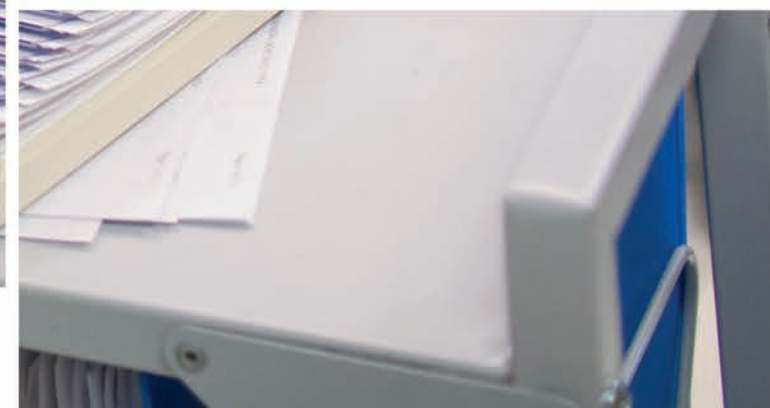
Thanks to the work of the nurses involved in the 40 multidisciplinary core measure task forces, JHH earned recognition for its work in improving quality and safety in patient care.

Johns Hopkins Medicine received the 2013 Joint Commission "Top Performer" designation in its *Key Quality Measures Program* and the Delmarva Foundation Excellence Award for Quality Improvement in Hospitals. Both awards recognize excellence in consistently delivering best practices for treating people who require surgery or receive care for specified conditions.





## LEADERSHIP AND INTEGRITY



# MAKING PERFORMANCE TRANSPARENT

## Hospital Patient Safety by the Numbers

### PATIENT FALLS

Many patients are admitted to Zayed 12 East having suffered multiple falls at home after seizures, or because of powerful medications, weakness, or confusion. "Sometimes it seems that falls on our unit are inevitable," says Christine Robson, RN. It's the job of the nursing staff to make sure they're not.

Robson is nurse champion for the Comprehensive Unit-based Safety Program (CUSP) on Zayed 12E, a role she's grown into since Nurse Manager Linda Huffman, MSN, RN, selected her for the job. Eager to learn more about the science of safety, Robson embraced the new role.

The Armstrong Institute for Patient Safety and Quality was seeking applicants for a patient safety fellowship at the same time. Robson applied and was selected. Her fellowship mentor was Melinda Sawyer, MSN, RN. "During our first meeting I had all these ideas for interventions," Robson says. Sawyer suggested she first figure out why patients fall on Zayed 12 East. Then, begin to introduce change. "I learned that it is a common pitfall of many quality and safety improvement projects—skipping the step where you really define the problem," Robson explains. "Patients on our unit fell for different reasons than patients on other units." They were younger; fell during the week, during the day, and often around shift change. Data in hand, she sought staff input.

"I think one of the biggest successes of my project was instituting the 7 a.m. and midnight huddles," Robson explains. All staff members get a chance to talk about who is at highest risk for a fall, "and have their voices be heard."

Robson says it makes her "very proud to see how, even in a small way, I was able to improve communication ... and reduce our fall rate." In the six months of Robson's fellowship, the staff reduced the fall rate on the unit by 46 percent.

### FALL AND INJURY RATE

RATE PER 1,000 PATIENT DAYS



### PRESSURE ULCERS

Unit-acquired pressure ulcers have no place in the Medical Intensive Care Unit (MICU). And every Wednesday, an elite wound team offers them a firm reminder (just in case).

Amanda Owen, RN, and Joanna Kaskasian, RN, both certified wound nurses, are part of the Skin and Wound Team assigned to conduct weekly rounds in the MICU. As internal experts to fellow nurses, Owen and Kaskasian focus specifically on evaluating the patients' skin condition. Their goal is to implement appropriate evidence-based prevention strategies for each patient's unique risk. If pressure areas do occur, action is swift and minimizes injury. The team makes treatment recommendations, carefully documents cases in the medical record, and reviews data on any wound trends ("used to re-educate staff," Kaskasian explains).

