

2017–2018 JOHNS HOPKINS BAYVIEW NURSING ANNUAL REPORT

# Creating a Highly Reliable Organization

Resilience. Integrity. Trust. Respect. Collaboration.



**JOHNS HOPKINS**  
M E D I C I N E

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BAYVIEW MEDICAL CENTER



Dear Colleagues,

In this year's Nursing Annual Report, I am happy to share with you 20 stories of our growth toward *Creating a Highly Reliable Organization*. These stories of resourcefulness, creativity and problem-solving demonstrate the vital role that our nurses play in the accomplishments of the Medical Center. These reports fall into a few broad themes: our identity as nurses; Lean management in action; technology in health care; and improving patient safety and satisfaction. You will find, however, that many of the articles address elements of all of these important ideas. Implementing significant process improvement projects such as these is a long and complex effort. In fact, some of these nurse-led initiatives spanned over several years, and have made a great difference in the clinical outcomes of our patients.

Our nurses from every level of leadership were tasked with contributing to this report. Each narrative that you will read started with an "A3" problem, identified by staff on our units. In Lean management principles, A3 is a structured problem-solving and continuous improvement approach that breaks down large problems into smaller steps. I marvel at the way our staff took small steps to address large problems this past year—patient safety, infection rates, staff morale, communication failures, confusing workflows—and then measured their success using data.

Working at the executive level, I spend most days thinking about strategic ideas, initiatives and issues that impact Johns Hopkins Bayview at a **macro** level. I see patterns in clinical and administrative data that allow me to consider innovative ways to attract, educate, train and retain the best staff to meet the public health needs of the community that surrounds our beautiful campus. I am proud to show readers the ingenuity of our nurses, who have identified and then tackled problems that they observed at a **micro** level on their units. Always keeping the needs of their patients in mind, our nurses make connections between everyday operations and the strategic imperatives of Johns Hopkins Medicine.

Within these pages, you will also see a snapshot of how these nurses focused on improving patient safety, clinical outcomes and service. We are proud of their accomplishments and celebrate the wonderful diversity of our nurses, which reflects the larger community here in Baltimore, and how the varied perspectives they bring to our Medical Center allow us to think independently, together.

The words of Vincent van Gogh are reflected each day in our patient care: "great things are done by a series of small things brought together." I hope you will enjoy these stories of small things that have been brought together in a remarkable way by the nursing staff at Johns Hopkins Bayview Medical Center.

Maria V. Koszalka, Ed.D., RN  
VICE PRESIDENT, PATIENT CARE SERVICES

# 1

## Nursing Identity

# DAISY Award Comes to Campus

The DAISY Award For Extraordinary Nurses is awarded by The DAISY Foundation to nurses for the education, training, brainpower, professionalism and extraordinary clinical skill they put into their work, and especially for the empathy and compassion with which they deliver their care. Today, there are more than 3,000 health care facilities and schools of nursing in all 50 states and 17 other countries committed to honoring nurses with The DAISY Award. The strategic impact of the program on nurses and their organizations is deep, affecting nurses' job satisfaction, retention, teamwork, pride, organizational culture, healthy work environment and more.

In 2017, Johns Hopkins Bayview was thrilled to begin offering this national recognition program on our campus. Our inaugural recipient embodies the mission, vision and values of our Medical Center:

Tina Dardamanis, RN, from our emergency department, was nominated by her peers for her clinical excellence, willingness to help others and positive attitude. Tina started in the emergency department at the Medical Center in 2004 and has worked diligently to improve her skills and further her knowledge in emergency nursing. In 2010, Tina completed her bachelors of science in nursing, and

most recently completed the requirement to become an advanced clinical (ACE) nurse.

"Tina consistently demonstrates her willingness to help others and fosters a positive attitude in the emergency department.

Tina's can-do attitude brings the team together to form an effective workgroup.

Her knowledge and enthusiasm for emergency nursing are wonderful examples of what ED nurses should

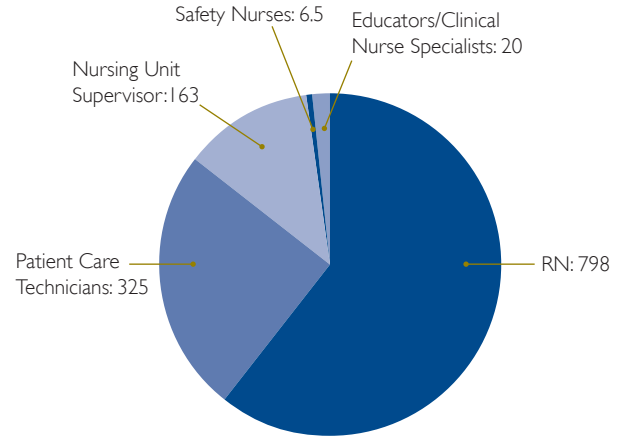
be to those that are new to the profession," read the nomination from a fellow ED nurse.

Tina Dardamanis, RN, inaugural DAISY Award recipient.

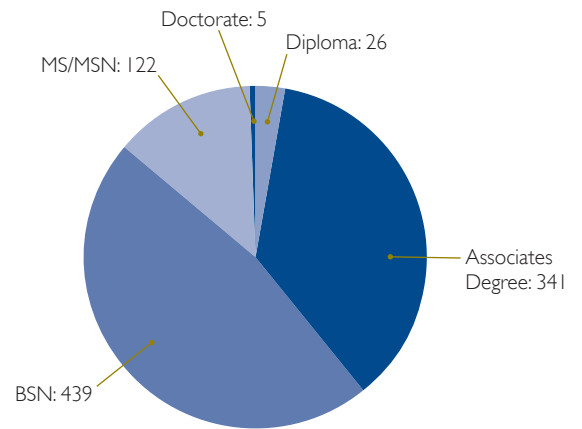


### NURSING BY THE NUMBERS

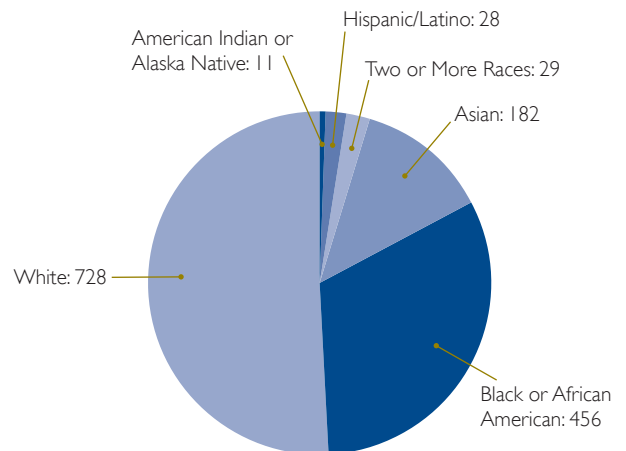
#### Nursing Job Roles



#### Educational Breakdown of Nursing Staff



#### Nursing Demographics



# The Power of Shared Decision Making

## Professional Practice Council leads journey to Magnet status

### Resilience. Integrity. Trust. Respect. Collaboration.

These words from the Professional Practice Council's (PPC) by-laws are the guiding principles behind its efforts to support the strategic direction of nursing at Johns Hopkins Bayview.

As an active leadership body, the PPC is responsible for many important nursing initiatives on our campus, including education, nursing practice and policies, the use of new products and technologies, the implementation of nationally benchmarked practice standards and communication to both executive leadership and frontline staff. The PPC also established a strong presence within our community, leading by example through its volunteerism with local events such as the Heritage Foundation of Dundalk's 4th of July Parade, and serving meals at the Moveable Feast and Maryland Food Bank.

Currently chaired by Beth Petterson, RN, advanced clinical nurse from the rehabilitation unit, under the direction of Maria Koszalka, RN, Ed.D., Michelle Cummings, RN, Ed.D., and Blanka McClammer, RN, MSN, the PPC now has 35 members

representing nearly every inpatient unit as well as ambulatory clinics. The members are clinical nurse specialists, nurse educators, patient care managers, patient safety nurses and frontline staff who showcase nursing leadership's commitment to shared decision making, a foundational requirement in Johns Hopkins Bayview's quest to obtain designation from the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program.

In the words of ANCC, "The Magnet Recognition Program designates organizations worldwide where leaders successfully align their nursing strategic goals to improve the organization's patient outcomes. The Magnet Recognition Program provides a roadmap to nursing excellence, which benefits the whole of an organization. To nurses, Magnet Recognition means education and development through every career stage,

which leads to greater autonomy at the bedside. To patients, it means the very best care, delivered by nurses who are supported to be the very best that they can be."

As Magnet champions, the PPC members are advanced clinicians and exemplars of best practices in their field. They communicate and coordinate between the PPC and their units, sharing news and information in both directions through meetings, presentations and Magnet boards. They work especially hard to promote a positive image of nursing at the Medical Center, including sharing stories of nursing efforts and achievements like the ones you will read in this report.



Professional Practice Council, June 2018

Johns Hopkins Bayview has been interested in pursuing Magnet status for many years. In January 2018, the Medical Center engaged a consultant, who spent several days on campus surveying staff and observing our units in action. The consultant was very complimentary of our nurses, and prepared a gap analysis, which was shared with executive leadership in April 2018. As Johns Hopkins Bayview embarks on the Magnet designation process, the Medical Center

will implement three of the consultant's recommendations immediately:

1. **We will conduct a full satisfaction survey of our RNs**, using a tool provided by the National Database of Nursing Quality Indicators (NDNQI). This is a baseline requirement for Magnet status, and is planned for September 2018.
2. **With guidance from the PPC and executive leadership, we will create a nursing inquiry council to promote the integration of nursing research and evidence-based practice**, as well as offer support and advice to nurses interested in clinical research. This new initiative on our campus will support the broader strategic imperatives of Johns Hopkins Medicine.



June 2018 PPC Leadership (l-r): Beth Petterson, RN, BSN, CCRN; Maria Koszalka, RN, Ed.D, Blanka McClammer, RN, MSN, and Michelle Cummings, RN, Ed.D.

3. **We will begin to expand the data that we report to NDNQI to include ambulatory falls with injuries**, as well as other inpatient data. Currently, we report hospital-acquired pressure injuries and falls with injuries. We plan to begin reporting CLABSI and CAUTI.

**“Magnet recognition would be a tremendous achievement that truly reflects a hard-wired culture of celebrating and promoting nurses,”** says Blanka McClammer, nursing projects coordinator. *“This effort will be a journey rather than simply a destination. We will continue to center our work on providing the nurses at Johns Hopkins Bayview a great professional environment, one that values them, encourages them and offers them every opportunity for education, research and advancement throughout their careers.”*

# 3

## Lean Management in Health Care

# Huddling for Health Care

BY BRANDON BUCKINGHAM, RN, MS

**H**uddle boards, an agile tool used to visually display project information, have long been used in patient care to share information quickly between members of a collaborative clinical care team. The Surgical Unit (6 Surg) recognized the importance of huddle boards and huddling, but realized that their previous huddle board approaches and methodology lacked dynamic or evolving data, which hampered the incorporation of real-time performance and process improvement measurements and initiatives.

Additionally, 6 Surg had only one team huddle for each shift (day and night), which were held at the beginning of the shift prior to patient hand-off between care providers. Each huddle presented large amounts of competing data and information, and was impacted by time constraints and other priorities for the team members. Frontline staff members could not achieve the best level of engagement, information retention and participation.

Despite their best intentions of using a huddle board and one team huddle, key safety and quality metrics on the unit remained lower than established goals and/or thresholds,



Mid-shift huddle on 6 Surg.

especially in critical areas such as patient falls, hand hygiene compliance, and purposeful hourly rounding (all important indicators of patient safety compliance).

*To begin to solve these issues, the team came together to embark on a project to make their huddle boards and huddling more efficient and impactful to improve staff engagement, overall accountability and ownership for patient safety and quality improvement initiatives. To this end, they added a mid-shift huddle into the unit routines and workflow, and revamped their huddle board.*

Education was provided prior to implementation so that leadership and frontline staff truly understood the purposes and utilization of the huddles in relation to identified areas of need. Key indices that were used to track success included:

- Levels of staff engagement/education on the 6 Surg unit
- Patient satisfaction scores related to staff responsiveness to (at a minimum) the Quality Based Reimbursement (QBR) benchmark standard of 65.2
- Improvement in the rate of patient falls to be less than or equal to the National Database of Nursing Quality Indicators (NDNQI) benchmark
- Increased hand hygiene compliance to meet the Medical Center’s institutional goal of at least 90%.

### HARNESSING THE HUDDLE BOARD

Though it sounded simple enough, the team had to look carefully at their current huddle board to ensure that it reflected key features, such as the inclusion of strategic objectives and priorities of the Medical Center; and concepts and principles of Lean and Six Sigma. They also had to ensure that it included components of unit activity and operational metrics, such as real-time National ED Overcrowding Study (NEDOCS) scores, as well as metrics of focus like patient falls, hand hygiene and staff responsiveness. The board also includes Problem-Solving Lanes along with Quality and Safety Dashboard information.

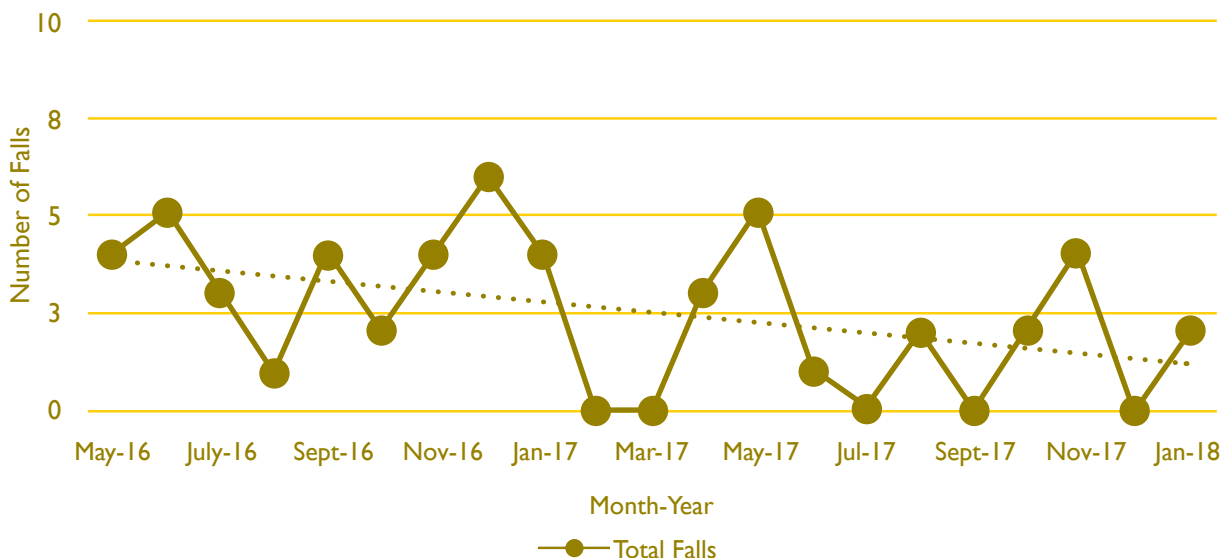
Metric #1		Metric #2		Metric #3		Unit Activity & Operations
WATCH	W H Y	WATCH	W H Y	WATCH	W H Y	Yesterday
DRIVER	T R Y	DRIVER	T R Y	DRIVER	T R Y	Today
BARRIERS	R E F L E C T	BARRIERS	R E F L E C T	BARRIERS	R E F L E C T	
Unit Dashboard						

Huddle board prototype on 6 Surg.

### SHIFTING TO INCLUDE A MID-SHIFT HUDDLE

The purpose of the huddle is to bring patient data to life: discussing and reviewing each shift in real-time, looking backward and forward. The implementation of a consistent huddle culture on 6 Surg has benefited both staff and patients greatly, as shown by the marked improvement in key metrics. All staff are required to attend the huddle, led by members of the management team, and other members of the interdisciplinary care teams are invited as well. Frequent huddles promote the additional advantages of sharing not just clinical details and census data, but also staffing updates, announcements and congratulations. Huddles build teams, reinforcing core values and promoting a collegiality and respect among staff as they deliver the best in patient care.

### TOTAL NUMBER OF FALLS PER MONTH – 6 SURG



## AT THE HEART OF HUDDLING

Since implementing the use of their revamped huddle board and mid-shift huddles, the team has gotten to the heart of their work and the data reflects these improvements:

- Staff engagement reflects significant improvements in 11 of 12 domains measured by the 2017 Gallup Q12
- Staff responsiveness shows consistent top box improvement towards QBR threshold, up nearly 6 points in the HCAHPS report
- Safety scores had a 13% improvement in the overall Safety Climate domain, as well as a 14% improvement in the Teamwork domain
- Hand hygiene compliance increased and remained above 90%
- Patient falls declined significantly in CY2017, and the 6 Surg Unit achieved five months with zero patient falls on their unit.

# 4

## Lean Management in Health Care

# Labeling Labwork

In the lab, the specimen collection process commands precise attention to detail. It's not a simple matter of drawing blood into a test tube. Every single patient specimen must be properly documented with a label and then also entered into the electronic medical record with an exact date and time stamp before the samples can be analyzed by the lab. Accurate electronic identification in hospitals is a critical component of patient safety.

In March 2016, an audit revealed that the Johns Hopkins Bayview rate of electronically “uncollected” lab specimens—specimens that had been drawn, but not entered properly into a medical record—was 7% of the overall collected specimen rate. The specimens were not properly documented and could not be analyzed by the lab, an error that required laboratory staff to interrupt their work and add additional steps to the process before completing their work. This error not only decreased efficiency and forced a recollection of specimens, it potentially could have resulted in delays in care and medication dose inaccuracies.

### USING LEAN IN THE LAB

Clinical informatics, determined to identify the root cause of this error, convened an interdisciplinary team that included clinical nursing leadership, laboratory staff, clinical nurse specialists, patient safety nurses and patient care managers. Using the principles of Design Thinking to explore the problem, the team outlined a new daily audit process to look for patterns or influences on the uncollected specimens count. The team then developed and implemented a robust

process improvement plan with the goal of reducing the overall percentage of uncollected specimens to 2% or lower of all specimen collectioned.

Using Lean methodology, standard work was introduced through the use of checklists. The checklists were reinforced with tip sheets, classroom training, skills workshops and super user updates. Clinical informatics staff provided continuous feedback and audit reports to nursing leadership, to help support and retrain the staff.

Between March 2016 and January 2018, these interventions resulted in a performance improvement of more than 60%. Electronically uncollected specimens now account for only 2.28% of all collections.

As part of the continued monitoring of this important safety issue, the audit results were reported monthly in multiple formal meetings to the directors of nursing, Epic Nursing Leadership Committee, and the Bayview Safety Improvement Committee (BaSIC); the results were also shared with other JHM entities.

In March 2018, clinical informatics transitioned the ongoing audit of uncollected specimens to the department leadership, who continues to monitor this gap to continue to improve the collection rate, and ensuring that the lab can perform its essential role in providing an excellent patient experience.

# Bundle of Care

**BICU works as a team to change the environment of care**

A great advance in modern health care is the use of data to drive decision making. Benchmarking, quality metrics and infection rates are tracked on every level of the delivery system, and offer hospitals like Johns Hopkins Bayview a snapshot of the quality of care we provide. Nursing leadership uses this data to drive decisions on the equipment they use and the workflow they follow every day on their units.

## MEASURING THE QUALITY OF CARE

How does this data-driven care make a difference in the lives of our patients? Leadership and unit nurses pay close attention to the metrics correlated to the quality of care. On the Burn Intensive Care Unit (BICU), some of the Medical Center's most vulnerable patients recover from their injuries in spite of the fragile medical status that makes them especially susceptible to hospital-acquired infections.

In 2017, the BICU confronted the incidence of Methicillin-Resistant *Staphylococcus aureus* (MRSA) on the unit. With 10 beds, the BICU is a small unit. However, six of the 16 facility-wide hospital-onset MRSA *bacteremia* events reported in 2017 occurred on the BICU—more than one-third of all cases.

## CHANGING THE NUMBERS

Not only are burn patients more prone to infection, but the manner in which they heal presents a bioburden on the space they inhabit. The theory is that burn patients regenerate skin and continually shed cells. BICU's objective is to minimize these excessive cells in the care environment. While the staff continued to use infection transmission prevention strategies such as frequent terminal cleanings and full barrier protection upon entering a patient room, they needed to add additional environmental cleaning measures.

The unit convened an interdisciplinary team of administrators, physicians, nurses, pharmacists, rehabilitation specialists, environmental services (EVS) and facilities workers. They were tasked with researching alternatives that could be used to improve their environment of care efforts, with the specific goal of lowering the MRSA infection rate. Patient care manager Lenore Reilly, RN, MSN, calls this approach to lowering infection the “bundle of care”: a small, straightforward set of evidence-based interventions that, when used together, significantly improve patient outcomes.

## NEW PROCESSES ARE BUNDLED TOGETHER

The BICU and the Burn/Wound Unit staff implemented some small changes to their unit workflows in collaboration with their partners in EVS, rehabilitation services and others.

**UV LIGHT:** This disinfection method uses short wave ultra-violet light to kill or inactivate microorganisms. Since some equipment in patient rooms is not replaced by a terminal cleaning process, the BICU purchased a UV Light device to disinfect permanent fixtures such as lights or hardware.

**HAND HYGIENE:** Hand hygiene protocols were upgraded, and now involve scrubbing at a newly installed hallway sink with 2% chlorhexidine soap followed by the application of Avagard surgical hand antiseptic. This new multi-step process minimizes transient microorganisms on the skin that could contribute to infection transmission. Additionally, the staff now have greater access to hand hygiene than they had when sinks were present only inside patient rooms.

**ROOM ROTATION:** Long-term stay patients' rooms are changed every 7 to 10 days. Patients are provided a new, fresh bed in a room that has been terminally cleaned. In this new room, the UV light process has been completed and the curtains have been changed. This work is an effort to further decrease the bioburden in the care environment and prevent the spread of infection.

**SINGLE SET-UP DRESSINGS:** Dressing carts for stock supplies have been eliminated by staff and a plan for single set-up dressings was put in place. The dressing cart was potentially a source of infection transmission due to multiple hands touching the cart throughout the day/night. Single set-up dressings are an opportunity to save cost due to less supply contamination and waste.

## CELEBRATING SAFETY

With new care bundle processes in place, the staff watched their infection rate numbers drop. Their May 2018 huddle board celebrated the BICU success rates with these important clinical indicators:

- Catheter Associated Urinary Tract Infections (CAUTI):  
31 weeks since last infection
- Central Line Associated Blood Stream Infection (CLABSI):  
29 weeks since last infection



- *Clostridium Difficile* (C-Diff): 20 weeks since last infection
- Patient falls: 0
- Hand Hygiene compliance: 96%
- Methicillin-Resistant *Staphylococcus aureus* (MRSA): 21 weeks since last infection
- Ventilator Associated Pneumonia (VAP): 11 weeks since last infection

**“The safety of our patients is only as good as the least protective member of our team,”** says Reilly. “It falls on every staff member who enters our unit to focus on keeping the space as sterile as it can possibly be, and we work as a team to remind each other that the care environment has critical impact on the safety of our patients.”

## Lean Management in Health Care

# 6

## Moving On Up Early mobility in the NSCCU

BY MICHELLE ATHERTON, RN, BSN; SARAH RYAN, RN, BSN; KIMBERLY GOLDSBOROUGH, RN, MSN, ADON

Albert Einstein has been quoted as saying, “Nothing happens until something moves.”

All of us benefit from exercise, including patients recovering in a hospital bed. Prolonged immobility is risky. It can lead to acquired weakness, muscle atrophy, nerve impairment, delirium and inflammatory response syndrome, all of which have a tremendous impact on the recovery and subsequent quality of life for neurology patients in the neurosurgery critical care unit (NSCCU). However, restoring ambulation to neurology patients is much more complex than it is for the general surgery population. Often, it can take a group of people to get these patients moving safely. This is sometimes called a lift team.

At Johns Hopkins Bayview, our goal is to improve patient outcomes through early mobility: sitting, standing, moving, bed exercises and any other activities that improve a patient’s range of motion. Early mobilization efforts in the MICU have resulted in a marked decrease in length of stay (LOS). How could our neurology nurses replicate this success on a unit where brain trauma, illness or injury greatly impact a patient’s ability to even move?

### WHY GET OUT OF BED?

Early mobilization in patients treated in a neurological ICU have shown clinical and psychological benefits:

- higher mobility levels that allow patients to regain strength

- reduced overall lengths of stay in ICU, hospital and rehabilitation step down units
- a higher likelihood of being discharged to home, shown by the research of Creutzfeldt and Hough to improve patients’ motivation and mood, as well as reduce anxiety.

Research reveals the important impact of early mobilization and rehabilitation. For patients with aneurysmal subarachnoid hemorrhage, the chance of a good global functional outcome one year later is **more than double** for those patients who have attained early mobility versus those patients who have not.

Sarah Ryan, RN, demonstrates new patient mobility equipment.



## WANTED: A MOVING CREW

In their quest to increase mobility rates, NSCCU built an interdisciplinary team of champions to make mobility part of the unit's daily routines. This workgroup analyzed nursing workflow, identified and purchased equipment, and trained the staff. They also built a mobility screening tool to identify patients who were ready for intervention, and educated the staff on how to screen patients and deploy their new equipment.

NSCCU nurses were challenged by the complexity of their patients' varying disease processes. The nursing staff and their dedicated physical therapy partners teamed up to design a strategy for safe lifting and practice new mobilization support for these complex patient cases.

## THE LAUNCH

The team launched their program in February 2018, changing the unit's daily routines. The nurses worked with physicians during morning rounds to identify which patients were able to mobilize and to what level. Physical and occupational therapists (PT/OT) introduced each piece of equipment to the staff and taught the nurses proper body mechanics and usage, so the nurses could use the appropriate equipment to benefit each patient.

Aiming to get every patient moving within 24 hours of admission (whenever possible), the staff employed several goals and metrics to track their patients' mobility, including:

- documentation of HLM scores, which are used to track highest level of mobility
- achievement of a minimum of 75 percent of patients mobilized on each shift
- identification and documentation of barriers to a patient's ability to participate in mobility efforts
- a 0.5 decrease in ICU length of stay within six months
- improvement in patient satisfaction scores.

## MOVING FORWARD AS A TEAM

Change is challenging, and the workgroup bumped into a few barriers as they implemented their vision. Team work, training and the implementation of new documentation practices and software usage were the keys to overcoming these obstacles.

The team solved problems by using Lean management practices such as huddles, huddle boards, peer coaching,

monthly mobility meetings and newsletters to keep communication flowing. The staff felt empowered to share any barriers, successes and challenges that they identified. The team continues their collaboration with frequent huddles that include an analysis of the patient experience along with frequent review of HCAHPS data.

## HEADING IN THE RIGHT DIRECTION

Although this program has been in place for less than six months, NSCCU notes some positive trends in the metrics they have identified to validate this effort: satisfaction with nurse communication has increased 12.2 points from July 1, 2017 to March 1, 2018 (per HCAHPS survey). Additionally, the patient LOS has already started to trend downward. The nursing staff will continue to measure the success of this initiative in the neurocritical care and neurosciences units to support the Medical Center's efforts to provide the best patient-centered care to these complicated cases. In the case of these early-mobilizing neuro patients, exercise truly is the best medicine.



## TOP BOX IMPROVEMENT TOWARD QBR BENCHMARK

JHBMC FY18 Neuro Units HCAHPS Top Box Results - Jul. 1 - Mar. 31 YTD

	FY18 QBR Threshold	FY18 QBR Benchmark	Hospital	Neuro Aggregate			NSU			NCCU		
			FY18	FY17	FY18	Δ +/-	FY17	FY18	Δ +/-	FY17	FY18	Δ +/-
# of Returned Surveys (n)			1,065	208	122		164	95		44	27	
HCAHPS Domain/Questions												
<b>Nurse Communication</b>	<b>78.7</b>	<b>87.0</b>	<b>79.0</b>	<b>77.4</b>	<b>89.6</b>	<b>12.2</b>	<b>75.5</b>	<b>90.1</b>	<b>14.6</b>	<b>84.4</b>	<b>87.7</b>	<b>3.3</b>
<i>Nurses treat with courtesy/respect</i>			85.7	87.2	93.6	6.4	84.9	94.9	10.0	95.6	88.9	-6.7
<i>Nurses listen carefully to you</i>			75.3	72.9	89.6	16.7	70.3	88.8	18.5	82.2	92.6	10.4
<i>Nurses expl in way you understand</i>			76.0	72.1	85.5	13.4	71.2	86.6	15.4	75.6	81.5	5.9

# 7

## Technology and Innovation

# Talking Our Way Through Trauma Care

BY CHRISTINE SNOW, RN, BSN, MHA AND ILENE JONES, DNP (C), APRN, CNS, CEN

Every day, emergency department (ED) clinicians confront crisis, often facing a complex and fast-paced set of circumstances that require all hands on deck: a medevac helicopter alights outside their doors with a car accident victim; an ambulance races straight from a house fire, delivering a patient for burn care; a panicked parent runs through the doors holding his child, an accidental gunshot victim.