**"Their vigilance is paying off with a 90 percent reduction in unit acquired pressure ulcer incidence over 12 months ..."**

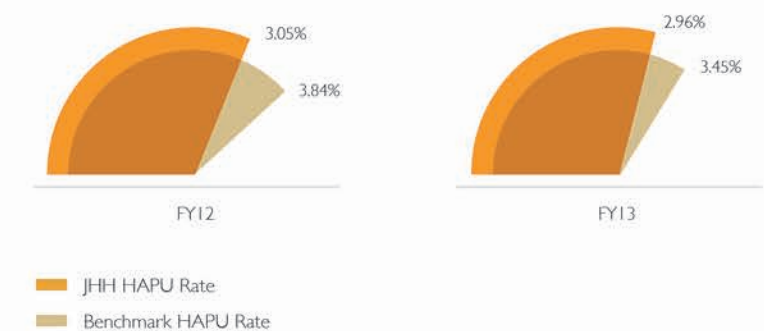
"Team members encourage staff to be proactive in patient care," she adds, ordering specialty beds or applying preventive dressings for at-risk patients, for instance. Their

vigilance is paying off with a 90 percent reduction in unit acquired pressure ulcer incidence over 12 months and an increase in staff engagement in measuring and monitoring their results.

The practice of conducting rounds may be old, but the focus on collecting and using the data is new. Owen explains, "Our current work to formalize the process has allowed us to get a better visual for the trends of skin issues so we can become more prevention-focused."

### HOSPITAL ACQUIRED PRESSURE ULCER RATE

PERCENT OF PATIENTS SURVEYED



## CENTRAL LINE-ASSOCIATED BLOOD STREAM INFECTION RATE:ADULT ICU

INFECTION RATE PER 1,000 CATHETER DAYS



## CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

These days, the nurses at the Weinberg Intensive Care Unit (WICU) are working—and walking—on a cloud. One reason is that central line-associated blood stream infections, or CLABSI, are under control. Another is a tool that has put key data at nurses' fingertips, putting more control in their hands.

Preventing infection requires the eyes and ears of a highly trained nurse in maintaining the safety of a patient with a central venous catheter. "We watch the procedure from stem to stern," says Amy Plotts, RN. There is little time for entering data and crunching the numbers. "Nurses in the WICU have taken the lead on entering those numbers into a cloud-based service from CECity® [a provider of quality reporting, performance improvement, and lifelong learning platforms] and get "access to real-time data, really for the first time." That lets nurses focus on what's happening at the bedside.

"Sometimes you don't realize what you might be doing [wrong] until you analyze the data. We were going to 14 different places to get supplies before we ever got to the patient," Plotts recalls of one protocol that could have introduced infection risk factors. "We had to take a step back. The data helped identify the steps in our processes that could be improved."

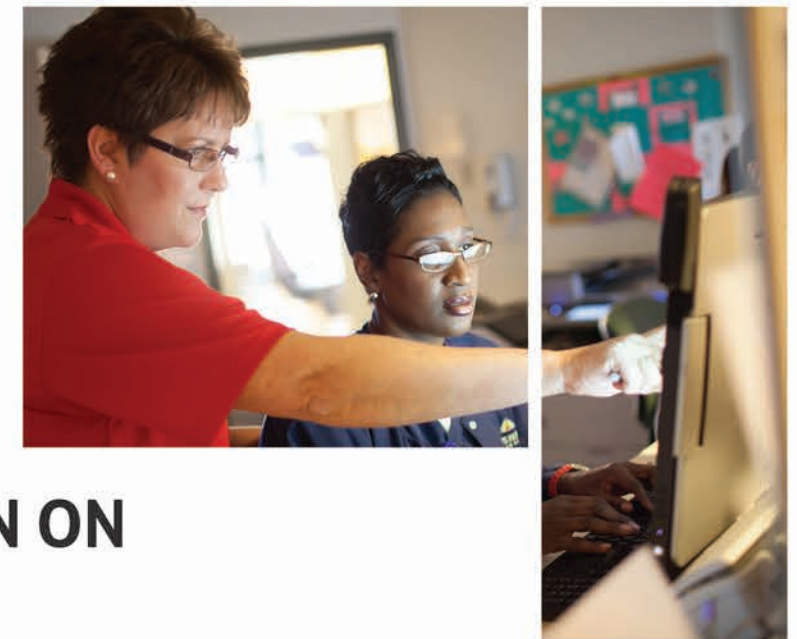
The nurses' success at mastering CECity has also given them the confidence to speak up with concerns when team members are not following sterile procedures, which they say is encouraged by the entire medical team. "It puts the power of the data behind us," Plotts says. "We're recognized as the experts at the bedside."

## COLLABORATION ON AN EPIC SCALE

### Nursing Plays a Key Role in EHR Implementation Process

For an enterprise-wide project like the rollout of the Epic electronic health record system to succeed, all stakeholders must have a voice in the change management process. When it came to nursing leadership, however, that voice spoke as strongly for others as for themselves.