Johns Hopkins Bayview is a Level II emergency department and the third busiest trauma center in the state of Maryland. To promote an excellent care experience for its patients, the ED recognized the need to utilize an electronic health record. But when a trauma case presents no time for manual data entry, how could this busy unit possibly track and share important patient health information in a way that other departments within the Medical Center could use?

### KEEPING TRACK OF TRAUMA: IMPLEMENTING NEW SOFTWARE PRODUCT

Focused on Johns Hopkins Medicine's strategic imperative to fully integrate health care delivery, the ED decided to implement Epic's **Trauma Narrator** software application, which supports the data collection needs of a trauma team, and seamlessly interfaces with the Medical Center's other electronic health record applications.

This evidence-based implementation project was led by an interdisciplinary team including staff from patient registration,

nursing, providers and leadership champions. They identified and met with stakeholders to learn how each operational area managed its current paper trauma documentation. The team knew that transitioning to an electronic-based system would impact the ED's workflow. They also were concerned with the vital importance of sharing pertinent patient care information between providers and clinical teams—an issue that was an ongoing challenge for care providers using paper documentation.

The team had some primary goals for implementation of the Epic Trauma Narrator:

- Minimize lost paper trauma documentation
- Improve documentation of trauma criteria as required by COMAR regulations



ED nurses Kristen Street, RN, Lisa Janicki, RN, and Andrea Richmond, RN, demonstrate usage of the Trauma Narrator software.

- Promote trauma response by delineating trauma roles and responsibilities
- Increase staff awareness, accountability and responsiveness in the treatment of trauma patients
- Facilitate interdisciplinary communication, collaboration through shared electronic health records
- Reduce the impact of unreadable record notes during patient care handoff
- Provide transparency and accuracy for billing.

The ED and trauma professionals carefully established a go-live date as they developed a project timeline, a performance improvement plan and benchmarks. The interdisciplinary project team worked to deploy the Trauma Narrator product usage to mirror the current workflow of the paper trauma documentation. Of particular concern were the requirements of the staff nurse to document, and for providers to view patient information with ease. Frontline staff were actively involved in each step of the process.

Critical factors for the successful implementation of the Trauma Narrator software included product training for all staff during skills days along with on-site support from product champions, who would be present during peak trauma times throughout the first two weeks of go-live. Additionally, members of the nursing leadership team were tapped as trauma observers and trauma chart auditors. An immediate benefit was improved communication with patient care handoff between the ED and other critical care areas.

### THE IMPACT TO TRAUMA CARE: ZERO HEROs

The benefits of electronic documentation in the health care space are widely known, especially with respect to data completion and integrity for regulatory purposes. It also is noted to have a positive effect on trauma patients' lengths of stay and improved patient safety. Lastly, converting to an electronic trauma documentation system has been noted to increase efficiencies for nursing, physicians and trauma registry data collectors.

*The Johns Hopkins Bayview ED has reported zero HEROs related to lack of access to documentation since the launch of Epic's Trauma Narrator product.*

Performance improvement has been noted in all areas of trauma care. Utilizing the trauma data, the department is able to drill down to see their documentation habits at a glance, which are then shared with the staff. Trauma documentation showed the greatest improvement with trauma activation time, pre-hospital Glasgow Coma Scale (GCS) scores, Pre-hospital Vital Sign documentation and emergency department attending response time. There is improved compliance in documenting pain assessments, vital signs and temperature. Compliance for those data points were initially in the low 80s, but are increasing to match the 90% compliance rates that the ED has seen across other data.

### AN ONGOING OPERATION

Even the most perfect implementation project requires a feedback loop and monitoring to continually improve. The Trauma Narrator project team built several important mechanisms to customize the use of the software, thus ensuring its ongoing success within the ED. We have initiated ongoing meetings with ED clinical nurse specialist Ilene Jones, RN, DNP, and Epic team leader Christine Trotta, RN, to discuss new workflow, Daily-Weekly Trauma Documentation Chart Audits, and individual or departmental feedback on the performance indicators for trauma COMAR requirements.

### MOVING FORWARD IN ELECTRONIC WORLD

As a tertiary care facility focused on trauma, Johns Hopkins Bayview's emergency department must meet challenging demands in a fast-paced environment. These demands are robust and require the clinical staff to document care in detail to ensure all regulatory requirements are met. The Trauma Narrator has helpful cues built in to the product that remind the staff to document their care in real time. A highly engaged staff and dedicated project team prepared the ED well throughout their move to Trauma Narrator. The ED staff has embraced their new electronic world, viewing the Trauma Narrator as an important tool in their quest to provide the best care to their patients.

## Key Benefits of Trauma Narrator

- 1 An interdisciplinary team can quickly visualize the vital signs and the chart of the trauma patient, allowing team members to have situational awareness and make preparations
- 2 Caregiver communication has improved as each member accesses a common chart, allowing time to review data and ask questions.
- 3 Charts are now accessible across the Medical Center.
- 4 Lost or illegible paper charts no longer impact the transfer of information between the emergency department and other departments.
- 5 Billing is more accurate and effective for trauma charts.
- 6 The staff has a single dedicated place to document care delivery and does not have to move between paper and the electronic systems during the patient's emergency department visit, thus eliminating any double charting.

## AvaSys TeleSitter

Video monitoring keeps patients safe and cuts costs

BY ANDY MAGALEE, RN, MS

Patient safety is an enterprise-wide concern on the Johns Hopkins Bayview campus. Some patients can require continuous monitoring by Patient Safety Attendants (PSA), trained support employees who are sometimes called “sitters.” The role of these attendants is simple: keep a watchful eye on at-risk patients to avoid injuries. PSAs support all types of patients, including pediatric and geriatric patients who may harm themselves. Patients who are impulsive, cognitively impaired, confused, or have an unsteady gait and those who are at risk to fall—all are served by PSAs.

**PSAs AT WHAT COST?**

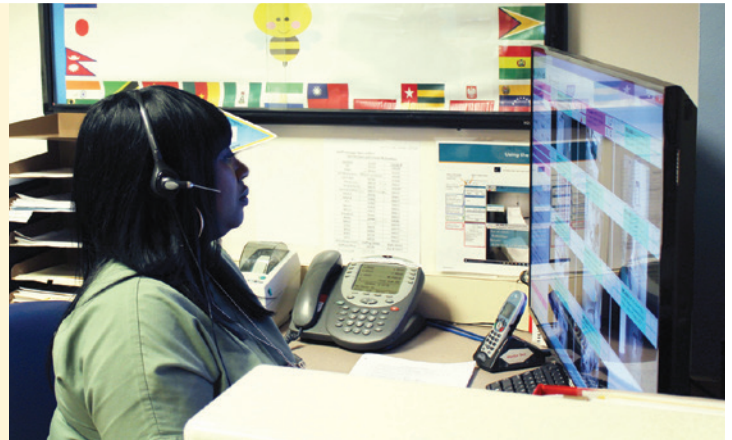
In 2016, nursing leadership noted that the use of PSAs had increased over each of the prior three years, placing increased demand on this limited pool of resources and requiring the Medical Center to pull patient care technicians (PCTs) and certified nursing assistants (CNAs) away from their normal routines to support patients who require close observation on our units.

The demand for PSA care was much greater than expected, and was taxing unit workflows as well as internal, agency and intrastaff (JHHS supplemental staff) resources. The labor pool didn't seem likely to grow in the short term, despite ongoing recruiting efforts. There was an overall shortage of these resources in the community, for both internal recruits and temporary labor sources. At the same time that demand for PSA support increased, the labor market experienced a decline in available PSA candidates.

Despite the benefits of the sitter program related to patient safety, the escalating use of PSAs coupled with a lack of PSA availability presented a financial and clinical operational concern to the institution. Expected costs related to the use of PSA care in the 2017 fiscal year were approaching \$2 million. Nursing leadership turned to technology to solve this dilemma.

**TECHNOLOGY PROVIDES AN ALTERNATIVE**

The AvaSys TeleSitter solution provides a cost-effective patient observation and communication system that utilizes camera feeds, two-way speakers and video monitors. Instead of direct observation by one sitter for each patient, a single



Taneka Thomas, VMT, keeps a close eye on patients.

video monitor technician (VMT) can safely monitor as many as 12 patients, avoiding the cost associated with monitoring 11 additional patients.

Balancing the nurses' mission to provide a safe experience and the patient's right to privacy, the AvaSys TeleSitter components are discreetly installed in hospital rooms and accessed from a central observation and communications station. Portable camera units which are mounted on a movable IV pole-like stand provide flexibility by allowing us to move the monitor to different rooms as needed. Patients are monitored remotely and communication to the bedside is initiated through built-in, two-way audio channels.

Not all patients meet the criteria to be supported via a TeleSitter video monitor technician. The main criteria is that the patient must be able to understand and respond to verbal instructions through the two-way speaker capability of the camera.

The nurses have established criteria for selection of appropriate patients who can be monitored safely using this technology.

Implementing the AvaSys TeleSitter technology has allowed the Medical Center to reduce its use of PSAs by nearly 30%. From November 2016 to June 2017, the Medical Center was able to avoid PSA costs of almost \$1 million. This fiscal year, July 2017 to June 2018, Johns Hopkins Bayview anticipates a cost avoidance of \$1.3–1.4 million. The AvaSys TeleSitter has allowed our nurses to use 21st century technology to safely support patient care while also providing great cost savings to the Medical Center.

# A New Plan of Care in Ambulatory

## An inpatient workflow comes to life in ambulatory care

Driven by innovations in technology and the demands of payors, hospital inpatient care is increasingly being replaced by ambulatory services; balancing that shift in the delivery of care is an important strategic consideration for Johns Hopkins Bayview. In fact, the national health care delivery model has shifted from one that rewards volume to one that rewards value. The implementation of nursing care plans in the ambulatory setting adds value by improving patient outcomes.

In an inpatient setting, Johns Hopkins Bayview nurses implement a customized plan of care to provide direction for the individualized treatment of patients, which focuses on their specific clinical and social needs. The plan of care provides an organized way for nurses to communicate with one another, document interventions and guide the staff as they coordinate care for a patient during an inpatient hospitalization.

Nurses are well-educated in the use of care plans, a holistic tool introduced to them in nursing school that is widely used to drive interventions within hospitals. In fact, The Joint Commission expects to see an individualized plan of care in place for every patient when they conduct an accreditation survey. Components of a plan of care may include, but are not limited to, documentation of the following patient-specific information:

- History of present illness(es)
- Active medications
- Patient-identified goals
- Prioritized recommendations on clinical care based on quality indicators
- Pharmacy or other specialty consults
- Clinical outcomes

During Johns Hopkins Bayview's 2015 Joint Commission survey, members of the survey team asked director of nursing Wendy Houseknecht, RN, MSN, what the Medical Center's process was for ambulatory care plans. It was not a requirement, the surveyor explained, but rather, could be beneficial in the ambulatory setting. Houseknecht took that message to heart, and performed a literature search to learn more about the usage of care plans in an ambulatory setting. She could find no exemplar to use as a model for an ambulatory plan of care for the Medical Center. She also reached out to her colleagues in other institutions to assess their processes related to an ambulatory plan of care, and again identified a gap in the use of a plan of care in

the ambulatory setting. However, she was determined to implement the recommendation of The Joint Commission regarding ambulatory plans of care before the next survey team arrived on campus.

The ambulatory staff collaborated with the clinical informatics team to develop an ambulatory plan of care. They leveraged best practices from care plans used by the Medical

Center's inpatient units as they developed care plans appropriate for the ambulatory setting. The goals of this project were simple:

- Improve patient outcomes and the patient experience
- Provide patient-centered, transparent communication within the interdisciplinary team
- Reduce preventable readmissions to an inpatient setting
- Limit inappropriate use of the emergency department
- Comply with regulatory requirements, which seemed to be heading in the direction of requiring plan of care documentation in the outpatient setting.

Recognizing that patient needs are different in each specialty, the nursing team tailored the use of care plans for specific



Custom plan of care fields in Epic, demonstrated by Tanya Simmons, RN, and Maya Nixon, RN, in the diuresis clinic.

high-risk patients in a limited number of departments. The leadership team focused on patients with the most complex needs, as these patients are at risk for high utilization of the emergency department and readmission. Typically, these are patients who are seen on an ongoing basis with multiple encounters for each episode of care. The team identified the following patients that would benefit from an ambulatory plan of care:

- Patients with chronic obstructive pulmonary disease (COPD) in the pulmonology clinic
- Patients with heart failure in the diuresis clinic
- Patients with active medical or radiation treatment/therapy plans in the hematology/oncology clinic
- Patients with rheumatoid arthritis and myositis in the infusion center
- Patients with diabetes in the endocrinology clinic.

Closely mimicking the features of Epic's inpatient electronic medical record, nursing leadership designed and implemented custom templates with preset goals that are common to each condition within the existing Epic outpatient software, which was already in use by ambulatory departments. The software modification of "goals" allowed the nurses to create a plan of care, monitor treatment goals, and track progress notes for a specific patient episode of care. The team ensured that the ambulatory plan of care included:

patient problems linked to the mutual goals of the patient, family and care team; documentation that reflects patient progress toward goals and barriers to progress; and goals that are specific, measurable, and include time frames.

The cardiology department pioneered their new care plan approach for heart failure patients who were seen over multiple encounters in the diuresis clinic. Diuresis, when tightly managed in an ambulatory setting, has a proven track record of reducing readmissions for this population.

The nurses use these new templates to track patient progress over time, to share information across multiple patient encounters, and to support the patient education and self-maintenance goals that are so critical to keeping these patients well. "If we can take care of them before they need to go into a hospital, then we help them maintain a better quality of life at home," says Tanya Simmons, RN.

Pilot care plans were launched into use within ambulatory departments in March 2018. During the May 2018 Joint Commission accreditation process, the surveyors shared that Johns Hopkins Bayview "has a superior process in place for the plan of care throughout the continuum" and reported that more than 80% of institutions are cited for inadequate plans of care. According to Houseknecht, "regulatory compliance is extremely important, but the true benefit of an ambulatory plan of care is improved care coordination and improved patient outcomes."

# 10

## Technology and Innovation

# BICU Takes the Pressure Off of Patients

BY EMILY WERTHMAN, RN, BSN

**B**urn patients are among the Medical Center's most vulnerable occupants and their care is tremendously complex. The multidisciplinary team who cares for these patients is highly skilled in critical care, and burn and wound management. Simply addressing the burn injuries of these patients is not the end of the story on the burn intensive care unit (BICU), a 10-bed unit where these patients are at great risk for pressure injuries due to the complexity of their injuries and their overall debilitation.

While effective methods exist to offload pressure from other areas, offloading the head from the bed is difficult,

especially with facial or head burns. A high number of occipital pressure injuries in 2017 (six cases) prompted the BICU to review best practices for offloading the head of these patients. A multidisciplinary team of physicians, occupational therapists and nurses evaluated several devices used to prevent occipital pressure injuries.

### EVALUATING THE PRODUCTS

A staff member willingly served as a patient subject and laid supine on a pressure redistribution mattress with the head of the bed at a 30-degree angle. A trained evaluator

used a calibrated pressure mapping device to measure all pressure points of their head. This process was repeated to evaluate the following offloading devices:

- specialty pressure redistributing mattress
- standard pillow(s)
- foam “donut” pillow
- fluidized position pillow

Each test was conducted both with and without a cervical collar in place. The fluid-filled positioner yielded the lowest pressures when compared to the other methods of offloading occipital pressure.

Education was provided to the staff about the result of the pressure mapping device tests, and on the indications for instituting a fluidized positioner for a given population of patients. After evaluation of these products, the BICU leadership made the decision to implement use of the fluidized positioner on the unit. This device had the lowest pressure reading.



Madeline Royston, PT, DPT, demonstrates fluidized positioner.

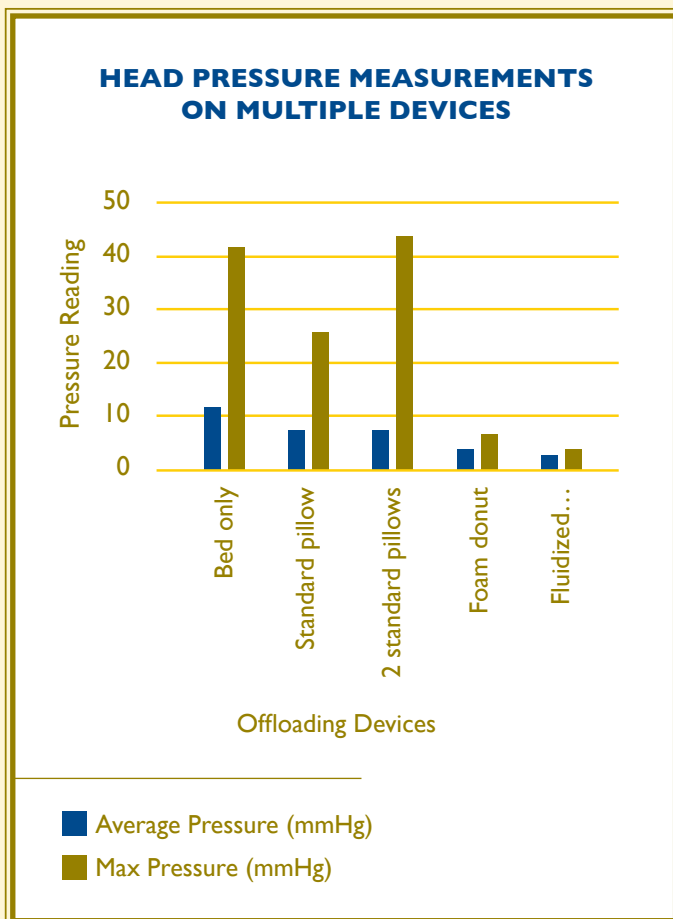
### MONITORING FOR SUCCESS

Patients experienced no occipital pressure ulcers after the implementation of fluidized positioners. Results are now monitored on a monthly basis on the BICU.

*There have been zero occiput pressure injuries in 2018.*

Nurses are very open to using the fluidized positioner and readily relate that the product has made a big difference in their patients' outcomes. Says Emily Werthman, RN, burn program coordinator, “In the past, the bedside nurse was unsure if the patient’s head was being properly offloaded. By measuring the different types of offloading surfaces used, nurses are now able to practice with the knowledge that the fluidized positioner is the best choice to prevent occipital pressure injuries. This data empowers nurses to provide safe, effective care to their patients.”

Ongoing education on patient risk for occipital pressure injuries, coupled with the implementation of a fluidized positioner, have helped BICU team members drastically reduce patient risk of a hospital acquired occiput pressure injury. Staff expects that the continued use of their new fluidized positioner strategy will maintain this safety record, and take one more risk off their list of things to worry about as they provide the best care possible to the patients on their unit.





# 11

## Patient Safety and Satisfaction

# Communicating Through CUSP Produces Positive Outcomes on Obstetrics Unit

BY MICHELLE CUMMINGS, RN, Ed. D., CNE AND MELISSA JOHNSON, RN, RNC-OB, MS

In the words of the Johns Hopkins Bayview Diversity Council, "the diversity of thought, perspective, experience and problem-solving ability seen throughout our institution are what keeps us the *best of the best*."

Interdisciplinary teams of clinical specialists, by their very nature, bring diverse education, skills and styles to their work. During the Comprehensive Unit Based Program (CUSP) process, an interdisciplinary clinical team partners with an executive to support the implementation of a five-step intervention, designed by the Armstrong Institute, that helps staff tackle safety hazards in their environment. They work together to educate staff on the science of safety, to identify and learn from safety defects, and to improve teamwork and communication.

OB CUSP is led by Kate Hackett, RN, and Cynthia Argani, M.D., who are the OB CUSP team champions at Johns Hopkins Bayview. The team is comprised of patient care managers, patient safety nurses, physicians, staff nurses, and OB residents. Through a review of HCAHPS scores, Safety Attitude Questionnaire data, and responses to a staff survey, the OB CUSP team identified poor team communication on the unit, which can be a precursor to patient harm.

The team shared this baseline data with staff, along with research showing that inadequate communication is a leading cause of medical error and adverse events in health care. The OB CUSP team was eager to improve interdisciplinary team work and communication to ensure the best possible patient outcomes.

The team identified a few observations in the way they communicated:

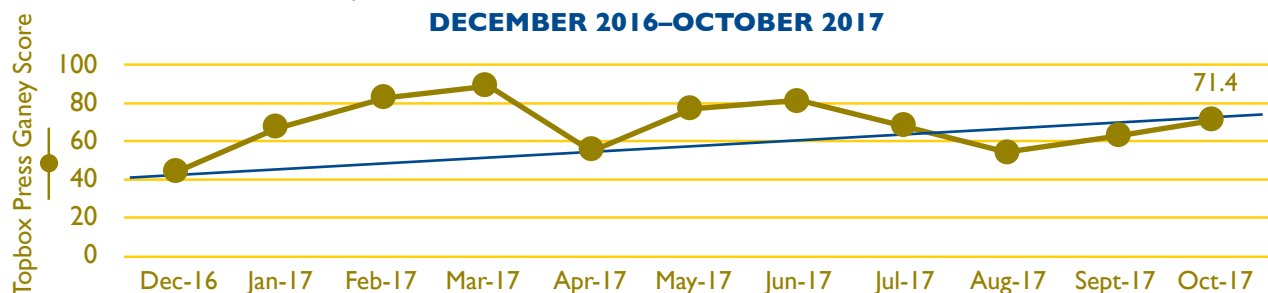
- Clinical staff rounded on patients at different times of day, which disconnected the plan of care from priorities for the day.
- Physicians and nurses were unclear about how to reach one another, leading patients to believe that the team was not "working well together to care for them."

The OB CUSP team implemented the following strategies to address the survey findings:

- Team rounding was established to include an attending physician, an attending RN, and the patient.
- Using Lean principles which reflect standard work concepts, the team created a new work list. This work list was developed by the physicians to identify RN interventions that would support the daily plan of care.
- Additional Spectralink phones were purchased to improve team communication.
- Training and education was provided for all clinical staff on the processes of entering orders into the electronic medical record.
- A double-check of all orders during handoff was used as a Lean management tool designed to lower error rates.

In nine months, these small process improvements have produced dramatic results, reflected by a **24% improvement** in team work climate on the Safety Attitude Questionnaire, and a **25% increase** in the HCAPHs score specific to the patient's perception in the question, "Is the team working well together to care for me?" By expanding their lines of communication, the OB CUSP team has created communication that is valued by staff and patients alike.

**PRESS GANEY QUESTION: STAFF WORKED TOGETHER TO CARE FOR YOU  
DECEMBER 2016–OCTOBER 2017**



## Back to the Basics

### Wenz Orthopaedic Unit uses teach back tool kit for medication education

According to the Agency for Healthcare Research and Quality, “40 to 80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect.” Communicating effectively with patients is not a simple conversation. It can include unfamiliar vocabulary, complex instructions and overwhelming details that patients may be too intimidated to question.

In 2015, Wenz Orthopaedic met the QBR Threshold targets in seven of the eight domains measured by the HCAHPS. This was great news; however, the HCAHPS and Press Ganey survey scores in the Medication Communication domain were significantly low.

Educating patients about medication is a critical part of preparing patients for discharge. A successful transition to discharge is linked to lower rates of readmission to a hospital or a visit to the emergency department. Patient education also encourages patients to be diligent about following instructions for self-care at home and the management of prescription medications.

#### CONVERSATION IS A TWO-WAY STREET

Often, patients who are discharged from the Wenz Unit are prescribed new or unfamiliar medications when they go home. Wenz Unit nurses set a goal to ensure that their patients had both the knowledge and the resources they needed to safely take their medications. According to Romero-Sanchez, et al, “knowing medication safety issues such as precautions and warnings, possible side effects, contraindications and interactions with certain foods and other medications is a key component of medication self-management.” With an eye on improving the HCAHPS scores, the unit decided to employ a teach back methodology, which is a strategy used by providers to confirm that patients understand the instructions they have received.

When using a teach back method, clinicians preface patient education by placing accountability for understanding the teaching upon the clinician rather than on the patient. Using humble inquiry, providers encourage open discussion and questions from patients. Clinicians may prompt patients to restate the instructions using language such as, “I want to make sure that I explained everything clearly. If you were talking to your neighbor, what would you tell him we talked

about today?” While hardwiring of the process took several years, incorporating a teach back methodology was successful because of the existing culture on the Wenz Unit.

#### A VISUAL TEACHING TOOL

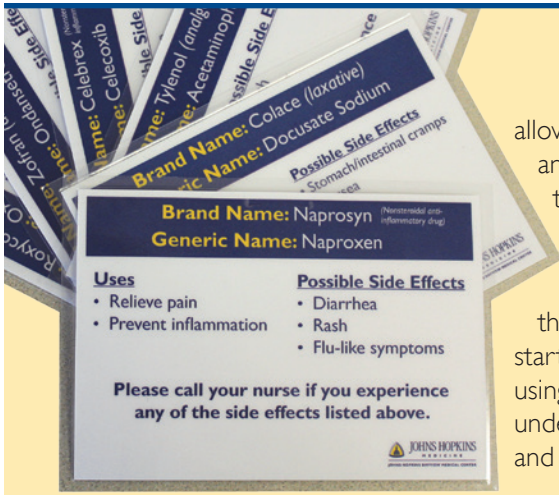
To support the new teach back conversations, a multidisciplinary orthopaedic team from nursing, pharmacy and administration investigated how to further enhance communication between doctors and patients about their medications. The team decided to incorporate printed instructions, and the new Medication Education Card (MEC) program was rolled out to the nursing staff in November 2015.

The first MEC education tool was specifically tailored for patients with a diagnosis of Primary Total Hip and Total Knee Replacement. The team identified the top 10 commonly used medications given these patients while in the hospital. Each MEC was carefully developed to encourage patients and caregivers to be engaged in the medication communication process as partners. To support early recognition of medication complications, the nurses emphasized side effects when training patients on the use of their medications. More importantly, each MEC listed key pieces of information such as drug interactions, side effects and contraindications, to allow patients to have this information at their fingertips.

The pilot MEC program was a success, prompting the frontline staff on the Wenz Unit to use this education tool more broadly with their patients. MECs were later developed for other conditions common to the patients admitted to this unit. The cards were incorporated into existing staff work flows and unit routines such as during the patient admission and discharge process, as well as in discussions during safety rounds, staff meetings, and huddles. Information regarding MEC was also included in a weekly newsletter. The unit charge nurse helps facilitates the use of the MEC cards on the unit.

#### PASSING THE TEST

Since the launch of the MEC teach back tool two years ago, Wenz Unit’s HCAHPS medication communication domain top box score has improved over 13 percent in April 2018. The program has been supported by the hospital’s Patient and Family Advisory Council and has



allowed the staff to proactively engage patients and family members in the planning and implementation of this initiative. Finally, use of the MEC card and similar tools has spread to other inpatient units on the Johns Hopkins Bayview campus, and throughout the Johns Hopkins Health System as a whole.

Effective communication is bidirectional. Using the teach back method with the MEC provides clinicians on the Wenz Orthopaedic Unit an opportunity to start the conversation about medication management with their patients. Nurses using the teach back method are more confident that their patients have a good understanding of how to take their medication at home. Message received, loud and clear!

# 13

## Patient Safety and Satisfaction

# Making a Call for Cleanliness

BY KELLY BACA AND THE NICU NURSING COUNCIL

Welcoming a new baby is one of life's great joys. In 2018, many of us will whip out a cell phone to call relatives, text photos to friends, or post baby news to social media. But what risk does this 21st century sharing pose to our littlest patients?

A staff member at Johns Hopkins Bayview asked that very question after visiting an infant niece who was a patient in another hospital's Neonatal Intensive Care Unit (NICU). In that NICU, all visitors were required to put their phones in plastic bags, away from any possible contact with the babies on the unit. That prompted the Johns Hopkins Bayview Nursing Council to ponder the safety of its own NICU patients in light of ever-present news stories about how "dirty" cell phones are. The council wondered, "If we know this, why are we not doing anything about it in our unit?"