"Bringing nursing to the Epic table wasn't just about our role in the workflow," says Renay Tyler, DNP, RN, Director of Nursing for Ambulatory Care. "Nursing was a convener; a patient advocate. We worked through potential issues with physicians. We were an intermediary in every aspect of the project." Tyler and Bryan Barshick, MS, RN, Ambulatory Clinical Informatics Program Coordinator, were the first nursing representatives to join the Epic implementation team. They worked with nurses to develop protocols and build structures to address the unique requirements of the ambulatory care setting. From there, the team began the process of identifying and addressing workflow challenges to smooth the transition for all members of the health care team.



One of Hopkins' major goals with Epic is making medical records management easier through a centralized system, but getting there has been a complicated process with many potential pitfalls. The contribution of nurses, says project manager Deb Sherman, RN, was a crucial part of the transition. "Nurses can easily communicate how the system needs to work to meet the needs of the clinicians," she notes, adding, "Support at the elbow was the key to success—it was nurses helping all members of the care team, in a variety of settings, to use the Epic system." The quality of clinical support was evident in lower-than-projected numbers of Epic support help tickets and quicker issue resolution.

Nursing will continue to be involved in Epic. "It's like moving into a new house," says Tyler. "We've unpacked the dishes and linens and now we're looking at unpacking everything else."

Over an eight-month period, 155 informatics support pool nurses worked over 6,000 hours across 30 Johns Hopkins Medicine ambulatory locations, answering Epic functionality questions, as well as tracking and reporting system and workflow issues to the Epic implementation team.

# CONSISTENT VOICE FOR PED BURN CARE

## Children's Center Nurse Leads Change in Protocol on Handling Wounds

Sarah Vanderwagen, RN, a pediatric nurse at the Johns Hopkins Children's Center, has never been afraid to ask questions.

On the Hopkins inpatient unit she joined in 2005, the model of burn care allows for trained nurses to do dressing changes, assess wounds, and provide patient and family education. When she moved to the Pediatric Emergency Department in 2009, Vanderwagen learned that the majority of burns there instead received surgical consults. Medical residents, often with no pediatric burn care experience, would perform the initial debridement rather than nurses.

The Johns Hopkins Children's Center is designated as Maryland's regional pediatric burn center, the first place emergency medical personnel bring young victims. Vanderwagen questioned whether nurse-managed care would be better for these patients. "Children would often wait for hours for a surgeon when the burn was minor and could have been treated just as safely and effectively by a nurse, in collaboration with the pediatric emergency physicians," says Vanderwagen. "These vulnerable patients need consistency of care, which is challenging given the rotating nature of a medical residency."

In fall 2011, with support from her nurse manager, Vanderwagen convened a 15-member

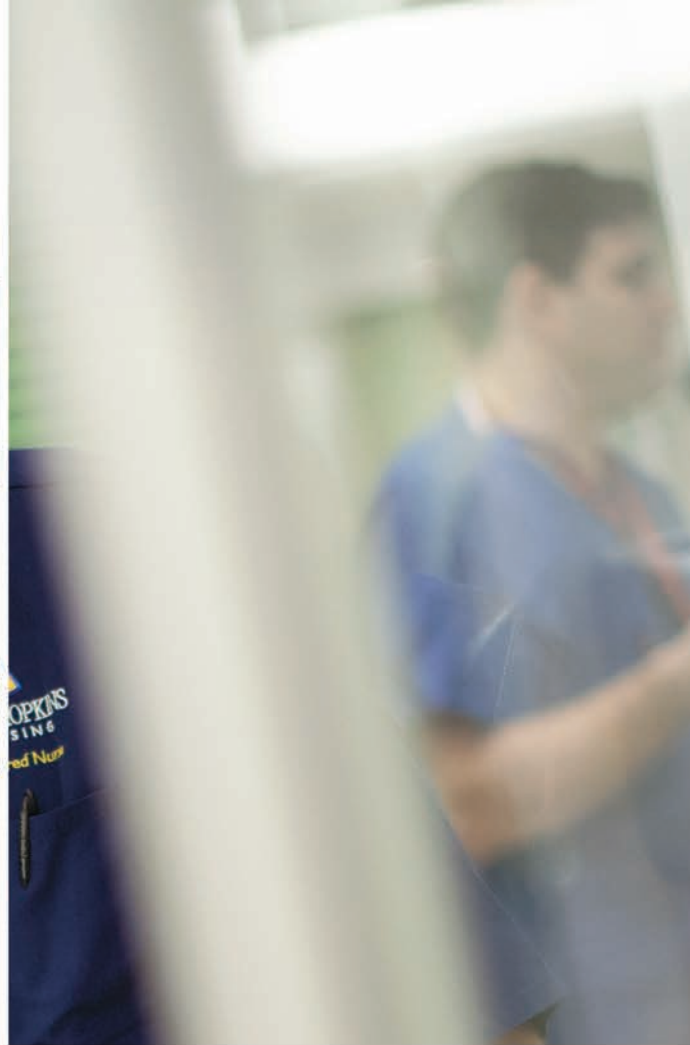
interdisciplinary work group to write an evidence-based PED burn care policy and develop an education plan to train unit-based burn care nurses to collaborate with PED and surgical providers from the time a patient arrives. Now certified in Advanced Burn Life Support, these nurses have decreased the need for surgical burn consults by 30 percent. Vanderwagen also solicited funding for a PED mobile burn cart and created a burn photo policy to enable nurses to take pre- and post-debridement photos for the patient's electronic medical record to expedite burn evaluation.