### CALLING IN THE EXPERTS

Multiple studies have shown that cell phone surfaces carry and breed bacteria. The most common bacteria found on cell phones are coagulase-negative *Staphylococcus*, methicillin-sensitive *Staphylococcus aureus* (MSSA), and methicillin-resistant *Staphylococcus aureus* (MRSA). **Evidence shows that only 8% of health care workers routinely clean their cell phones.** Of people who report that they do clean their cell phones, there exists wide variability in how phones are cleaned, which cleaning product is used,



and how often cleaning occurs. Bacteria from cell phones can easily be transferred to the hands or other surfaces and vice versa.

Staff, patients and visitors constantly carry and handle their cell phones, but there was no hospital policy, protocol, or guideline for cell phone disinfection. Our nurses are always conscious of the risks to this vulnerable infant population in the NICU. In the hospital setting, we are tremendously concerned with hand hygiene; it was time to become tremendously concerned with phone hygiene as well. But how?

## BACKGROUND NOISE

To measure the success of any new policy, the council needed to identify metrics. They decided to use statistics about compliance rates with cell phone disinfection procedures along with MRSA surveillance data for the NICU.

- To monitor a targeted staff compliance rate of 90%, an audit tool and “secret” observers were used.
- Pre-policy MRSA prevalence was compared with 6 to 12 month post-implementation data to see if cell phones with the new disinfection procedure reduced the risk of MRSA.

Next, the NICU Nursing Council researched best practices for cell phone disinfection in a hospital setting and also specifically for a NICU. A literature review identified new guidelines for cell phone use and procedures for disinfection that can decrease the risk of exposure. The council also reached out to other neonatal intensive care units in the Baltimore area to determine what our peer hospitals were doing.

This survey revealed that:

- Two neonatal intensive care units had documented cell phone cleaning procedures and guidelines for visitors, but these guidelines varied widely in process and method.
- None of the NICUs surveyed had a cell phone disinfection procedure for staff.



NICU nurses tend to their charges with care, compassion and clean hands.

As a group, the nursing staff worked to identify barriers to the success of a new cell phone disinfection policy, but the team found none. It was time to implement a plan:

- A new cell phone disinfection procedure was developed and implemented for NICU staff and visitors.
- Staff and visitors were provided with education regarding bacteria on cell phones and the disinfection procedure.
- Cell phone use guidelines for staff and proper hand hygiene practices were reinforced with observation audits.
- 90 percent compliance rate for cell phone disinfection was established as a target.
- Finally, cell phone cleaning stations were created, which included approved disinfectant wipes and posted instructions.

## THE RESULTS

At the start of the campaign, staff compliance was 55%. In December 2017, the targeted rate of 90% was met and by January 2018, NICU staff were routinely exceeding the goal and sustaining a compliance rate of 95%.

Are we keeping our patients safe with all this new disinfecting? A pre- and post- implementation comparison of monthly positive MRSA results showed a marked decrease in the rate of MRSA infection. MRSA infections were at zero from September 2017 to January 2018. This is a welcome improvement related to the new disinfection procedures and demonstrates the impact on overall safety of the babies in the NICU.

The NICU's new focus on cell phone hygiene has already made a difference to the safety of Johns Hopkins Bayview's youngest patients and their families, giving the nurses one fewer risk to worry about as they support their tiny patients through their launch to 21st century life.

# Perception Becomes Reality

## Increasing staff responsiveness and communication

LENORE REILLY, RN, MSN, MS, CCRN-K, CNML, NE-BC AND ROWENA OROSCO, RN, BSN

**B**urn injury is a trauma with great impact on patients and their families. Burn patients often have a long road to recovery, both physically and emotionally. Caring for the burn patient is immensely complex. They are medically fragile and at great risk for infection, requiring intervention from a large team of specialists.

To allow burn patients to participate in the rigorous demands of their treatment, such as wound care and therapies, their nurses must ensure that patients understand their treatment plan and can tolerate their pain.

The staff on the 10-bed Burn-Wound Unit considers responsiveness to patient pain their highest priority. They go to great lengths to communicate with their patients to ensure they understand the complexities of their medication and care, especially with respect to planned dressing changes.

### AREAS OF OPPORTUNITY

The HCAHPS results from FY 2017 (20 surveys) demonstrated the areas of greatest opportunity for improvement in the questions related to staff responsiveness, and education communication.

The nursing staff is passionate about improving their patients' perception of care, and established two goals for ongoing improvement:

- Staff responsiveness on HCAHPS will increase by at least 10% by June 30, 2018.
- Communication about medication will increase by at least 10% by June 30, 2018.

Beginning in December 2017, the team reinvigorated hourly rounding by focusing their attention on the four "Ps" (pain, potty, position, possessions). They decided to use a visual cue to ensure they kept up with hourly rounding and posted a cardboard clock outside each patient room. Each time a nurse entered a patient's room, the hour hand on the clock was moved to the next hour, providing a visual prompt to keep the nurses on schedule.

To address the needs for medication education, the nurses partnered with the unit pharmacist. The pharmacist developed a teaching tool that would facilitate patient education for the

most frequently prescribed medications for the burn-wound patient population.

Next, the unit instituted huddles to discuss the clinical status of their patients. Burn Intensive Care Unit (BICU) charge nurses were taught to round on burn-wound patients once per shift to discuss patient progress and to address any additional needs the patients or families may have. During rounding, the patients were specifically asked if someone had rounded on them in the last hour utilizing the four "Ps". The nurses also used the admission folders, which provided teaching materials. Outcomes of the charge nurse audit were collated and posted on the unit huddle board for review during huddle. The goal of achievement across all categories was 90% completion.

### MONITORING FOR SUCCESS

To achieve high reliability, staff continues to monitor its active partnerships with BICU charge nurses to be sure they are rounding on the patients once per shift.

- Feedback from patients is addressed in a timely way so they feel heard and their concerns addressed.
- Feedback from staff is elicited related to the process of using visual clocks for rounds as well as hourly rounding.
- A new log book is kept for staff to sign in or out each time a nurse picked up a Spectralink phone.
- Engagement with the unit pharmacist continues related to the medication education teaching tool.
- Monthly HCAHPS results are shared at unit staff meetings, as well as at unit huddles.
- Charge Nurse rounding results are collated and shared at unit huddles.

Tracking the metrics of these new improved processes shows a high level of compliance with tools, exceeding their goal of 90% in all categories. The staff is following their new strategies closely. During rounding on one particular shift, a patient said to the charge nurse, "I don't know what you are doing, but keep it up—the staff is great!"



Nurses use visual cues to remind them to follow-up: cardboard clocks for rounding and colored stickers for equipment change.

The Burn-Wound Unit, is already seeing improved patient satisfaction scores. In the April 2018 review of HCAHPS data, the Medication Communication domain has increased 7.4 points. Due to the complexity of managing these burn patients' cases, the Staff Responsiveness domain remains a challenge. However, the Care Transitions domain is 5.7 points higher than the 2017 score, reflecting the staff's overall devotion to the needs of their patients.

Patient satisfaction is the highest priority for the clinical staff of the Burn-Wound Unit and they are committed to providing these patients the best possible recovery. They care for clinically complex patients who frequently have great pain management needs. The communication and teamwork between the Burn-Wound team and the charge nurses of the BICU is fully dedicated to the complex needs of these patients, and the staff constantly monitors the progress toward their rounding and responsiveness goals.

# 15

## Patient Safety and Satisfaction

### Call, Don't Fall Campaign raises awareness of falls

BY HAIMANOT MULAT, RN, BSN

According to the American Nurses Association (ANA), a patient fall is an unplanned descent to the floor with or without injury to the patient. Patient falls pose a significant safety concern in hospitals and are the most frequently reported adverse event during a hospitalization, ranking at the top of hospital-acquired injuries (HAI). When a patient falls, this complicates their recovery, causes prolonged hospital stays, greatly increases their chances for hospital readmission and is the leading cause of death and injury to patients age 65 and older.

Falls occur most frequently in units that focus on elder care and on neurology and rehabilitation, where the average hospital cost for a fall injury can exceed \$30,000. In fact, Medicare costs associated with falls totaled more than \$31 billion in 2015. The impact of a fall is felt by patients, families, caregivers, hospitals and insurers. They all have a stake in keeping our patients safe from this avoidable injury.

Studies have shown that in acute care hospitals, the rate of falls ranges from 1.3 to 8.9 falls/1,000 patient days. This

important metric provides the nursing staff at Johns Hopkins Bayview a way to measure how the Medical Center compares to other hospitals and is an indicator of patient safety. When the nurses on the Medical Center's inpatient rehabilitation unit observed that the rate of patient falls had risen drastically above this range in a short period of time, they knew they had to act.

The unit, a 20-bed capacity, stroke-certified service, cares for patients with complicated medical needs, such as those with strokes, amputations, burns, traumas, brain surgery and complex neuromuscular diseases. The unit's overall rate of falls had grown into a major cause for concern in 2017:

YEAR	RATE OF FALLS
2015-16	6.12/1000 patient days
2017 (Q2)	17.84/1000 patient days
2017 (Q3)	14.68/1000 patient days

\*ALL DATA FROM NDNQI REPORT, JHBMC

Responding to this concern, the team designed and implemented an intervention project. **The Interdisciplinary Falls Prevention Project (IFPP)** which evolved from evidence-based research of a capstone project in the summer 2017, was led by Haimanot Mulat, RN, BSN, of the inpatient rehabilitation unit (formerly known as the terrace unit).

### CAUSE OF THE FALLS

Data review and analysis of HERO reports revealed the following characteristics about falls on the inpatient rehab unit:

- Toileting was the main cause cited for falls.
- Transfers to and from beds/chairs were the second most common cause.
- Most falls occurred during peak hours of rehabilitation (8 a.m. to 1 p.m.).
- Patients between 60–70 years of age experienced more falls than patients of any other age group.
- More women than men fell in the unit.

Since the unit had no consistent falls prevention strategies or measures in place, the team began to examine the best options to prevent falls. Their goals:

- Reduce falls by 10% from the current levels by the end of 2018.



- Raise staff awareness, accountability and responsiveness to new fall prevention measures.
- Promote patient and family accountability by assigning responsibility through the use of a new questionnaire and initiating patient contracts.
- Increase collaboration between nursing, physical and occupational therapists (PT/OT), physical medicine and rehabilitation (PMR) through professional development and training on new workflows.

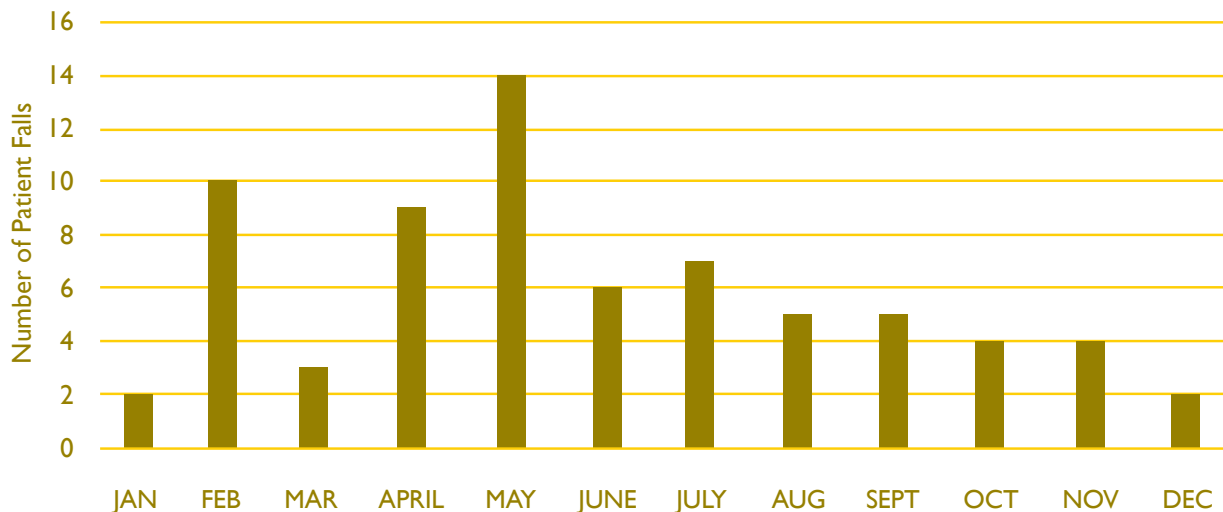
### FALL CHAMPIONS RISE TO THE OCCASION

Fall Champions were identified to implement the **IFPP** and went through professional development before launching a campaign to educate patients, families and staff. These champions worked with an interdisciplinary team of staff including PT/OT, nurses and techs from the units with the greatest incidence of falls. The IFPP also received support from The Armstrong Institute for Patient Safety and Quality to develop processes and outcome metrics.



Yellow is the signature color of the "Call, Don't Fall" campaign.

### REHABILITATION UNIT (BURTON PAVILION) FALLS BY MONTH, 2017



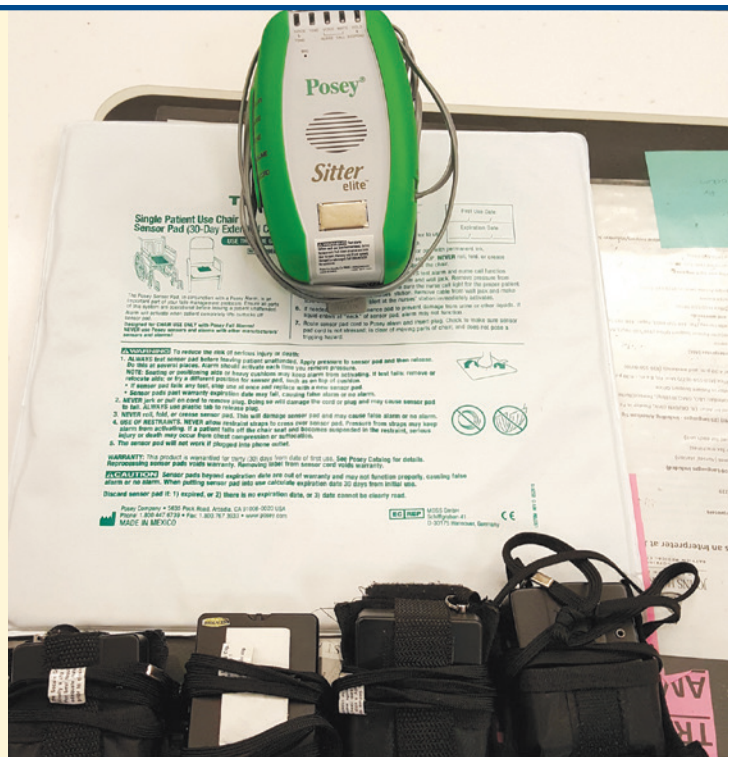
Key features of the campaign included:

- New cognitive and impulsivity screening given to patients upon admission and again within 72 hours after admission
- Daily falls audit
- Reminders and awareness materials for nursing staff and patients
- Patient and family education, including signature yellow identifiers (socks, wrist bands, and wheelchair tags)
- A new “Call, Don’t Fall” contract, with patient and family signature required
- Stronger safety measures, including bed and chair alarms, clipped alarms, tele-monitoring cameras, and peer accountability measures through random safety checks

Perhaps most importantly, a discussion about falls became part of the huddle routines, bedside reporting, patient conferences and safety rounds.

### FALLING NUMBERS

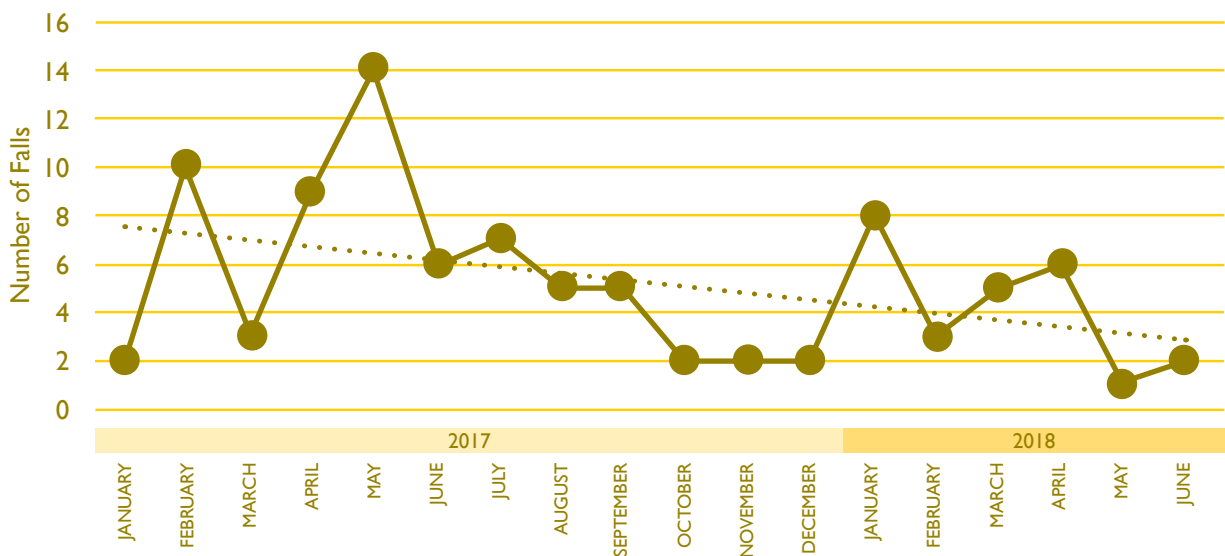
The **IFPP** successfully rolled out its new robust falls prevention strategies to an interdisciplinary team by increasing awareness of the new measures and educating patients, families and staff about the critical impact of falls to patient safety. The “Call, Don’t Fall” contract achieved nearly 100% compliance from patients, and new tele-video cameras were being put to good use on the unit by allowing nurses to remotely visualize patients in their room.



Clip and chair alarms.

The impact of these new interventions will be monitored monthly to determine their effectiveness. In addition, The Johns Hopkins Medicine Nursing Clinical Quality Community, Co-chaired by Dr. Koszalka and Dr. Miller, have started to focus on strategies to prevent patient falls and will monitor fall rates for hospitalized adults in all Johns Hopkins Medicine hospitals. Best practice bundles of care will be implemented across the Johns Hopkins Health System to address this important patient safety issue.

### HOSPITAL-WIDE PATIENT FALLS, 2017–2018





# The No Pass Zone

## Making a play for patient care

BY RONA CORRAL, RN, MSN

Patient safety and satisfaction are primary forces driving the quality of nursing care on The Carol Ball Medicine Unit (CBMU) at Johns Hopkins Bayview. Director of nursing Michelle D'Alessandro, RN, DNP, reviewed the 2017 survey statistics for her unit and grew concerned because the HCAHPS data for CBMU did not reflect the excellent delivery of patient care that she saw every day on her unit.

CBMU patient admission criteria had changed over time and higher acuity patients were admitted to the unit. At the same time, the unit faced a staffing challenge. It made sense that the unit would try to find a way to improve staff morale that would have the added benefit of increasing patient safety and satisfaction. D'Alessandro decided to implement a buddy system similar to one she had used in her previous work at The Johns Hopkins Hospital.

The buddy system, dubbed **The No Pass Zone Interdisciplinary Pilot Program**, was kicked off in October 2017 using teamwork, a rewards system and a little friendly competition to score points with patients and staff alike.

### BEHIND THE SCENES

Recent survey data showed two areas of concern:

- HCAHPS domain score measuring staff responsiveness
- The Safety Culture Assessment (formerly the SAQ) score measuring teamwork

### UNDER THE LIGHTS

The top reasons patients use their call lights are sometimes known as the 3 "Ps": pain, position, and potty (need to use the bathroom). Patients view call lights as their "lifeline," an assumption confirmed when staff use the phrase "Call me if you need anything." Call lights are one of the few things over which patients have control, and are more likely to be used when the patient is fearful or has little confidence the nurse will go into their room.

An audit of CBMU call light logs showed an unwelcome pattern of late response time. Since a rapid response to call lights is the factor most highly correlated to a patient's overall satisfaction with his/her hospital stay, CBMU nursing



Raleigh Ayala, PCT, with Rona Corral, PCM, was Superbowl MVP and scored 48 touchdowns for patient care.

leadership suspected that speeding up their response to call lights could improve overall patient satisfaction.

### LEAVE NO CALL LIGHT UNANSWERED

The No Pass Zone initiative went live during the football season, just in time to have some fun. The staff determined that **immediately** responding to patients' call lights would be an obvious and effective way to increase safety, satisfaction and collaboration. Competing on teams made it more exciting.

The strategy:

- **DRAFTING A TEAM.** Involving all staff in a common effort would improve unit morale. No one would pass a light without trying to help: nurses, providers, patient care technicians, social workers, case managers, physical/occupational therapists, pharmacists, housekeepers, dietary, and respiratory therapists, were included in the project.
- **RAISING THE SCORE.** CBMU set a goal of a 3–5% increase in the HCAHPS Staff Responsiveness Domain score by the end of FY18.
- **WINNING THE GAME.** Unit leadership established a reward structure to recognize individual efforts to leave no call light unanswered.

## THE PLAYBOOK

To kick off the season, the unit identified Champions to reinforce expectations and recognize team members who were observed “answering the call” when a call light was on. Training materials, guidelines and expectations were shared with the team. A playbook was implemented which included scripting, definitions and a few rules of the game. It included guidelines on what all team members could do, and what could only be done by nurses.

In the No Pass Zone, a “touchdown” was given to a team member who was observed entering a patient’s room in response to a call light. A “foul”

was given to a team member who walked past a patient’s call light, as a simple reminder of the unit’s expectations.

## THE FINAL SCORE

Implementing the interdisciplinary No Pass Zone program was a creative, team-based approach to solve a specific problem on the CBMU: patient call light response times. Patient safety, patient satisfaction, and staff morale were all problem areas tackled by the No Pass Zone, as the unit developed an action plan to create an exceptional patient experience on the floor. All three measures continue to

show improvement and are becoming part of hard-wired staff behavior.

This creative team solution is now spreading campus-wide to other units as a way to start this practice through different sports seasons. The No Pass Zone Basketball Spring Edition went live on the CBMU in March, and they are meeting the goal over 90% of the time. Medicine A and Medicine B launched their own No Pass Zone on opening day of the 2018 baseball season.



Med B launches No Pass Zone Spring Edition (baseball).

The No Pass Zone continues to flourish as it creates a culture of teamwork focused on patient satisfaction. “All of our patients are **ALL** of our patients,” the CBMU

team players like to say. This initiative ensures that the entire Johns Hopkins Bayview staff answers every call light efficiently: a win/win for staff, patients and families.

## THE NO PASS ZONE SEASON STATS

- On the HCAHPS survey, the Staff Responsiveness Domain QBR score has increased five points over the FY2017 score.
- No Pass Zone Champions have observed staff/interdisciplinary team members scoring over 95% of the time.



No Pass Zone team memories.

# Following the Doctor's Orders

## Preventing self extubations (SE) in SICU

BY LENORE REILLY, RN, MSN, MS, CCRN-K, CNML, NE-BC

Many patients do their best to follow the orders of their doctor, especially after surgery. But when patients are restless or agitated, they may not have the self-control to follow orders, especially for the patient on mechanical ventilation who may accidentally remove his breathing tube. This lack of control can result in self-extubation (SE).

Self-extubation is defined as the unplanned removal of a mechanical ventilator breathing tube, is frequently initiated by a patient and can cause serious complications. Unplanned extubation has been reported in 35.8% of patients on mechanical ventilators and presents a significant health risk to already fragile patients. It can lead to hemodynamic compromise, airway complications, arrhythmias and even death. The rate and degree of injury from SE varies according to the literature. However, it is reported that incidences of SE can result in both prolonged mechanical ventilation and a longer ICU stay.

The Surgical Intensive Care Unit (SICU), a busy unit at Johns Hopkins Bayview, delivers care to critically ill adults who have undergone surgery or have sustained physical trauma. Many of these patients require mechanical ventilation at some point during their hospitalization.

The SICU saw a spike of eight cases of SE in late 2017 and made a commitment to reduce the frequency of these incidents. The SICU staff's goal was to decrease the rate of self-extubation to no more than one SE per month with a stretch goal of zero SE per month.

To begin, the nurses developed an audit tool to retrospectively review the charts of the eight patients who had self-extubated.

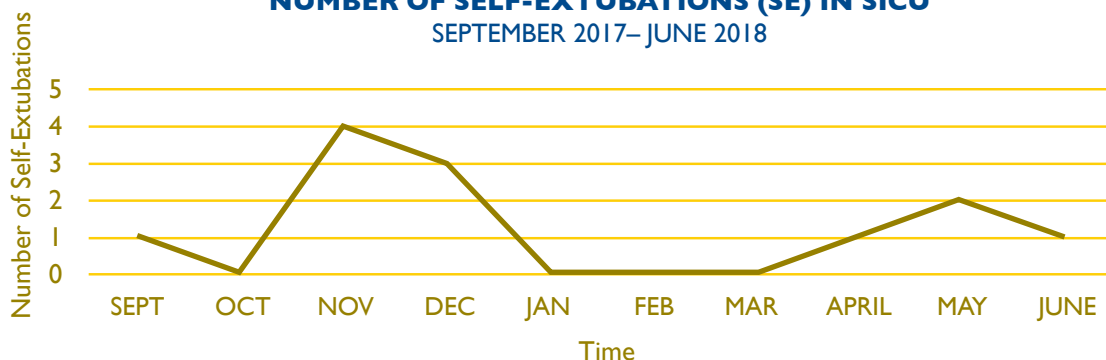


Yvette Wilson, Clinical Nurse Specialist (CNS), reviews the CUSP Board with the SICU team.

The staff was hoping to identify patterns and causes of the SE incidents to identify ways to decrease the SE rate. A multidisciplinary team held brainstorming and audit review sessions and formed workgroups to find opportunities for education and improvement. These sessions focused on:

- Restraint competency
- Titration education
- Relocation of mechanically vented patients to visible beds
- Development of a post SE huddle
- Confusion Assessment Method (CAM) for the ICU competency tests
- Opportunities to wean and extubate in the evenings
- Medication transition education
- Medication titration audits
- Increased response to alarms
- Identification of patients at high risk for SE
- Early morning wean screen communication with RN and RT – sedation vacation

**NUMBER OF SELF-EXTUBATIONS (SE) IN SICU**  
SEPTEMBER 2017–JUNE 2018



- Endotracheal Tube (ETT) securement device manufacturer recommendations for facial hair

### MONITORING FOR SUCCESS

By identifying patients at high risk for SE and implementing new policies and processes for monitoring their care, the SICU staff was able to reduce the SE rate to zero in January 2018. To ensure that this success continues, the SICU will employ a few tools:

- Patients on mechanical ventilation are considered for relocation to the most visible rooms, keeping them within the staff's line of sight.
- Respirator alarms are responded to promptly by all member of the clinical team.
- Educational groups continue to work on their identified action items and their ongoing work is discussed during unit huddles and at staff meetings.
- Early-identification methods were initiated to allow the staff to proactively discuss who is at greatest

risk for SE, and implementing strategies to prevent an SE event before it starts.

The SICU multidisciplinary team, reacting to an unwelcome development of self-extubation on their unit, has successfully raised awareness among staff and implemented strong measures to keep their SE rate at zero. "The SICU staff are committed to patient safety," says Lenore Reilly, Patient Care Manager of the SICU. "Their efforts to identify patients at high risk and proactively prevent SE have made a difference in keeping our patients safe."



SE is a primary focus of the SICU's June 2018 staff meeting.

# 18

## Patient Safety and Satisfaction

# The Right Care at the Right Time

BY FREDDIE JENKINS, RN, MSN, CDNC, ASSISTANT DIRECTOR OF NURSING

A myriad of treatment options and models have exploded the possibilities for care of mental health and substance abuse patients. Widely known are inpatient hospitalization and outpatient therapy, but the spectrum of care now has a full continuum in between: intensive outpatient therapy, outpatient detox, short-stay hospitalizations, medication management, complementary therapies and group or individual sessions. But when a suicidal teen or an addict in withdrawal presents within the emergency department, how do we make sure that we have the right care in place to serve and guide those patients in a time of great need?