This innovative approach to emergency care has transformed the PED experience for Maryland's youngest burn patients and their families. "I always had a clear vision of nurses

**"I always had a clear vision of nurses performing the burn wound care and collaborating with the interdisciplinary team across the health system to reach our goal."**

performing the burn wound care and collaborating with the interdisciplinary team across the health system to reach our goal," says Vanderwagen, who received the American Pediatric Surgical Nurses Association Spotlight Award in 2012. "It's been a challenging but an enormously rewarding process."





## RESPECT AND COLLEGIALLY



## SOARING TO SUCCESS

### Training Program for UAPs Slows Attrition and Improves Care as It Fosters Respect

Building mutual respect and trust are important for partnerships to succeed. A one-year program called SOARING has been a pretty good place to start for nurses and unlicensed assistant personnel, or UAPs.

Rolled out in January 2012 with the first of its seven cohorts to date, SOARING trains UAPs to become key partners in nursing care throughout The Johns Hopkins Hospital and mentors them on that journey. By boosting the skills and confidence of UAPs, it slows attrition in a challenging job and shrinks a staffing gap that can leave RNs stretching to complete essential tasks normally handled by clinical technicians. "The sheer size of UAPs' patient assignments did not allow for accountability or skill building," explains Rosemary Okpolor, RN, a nurse champion for SOARING. "The new technicians gave a facelift to the role."

As a trainer and then colleague to those in the program, Okpolor has seen firsthand the skill of the newly trained UAPs as well as the efforts of RNs to welcome them into the Neuroscience Critical Care Unit. "Trust is fostered when both the nurse and the UAP are proactive," says Okpolor, adding that this means being responsible and responsive to each other's needs. Nurses know that key tasks will be handled efficiently, and UAPs feel like a respected part of the team. This takes time and effort from the entire team. But once it happens, job satisfaction and patient care improve.

"The dynamic and the culture of nursing on the NCCU is intense," says clinical technician Katie Murray, "but the nurses are always ready to share knowledge. And I feel as though my training and the standard that Rosemary set have thoroughly prepared me for the expectations."

"The most pleasant surprise is we've served so many units across the hospital," says Margo Preston-Scott, RN, MSN, program manager for SOARING, which stands for Success, Ownership, Accountability, Respect/Responsibility, Independence, iNtegration, and Growth. "It's working. The UAP vacancy rate has dropped to 16 percent from 35 percent. The plan is to expand the program to all units that staff UAP roles."

**"The most pleasant surprise is we've served so many units across the hospital. It's working. The plan is to expand the program to all units that staff UAP roles."**



## THE JOHNS HOPKINS HOSPITAL NURSING STRATEGIC PRIORITIES FY14-FY15

The Johns Hopkins Medicine Strategic Plan comprises six priorities—critical areas of focus for the success and sustainability of the institution. The Department of Nursing has aligned our strategic plan with these priorities to define our work for FY14-15 as noted below.



### PEOPLE

Establish & sustain a healthy work environment

### BIOMEDICAL DISCOVERY

Advance translational research

### PATIENT- & FAMILY-CENTERED CARE

Build capacity for nurse leadership in patient- & family-centered care.

### EDUCATION

Modernize educational approach

### INTEGRATION

Maximize continuity of care & facilitate transitions

### PERFORMANCE

Develop rigorous financial & quality improvement project management

"THE PAST HAS BEEN  
PRODUCTIVE; THE  
PRESENT IS POSITIVE;  
AND THE FUTURE IS  
PROMISING." Karen Haller, PhD, RN