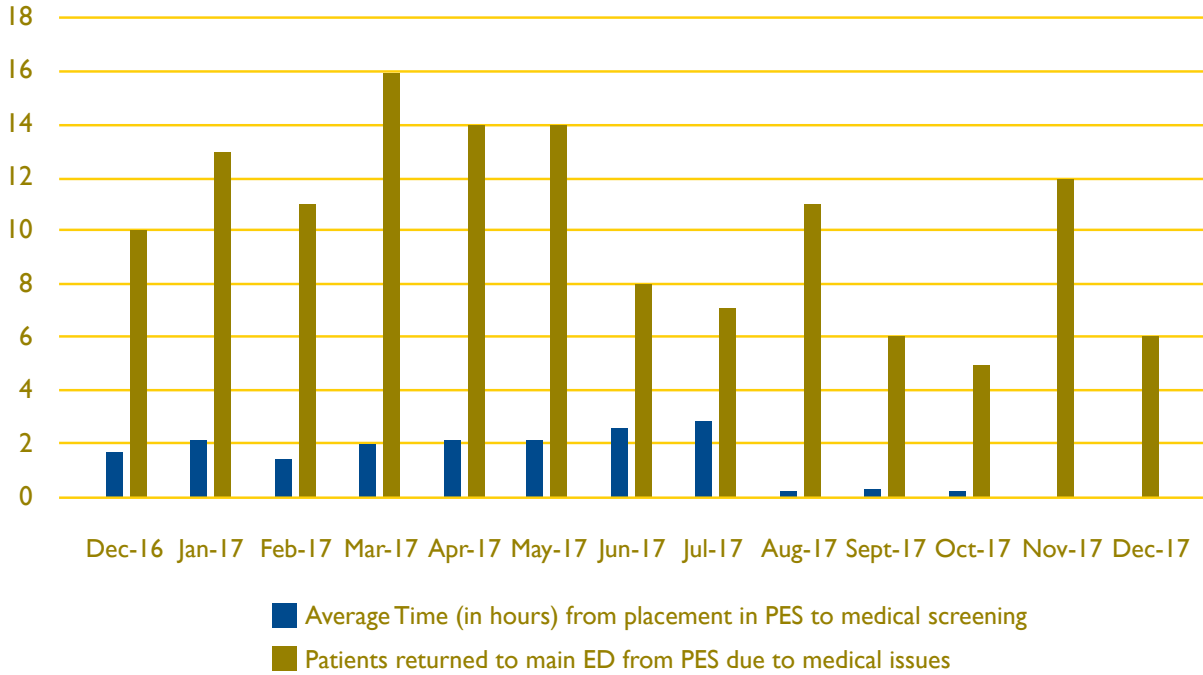
### PES AT JOHNS HOPKINS BAYVIEW

The Psychiatric Emergency Service (PES) unit at Johns Hopkins Bayview is a 10-bed observation unit housed

within the emergency department (ED). PES units are a relatively new delivery model designed to provide urgent or emergent walk-in evaluation 24 hours a day, 7 days a week, for people of all ages. The unit provides a way to separate these patients from other ED patients in a dedicated safe environment, so clinicians can provide psychiatric evaluation, treatment recommendations, crisis intervention, screening for inpatient psychiatric hospitalization and mental health or substance abuse treatment referral information.

The PES uses a complex and interdependent staffing model. Many of their patients have comorbid conditions that require medical intervention as well as psychiatric care. Patient care is managed by the ED staff with the support of the psychiatric consult team. Although the PES unit is a physical part of the main ED, the nurses who deliver care in the PES are department of psychiatry staff. The psychiatry provider on

## TIME TO MEDICAL SCREENING AND PATIENTS RETURNED TO MEDICAL ED



call is available to the ED and nursing staff after hours to consult on the admission criteria as well as the medical management of the patients once they are admitted to the PES.

### CARING FOR THE PES PATIENT

Unclear communication hindered the staff’s ability to manage patient behavior effectively. In order to address the PES staff concerns, nursing leadership decided to drill down on issues related to process, workflow and communication. A multidisciplinary team which included staff from many areas of the Medical Center’s operation was established. The team included nurses, physicians, security staff and a hospital administrator from the ED and PES. Many stakeholders offered thoughtful suggestions on how to serve these patients while promoting a culture of safety within the units.

As the team reviewed the PES/ED workflow, several opportunities for improvement became immediately obvious. The PES implemented workflow improvements, including:

- Patients presenting with psychiatric complaints were assigned as **ESI-2** and screened within 20 minutes of presentation in the ED.

- After determining that a patient was appropriate for PES placement, orders were written by the screening provider prior to the patient being moved into the PES.
- An ED provider was assigned for ongoing medical management prior to transfer to the PES.
- Handoff report was given to PES staff **prior** to the patient being transferred into the PES.

PES admission criteria policy and procedure were also revised to reflect these changes in admission criteria and workflow.

### OUTCOMES

The new ED-PES workflow process has directly improved patient care and staff satisfaction:

- Patients coming into the PES are screened and medically cleared according to protocol.
- Orders are written an average of two hours before the patient actually enters the PES unit, allowing the nurses to prepare for the admission and be better able to manage patient behavior upon arrival.
- Patient wait times for admission continue to decline dramatically, and fewer patients require transfers between the PES and ED to coordinate medical management.

- Communication between ED and PES nursing staff and providers has markedly improved the culture of safety, as demonstrated through local survey questions that the department based on an earlier Safety Culture Assessment. The PES's scores have improved after implementation of these interventions:



**Patient safety is a priority in my department.**

Improved from 3.08 to 4.1 on a Likert 5-point scale. 1- STRONGLY DISAGREE, 5- STRONGLY AGREE



**Safe work practices encouraged and supported in the department.**

Improved from 3.42 to 3.75.

The outcomes of the new workflow are exactly what the doctor ordered. These important clarifications meant that the nursing staff could once again focus their attention on the clinical needs of the emergency patients in front of them, knowing that this new workflow has improved the patient experience and nurse satisfaction. In a demanding environment such as a PES, championing the strategic priorities of professionalism and collegiality has created a safer and more positive space for patients and staff alike.

# 19 Nursing for the Future

## Bedside & Beyond

### Finding the best nurses in a tight labor market

BY ANDY MAGALEE, RN, MS

The country's well-chronicled and ever-growing shortage of trained RNs won't be eased any time soon by the overflowing classrooms of the country's top nursing programs. It takes a long time to find qualified nurses.

Recent research published in the *Journal of Health Care Organization, Provision and Financing* estimates that supplemental staffing accounts for more than 30 percent of total nursing hours nationwide. Like many hospitals, Johns Hopkins Bayview obtains nurses from agencies to temporarily fill vacant positions and to enhance the work schedules. This is an expensive and unsustainable model of covering the Medical Center's needs because of the cost of staffing at premium rates.

**THE HIRING PUZZLE**

Over the past five years, Johns Hopkins Bayview has seen an upward trend in the time it takes to fill a vacant, budgeted RN position, which currently is 60 to 75 days. There are many reasons behind this phenomenon, but our directors of nursing have only one concern: find the most qualified nurses as soon as possible.

The important safety initiatives on our floors rely on interpersonal relationships and team-building, features of our care model that are made more difficult when a unit is



June 2018 orientation class for new nursing staff.

only partially staffed. Also, dependency on temporary labor nursing resources is associated with increased cost and a lack of consistency with regular staff. Nursing leadership decided to develop a hiring model that supports the strategic priorities of the Medical Center; creating a flexible and cross-educated workforce that is available to supplement unit staffing when shortages occur.

**SOLVING THE PUZZLE**

To solve this hiring puzzle, the Medical Center piloted a new initiative called the Advanced Hire Pool, dedicated to hiring nurses who specialize in Medical/Surgical and Critical Care. This initiative allows our nursing program to develop and grow its own team of resources by hiring new staff, either recent graduates or experienced nurses. This creates a cross-training experience during their orientation period that exposes them to each one of the Medical Center's Medical/Surgical or Critical Care (CC) units.

After cross-training, the new staff can select up to two temporary 13-week assignments before deciding if they want to apply for a vacant position on a specific unit or if they want to continue to “float.” By that point, these new staff nurses have seen each unit and can make an informed decision about which one best fits their own skills and work style.

## PUZZLE PIECES

The pilot Medical/Surgical Advanced Hire cohort was implemented in June 2016 for fiscal year 2017 with four nurses. The Critical Care Advanced Hire cohort was implemented in August 2017 for fiscal year 2018 with the hiring of an additional four nurses. Of the original four Med-Surg Advanced hires, one resigned, one transferred to a maternal child health position, and two were assigned to vacant positions on medical/surgical units, reducing the need to continue hiring temporary nursing positions. Of the four original Critical Care Advanced Hires, one resigned and three will be filling vacancies in CC or picking a new 13-week assignment after their two 13-week assignments are complete.

All told, 66% of the first Medical/Surgical Advanced Hire Cohort and 66% of the first Critical Care Advanced Hire Cohort will be placed in open RN positions this year. Our Directors of Nursing are thrilled with the quality of their new recruits. “The Advanced Hire Project has given us the opportunity to quickly recruit qualified nurses, who can be trained and molded to our environment under our watchful eye, as well as give these recruits the experience of working in several specialties,” says Andy Magalee, Director of Staff and Resources Management. “We believe this will create a competent and dedicated employee as well. The success of these recruits is due in large part to the cooperative relationship between Nurse Recruitment, the Float Pool Management Team and the PCMs, Unit Educators and Clinical Nurse Specialists. They helped to select the right individuals for this unique position and assisted in planning the orientation for them.”



In March 2018, the Medical Center started the second round of the Advance Hire Pool with a cohort of three new Medical/Surgical staff; a second Critical Care Advance Hire Pool cohort is planned for later this year.

## THE COMPLETE PICTURE

Our nurses have found that this orientation process provides a thorough orientation experience. New hires are partnered with reliable and experienced float pool nurses. They also are coupled with veteran unit-based staff, clinical nurse specialists or unit-based educators, and are exposed to a wide variety of practice models within the different units of the Medical Center. After 13 weeks, these new employees have seen quite a bit!

The first cycle with the Advanced Hire Pool process has taught our nursing directors to match schedules of float staff with their new cohort members within the units more efficiently. After this successful launch, our directors expect that this pilot will continue to achieve good results on our campus, allowing Johns Hopkins Bayview to further reduce its reliance on temporary labor. The Advanced Hire Pool will maintain eight slots in each cohort for upcoming hiring cycles, as the Medical Center works to launch highly-qualified and well-oriented new nurses to our units.



Jessica McGrath, RN, pictured center, loves her new role on the MICU.

*“My dad worked here for 29 years, so I grew up thinking of this campus as home. I started as a secretary in the MICU on my 20th birthday. Later, I was accepted to nursing school and, through the tuition support program at work, my entire nursing school was paid for. I went to school during the day and worked nights as a secretary and a Certified Nursing Assistant in the MICU. The people on my unit have known me for 16 years and have seen me grow from a teenager to a young wife and now a mom. I feel so supported and comfortable in the MICU, and I was exposed to so much on the unit even while I was in school—the routines, the staff, the workflows. It’s a great learning environment. There are amazing and smart nurses who really understood the stresses of nursing school and what it’s like to be a brand new nurse. In the MICU, they really want you to ask questions and learn and grow and do well. I am honored to work with the nurses on my unit and am so lucky to have them shape me into the kind of nurse I want to become here.” —Jessica McGrath, RN*

# Baby Boomers Bring Transformation to Bayview

Geriatric surgery becomes a new NICHE for nursing

The U.S. Census Bureau reports that baby boomers began turning 65 in 2011 and will continue to do so for many years to come. The U.S. population age 65 and older grew from 35 million residents in 2000, to 49.2 million residents in 2016.

At Johns Hopkins Bayview, seniors have a special place on our campus. The Medical Center is widely known as a Center of Excellence for Geriatric Medicine and Gerontology, a care model which has been a focus for our physicians for more than 50 years. Inpatient care, primary and specialty outpatient services, dedicated research, population health management, community outreach and home care make up the seamless continuum of health care that we deliver to the aging population we serve.

When the American College of Surgeons (ACS) sought to build a new program to credential Centers of Excellence in Geriatric Surgery, Johns Hopkins Bayview was one of eight hospitals nationally invited to develop the credentialing standards. This relationship started nearly two years ago when ACS visited our campus to learn about the Medical Center's programs dedicated to geriatric medicine and to ask for our help. As a member of ACS's Coalition for Quality in Geriatric Surgery, we are actively working to create a geriatric surgery pathway, which will require specialized education to meet the needs of this population.

To support the work of the coalition, nursing leadership made the decision to educate our nursing staff to learn more about the care associated with geriatric surgery. This will be achieved through the reengagement of a dormant membership with NICHE, which stands for Nurses Improving Care for Healthsystem Elders. NICHE is the leading nurse-driven program designed to improve the care of older adults. The NICHE program has helped health care organizations implement proven strategies and methods to address specific needs of the older patient, improve outcomes, and raise patient and family satisfaction levels. The NICHE leadership team, chaired by Kim Goldsborough and Elaine Gittings, is in the midst of an eight-week leadership training course to be able to bring the power of NICHE's training modules and resources to our nurses here on campus.

"NICHE is a great way to propel us forward as we work to create the accreditation standards for hospitals seeking to



NICHE Leadership Team: Carolyn Bailey RN, CNS; Kimberly Goldsborough RN, MSN; Brandon Buckingham RN, MS; Elaine Gittings RN, MSN; and Dianne Bettick RN, MSN.

become Centers of Excellence in Geriatric Surgery," says Goldsborough. "NICHE offers a huge library of resources, online learning modules and certifications that we will be promoting among our staff, with a goal of having multiple nurses on each unit who have attained the Geriatric Resource Nurse (GRN) credential." The leadership team hopes to pilot this program by deploying its new GRNs within the Surgical unit (6 Surg), the Wenz Orthopaedic Unit and the Medical Behavioral Unit.

The NICHE leadership team has gone through exercises of self-reflection by conducting a SWOT analysis to determine the strengths, weaknesses, opportunities and threats of current service offerings related to geriatric nursing. They also are doing research, and are in the process of using what they have learned to increase access to staff learning as well as measure the success of the new training program on their units. Using the Geriatric Institutional Assessment Profile (GIAP) Benchmarking data, the NICHE leadership team will measure its growth in the staff's knowledge level related to the care of the elderly.

*SWOT: Strengths, Weaknesses, Opportunities and Threats*

Look for the NICHE leadership team to launch learning resources more widely on campus, using technology and distance learning to provide the best care to patients enjoying their sunset years in our community.



# Nursing Accomplishment

Each year, Johns Hopkins Bayview celebrates the nursing staff with its Nursing Accomplishment Ceremony, an event which recognizes the tremendous effort and professional growth that has occurred during the year.

I am delighted to recognize our fellow nurses for their achievements. Please take a moment to enjoy the list below of award winners and nominees, presentations, new certifications, promotions, and college degrees.

We are incredibly proud of our nursing colleagues and applaud these nurses for their commitment to lifelong learning and continual professional development, showcasing the Medical Center's commitment to excellence in everything they do.

Michelle Cummings, Ed.D., RN  
SR. DIRECTOR INTERPROFESSIONAL PRACTICE

## ANCILLARY STAFF PROMOTED TO RN

Kara Maguire, RN  
Jessica McGrath, RN  
Jasmin Orara, RN  
Gabrielle Prestianni, RN  
Darya Smith, RN

## BACHELOR'S OF SCIENCE IN NURSING

Erik Baze, BSN, RN  
Kristen Beckerman, BSN, RN  
Anne Brady, BSN, RN  
Anna Cardarella, BSN, RN  
Chante Carroll, BSN, RN  
Natalie Davis, BSN, RN  
Stephanie Deise, BSN, RN  
Amanda Dunlap, BSN, RN

Taylor Ferguson, BSN, RN  
Mleanen Gilman, BSN, RN  
Mulat Haimonot, BSN, RN  
Tami Lewis, BSN, RN  
Kristel Megan, BSN, RN  
Elizabeth Marshall, BSN, RN  
Harriet Ngugi, BSN, RN  
Hellen Nyamu, BSN, RN  
Elizabeth Otieno, BSN, RN  
Rabennia Peaton, BSN, RN  
Nina Pili, BSN, RN  
Kadia Seaton, BSN, RN  
Laila Sherestha, BSN, RN  
Shanice Simpson, BSN, RN  
Toni Stiles, BSN, RN  
Casey Wallner, BSN, RN  
Glen Wildberger, BSN, RN  
Caiyun Zhao, BSN, RN

## GRADUATE/ ADVANCED DEGREE

Michelle Atherton, MSN, RN  
Edna Kaileigh-Bailey, MSN, RN  
Dianne Campo, MSN, RN  
Kim Damon-Gant, MSN, RN  
Joan Jones, MSN, RN  
Sharon Keise, MSN, RN  
Christina Kontogeorgos, MS, RN  
Annette Lewis, MHA, RN  
Samantha Weippert, MSN, RN

## ADVANCEMENT IN CLINICAL EXCELLENCE (ACE) PROMOTIONS

Nicole Domanski, BSN, RN CCRN, promoted to Advance Clinical Nurse  
Cathleen Hedge, RN, promoted to Senior Clinical Nurse - Leadership  
Maria Lao, RN promoted to Advanced Clinical Nurse  
Rossana Oakley, RN, APCM, CMSRN, promoted to Advanced Clinical Nurse - Education

Victoria Wotorson, RN promoted to Senior Clinical Nurse  
Patricia Young, RN, promoted to Advanced Clinical Nurse

## NATIONAL CERTIFICATION

Nadya Alboschy, RN, CCRN  
Chris Boileau, RN, CNRN  
Tina Dardamanis, RN, CEN  
Nicole Domanski, RN, CCRN  
Kim Early, RN, CMSRN  
Mindy Edmisten, RN, PCCN  
Jason Kafka, RN, CCRN  
Florita Krieger, RN, SCRN  
Kristel Megan, RN, CEN  
Andal Mayilvaganan, RN, CCRN  
Sarah Ryan, RN, CCRN

Jennifer Sites, RN, CNOR  
Howard Ward, RN, CCRN

## ADVANCED TRAUMA CARE NURSE PROGRAM

Tina Dardamanis, RN, ATCN  
Avi Gross, RN, ATCN  
Dan Shepard, RN, ATCN  
Ted Stephens, RN, ATCN  
Mark Straughn, RN, ATCN  
Sarah Thomas, RN, ATCN

## WOUND CARE TEAM ASSOCIATE PROGRAM

Sally Adams, RN  
Rachel Angeline, RN  
Brigitte Boyle, RN  
Leslie Hall, RN  
Kimberly Kries, RN  
Holly McDaniel, RN  
Hyunjeong Orbeta, RN  
Valerie Vavaro-Chlan, RN

## PROMOTIONS AND LEADERSHIP CHANGES

Dianne Campo, MSN, RN, CMSRN to PCM  
Andrea Deyo, RN to PCC  
Stephanie Hansen, RN to Case Manager  
Kerri Huber, MSN, RN, CIC to Director of Interprofessional Practice and Patient Safety  
Linda Jakelski, RN to Case Manager  
Freddie Jenkins, MS, RN, PCM to Assistant DON  
Darlene Jones, RN to Specialty Service Coordinator  
Kelly Watson, RN to Orthopedic Coordinator  
Barb Ziegler, MSN, RN to NPS

# Resilience

## AWARDS

Alphie Rahman, DNP, APRN-CNS, CCRN Johns Hopkins School of Nursing Preceptor Shining Star Award

Tina Dardamanis, BSN, RN Daisy Award

Tina Dardamanis, BSN, RN Patient Safety Star

Yamisi Daniel, BSN, RN, Patient Safety Star

Rona Corral, MSN, RN, Jonathan Espenancia, BSN, RN, CMSRN, Shining Star Award  
Nominees: Johns Hopkins School of Nursing's Annual an Evening with the Stars Celebration, October 2017

## FORMAL PODIUM PRESENTATIONS

*"Everyday Leadership"* Rachel Moseley, MS, BSN, RN, CWON, APHN presented at PNAMC General Assembly, February 2017

*"Know Your Role During a Code"* Greily Persia, MSN, RN, CMSRN, Jonathan Espenancia, MSN, RN, CMSRN, Shahida Khan, BSN, RN, CMSRN, Alphie Rahman, DNP, APRN-CNS, CCRN presented at JHBMC Nursing Grand Rounds, March 2017

*"Avoiding Victimhood: Coping with Moral Distress"* Cindi Wood, MSN, RN, APRN/PMH-BC, CPHQ, presented at the JHBMC Social Work Conference, March 2017

*"Code Role Education"* Rossana Oakley, BSN, RN, APCM, CMSRN, Dianne Campo, MSN, RN, APCM, CMSRN, Alphie Rahman, DNP, APRN-CNS, CCRN, Michele Applegate, MSN, RN, presented at Interprofessional Practice and Patient Safety 6th Annual Patient Safety Week Celebration, April 2017

*"Nurse Led Telemetry Discontinuation"* Marcie Dawson, MS, RN-BC, NE presented at the Premier Conference in Washington, DC, June 2017

*"Taking Action to Stop Infections"* Sheilla Membrebe, MS, RN presented at Premier Conference, June 2017

*"STRIDE Steps to Restoring Independence and Dignity Early"* Susan Kraeuter, MS, RN and Heather Thornton, RN, presented at JHH Safety Symposium, October 2017

*"Nurse Attending Model: Improving Communication, Collaboration and Patient Safety"* Alphie Rahman, DNP, APRN-CNS, CCRN presented at the National Association of Indian Nurses of America 2017 Leadership Conference, September 2017 and the JHH Patient Safety Summit, October 2017

*"Nightmares on Holiday Drive"* Cindy Walker, MSN, APRN-CNS, CWON presented at the Mid-Atlantic Regional Conference, October 2017

*"Cutaneous Drug Use Concerns"* Rachel Moseley, MS, BSN, RN, CWON, APHN and Cindy Walker, MSN, APRN-CNS, CWON presented at JHBMC Fall Nursing Conference, November 2017

*"Addiction—A Hometown Crisis: An Integrated Approach to Care"* Cindi Wood, MSN, APRN/PMH-BC, CPHQ, CDNC presented at JHBMC Fall Nursing Conference, November 2017

*"Suicide Prevention in Healthcare Settings"* Cindi Wood, MSN, APRN/PMH-BC, CPHQ, CDNC presented at JHBMC Nursing Grand Rounds, December 2017

## POSTER PRESENTATIONS

*"Medicine A—Hand Hygiene Champions"* Marcie Dawson, MS, RN-BC, NE, Jennifer Magliano, BSN, April Zakes, RN, Megan Brothers, BSN, JHBMC Safety Week, April 2017, JHH Safety Summit, October 2017, JHBMC Fall Nursing conference, November 2017

*"Sepsis Education & Awareness"* Yamisi Daniel, BSN, RN, JHBMC Patient Safety Week, April 2017

*"Intraosseous Devices During Emergency Situations"* Alexandra Droboniku, RN, Kathleen Liptak Harris, RN, Morgan Keetley, RN, and Jessica Yolain, RN, JHBMC Nursing Fall Conference, September 2017

*"STRIDE (Steps to Restoring Independence and Dignity)"* Early Heather Thornton, RN, Kelly Turner, RN, Tammy Kessler, RN and Sue Kraeuter, MS, RN, JHBMC National Patient Safety Week Poster August 2017 Session and JHH Safety Symposium, September 2017

*"Hidden Danger in Skin Care Products"* Rachel Moseley, MS, BSN, RN, CWON, APHN Wound, Ostomy and Continence Nurses Conference, October 2017

*"Patient Care Tech Council: Together We Care"* Sheilla Membrebe, MS, RN, NAON Congress, May 2017, Armstrong Institute at Bayview Kick-off, May 2017, Johns Hopkins Medicine Patient Safety Summit, October 2017

*"Admission/Discharge/Transfer Nurse Program: A Quality Initiative to Decrease Boarding Time, Increase Patient Throughput and Enhance Patient/Staff Satisfaction"* Winsome Christian, Rona Corral, MSN, RN, Paul Deya, BSN, RN, Jonathan Espenancia, BSN, RN, CMSRN, Shahida Khan, BSN, RN, CMSRN, Leilani Turman, BSN, RN, CMSRN, JHH Safety Summit, October 2017

*"Promoting High Reliability through the Utilization of Team Huddles and a Huddle Board"* Brandon Buckingham, MS, RN and Morning Gutierrez, BSN, RN Johns Hopkins Medicine Patient Safety Summit, October 2017

*"Creating New Culture/Building Strong Teams through Evident Leadership Presence and Visibility"* Brandon Buckingham, MS, RN and Morning Gutierrez, RN Johns Hopkins Medicine Patient Safety Summit, October 2017

# Integrity

*"Zero CAUTI: Successful Application of a Care Bundle"* Sheilla Membrebe, MS, RN, JHBMC Patient Safety Week Poster Presentation, April 2017, AMSN Conference, September 2017 and Johns Hopkins Medicine Patient Safety Summit, October 2017

*"Purposeful/Daily Nurse Leader Focus Rounding Improves Patient Experience and Effective Multidisciplinary Communication"* Brandon Buckingham, MS, RN and Morning Gutierrez, BSN, RN Johns Hopkins Medicine Patient Safety Summit, October 2017

"Opiate Abuse in Baltimore City"  
Jordyn Jersey, RN, Presented at  
the McGinley-Rice Symposium,  
Pittsburgh, PA, October 2017  
and JHBMC Fall Nursing  
Conference, November 2017

"Mass Casualty Reverse Triage"  
Kirk Koneval, RN, ENA  
Conference 2017

#### PUBLICATIONS

Stephanie Walter-Coleman, RN  
Co-authored a Chapter in  
Medical Surgical Nursing: Making  
Connections to Practice (pp. 441-  
455) Walter-Coleman, S. and  
Sullivan, N. (2017) Coordinating  
Care for Patients with Infectious  
Respiratory Disorders.

Dorene Holcombe RN, Co-  
authored a Chapter in Acute  
Kidney Injury and Chronic Kidney  
Disease in Critical Care Nursing  
A Holistic Approach (2017) 11th  
Edition, Morton, Patricia G, Fon-  
taine, Dorrie K.

#### ADDITIONAL ACCOMPLISHMENTS

Rona Corral, MSN, RN, Paul Deya,  
BSN, RN, Jonathan  
Espanancia, BSN, RN, CMSRN,  
Shahida Khan, BSN, RN, CMSRN,  
Griely Persia, MSN, RN, CMSRN,  
Launa Theodore, BSN, RN,  
CMSRN, Leslie Hall, BSN, RN,  
WTA, Yani Hu, MSN, RN, Leilani  
Turman, BSN, RN, CMSRN,  
*JHBMC Clinical Excellence Nominee:  
Collaborative Rounding-Nurses &  
Providers on CBMU, January 2017*

Chanelle Allen, PCT, Jonathan  
Espanancia, BSN, RN, CMSRN,  
Asha Felton, PCT, Vanvura Francis,  
PCT, Parris Grant, PCT, Ashley  
Howell, PCT, Shahida Khan, BSN,  
RN, CMSRN, Audrienne Johnson,  
PCT Floria Marshall, PCT, Brianna  
Reed, NUS, Brittney Thomas,  
PCT *Hand Hygiene Logo Contest  
Winner, August 2017*

Yamisi Daniel, RN, Coordinator  
of the *World Sepsis Day at JHBMC*

# Respect

#### 2018 NOMINEES FOR SUPPORT STAFF OF THE YEAR

Deborah Napier, unit Services  
Coordinator, ED

Jennie Ford, PCT, Float Pool

Larissa McRoy, PCT, Imaging/  
Interventional Radiology

Sandy Naimaster, NUS, Med B

#### 2018 NOMINEES FOR NURSE OF THE YEAR

ED – Brittany Paterson

Psych/addictions – Larry Taylor

Float Pool – Sara Bagley

Medicine – Victoria  
Wotorson

SHP – Haimonat Mulat

Surgical/Periop – Rowena  
Orosco

MCH – Cathy Hedge

Ambulatory – Mary Beth Carlin

# Trust

Anne Kelly, RN, Dunn, K.EI, Yopez-  
Laubach, C., Nuzzo, PA,  
Fingerhood, M., Kelly, A., Berman  
S., & Bigelow, G. E. (2017).  
Randomized controlled trial of a  
computerized opioid overdose  
education intervention. *Drug  
and Alcohol Dependence*,  
Vol. 173 (Suppl 1), pp S39-S47

Rowena Orosco, RN Co-  
authored Burn Patient with  
ARDS: A review of evidence and  
Practical Considerations, *Journal  
of Burn care and Research*,  
June 2017

MICU's STRIDE Program,  
*Innovations in Clinical Care, Clinical  
Excellence from Johns Hopkins  
Medicine*, November 2017

#### 2018 NOMINEES FOR VIDEO CONTEST

Carol Ball Medicine Unit –  
Safety with Aggressive Patients

Carol Ball Medicine Unit –  
No Pass Zone

Clinical Research Unit –  
Team Engagement: We are CRU!

Float Pool – Star Wars  
Float Pool

Medicine A – Calming  
the Restless

Vent Rehab Unit – The VRU:  
Together Does Better

# Collaboration



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