2015 Nursing Annual Report

SENTARA®

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Dear Colleagues,

It is with sincere pleasure I present to you the 2015 Sentara Nursing Annual Report.

As I look at our accomplishments and areas of challenge in 2015, several words come to mind: high performance teams, practice forums, clinical quality and safety, and staffing, to name a few. As we review the results of our efforts in 2015, our improvement in clinical performance outcomes highlight some of the areas in which we excelled. Exceeding our CLABSI, DVT, Clinical 3 outcomes, and consistent use of the Universal Pause in our operating rooms was the result of hard work by many of our high performance teams, physicians, nursing and support staff. Although we did not meet our mammography goal, we did see significant improvement in our turnaround times for diagnostic breast studies. These improvements are so important for our patients and their families. Congratulations and a heartfelt thanks to all staff for achieving four out of our five clinical performance improvement goals.

New areas of focus also include our 2016 Clinical Performance Improvement (CPI) Goals:

1. Reduce hospital readmissions.
2. Improve the appropriate utilization of hospice and palliative care.
3. Reduce the rate of hospital-acquired clostridium difficile infection (CDI).
4. Achieve zero wrong events in the OR, Interventional Radiology, Vascular and Catheterization Labs.
5. Achieve three out of four patient access measures:
    a. Improve percent of new patient appointments within seven days for a PCP and 14 days for a specialist.
    b. Improve mammography to biopsy turnaround time.
    c. Improve patient flow (ED treat and release/treat and admit).
    d. Contact Centers access goals.

Several areas in 2015 did bring challenges and we will continue to work toward improvement in these areas in 2016. These areas of focus for nursing include customer satisfaction, hospital-acquired pressure ulcers, falls with injury, and sustainment of our gains in CLABSI.

Another challenge we found this year was staffing. I would like to thank our colleagues in recruitment for their hard work and dedication as we hired more than 960 registered nurses in 2015. The work for 2016 will include retention of these nurses and a continual adjustment of our staffing assignments to meet patient volumes and acuity. We have put several programs in place to assist in our retention endeavors. These include our Nurse Residency Program and Queuing Committee, which assist in pace of work for bedside clinical staff. Orientation has been redesigned for new staff to incorporate use of our simulation centers so expectations of Sentara nursing skills can be practiced in a "live situation" before new staff enter the practice environment. Along with this orientation redesign, all new graduates will participate in our formal Nurse Residency Program, which is designed to support their transition into nursing.

We have also spent time and effort this year in refining our nursing committee structure with particular emphasis on training our practice forum and committee chairs. Managing a meeting across multiple venues of care is not an easy task. Training for the leads of this important work began and will continue going forward. In 2016, I have challenged our nurse executives and committee/practice forum chairs to make significant improvement in our staff nurse participation to ensure we are lifting the voice and concerns of our experts at the bedside.

As we continued our nursing excellence journey in 2015, hearty congratulations to Jennifer Kreiser and her nursing team at Sentara Leigh Hospital for their Magnet® designation! We fully expect to add Sentara Princess Anne Hospital to that esteemed list of Sentara Magnet designated facilities in 2016, which already includes Sentara Martha Jefferson Hospital, Sentara Norfolk General Hospital, Sentara Williamsburg Regional Medical Center, and Sentara RMH Medical Center. All Sentara divisions have been busy planning their journeys to professional nursing designations.

As we embark on our 2016 journey to continue improving our nursing excellence and high quality patient-centered care, I want to thank each of you for your attention, dedication and perseverance in 2015! We deliver nursing care in many different ways and in many different venues. When we speak and advocate as one, our power to care for our patients and their families improves exponentially.

You are Sentara Nursing!

Genemarie McGee

Genemarie McGee, MS, BSN, RN, NEA-BC
CVP, Chief Nursing Officer, Sentara Healthcare

Challenge 1

INTERRUPTIONS

Lower the number of interruptions experienced by nurses to decrease related medication errors

According to the Institute for Safe Medication Practices, nurses administering medications are interrupted as often as once every two minutes. A study found that medication errors increase 12.7 percent with each interruption, and that the risk of a harmful medication error doubles when nurses are interrupted four times and triples when interrupted six times.

Solutions presented by

Kelly Via, BSN, RN-BC

Nursing Quality Coordinator

Sentara Martha Jefferson Hospital

"In late 2014, we identified an increase in medication administration errors and wanted to improve. We started our effort to do that in January 2015 with a study looking at ways to decrease interruptions during medication administration on our med-surg orthopedics unit.

Our team found that nurses were frequently interrupted during their heaviest medication administration times. We noticed interruptions from patient call bells; from nurses on other units calling for reports; from transport staff; and from physicians. The biggest thing we found was that 8:30-9:30 a.m., our medication administration time, was also the time when the patients were going to physical therapy and occupational therapy. The PT/OTs (physical therapists/occupational therapists) might take the patient before the medication was given. Or they'd have to interrupt the nurse as she was giving one patient medication to ask if they could take another patient. We prioritized that as the biggest concern.

Introducing timeouts

Our solution was to implement a medication administration timeout. The point was to bring awareness of this critical patient safety time to the nurses, the patient, their family and the staff.

The first thing we did was to begin posting signs at 8:30 a.m. each day. The signs say 'medication administration timeout 8:30-9:30 a.m. for patient safety.' The unit secretary now posts them at the entrances to the unit and the nurses' stations.

Dimming the lights

Our team also chose to dim hall lights on the unit, so it seems like a different atmosphere for those people already here. The dimmed lights draw attention to the fact that something different is happening.

Deferring phone calls

For triage phone calls that come in during the medication administration timeout, the secretary or charge nurse answers and determines if immediate attention is needed. The charge nurse might handle the call or take a message.

Communicating with red light-green light signs

Our team also implemented a 'red light-green light' sign that's placed on the door to communicate with the PT/OTs. Those signs are red until the nurse provides medication and then they are turned green. When the PT/OT sees red, that means that they should not interrupt. If the nurse isn't there and the sign is red, the PT/OT can then find the nurse to ask if the patient has had his medication and how to proceed.

Creating new work flows

We asked other teams to work in new ways. For example, transporters now go directly to the nurses' station. They used to go to the patient's room and then find the nurse. With the new process, the charge nurse fills out what we call 'a ticket to ride' for the transporter.

"Our solution was to implement a medication administration timeout. The point was to bring awareness of this critical patient safety time to the nurses, the patient, their family and the staff."

– Kelly Via, BSN, RN-BC

Giving nurses permission to stay focused

We worked on a current-state process flow and a future-state process flow. The nurses were hesitant when they saw the proposed process flow. They didn't think of the PT/OT requests as interruptions. They felt they were being part of a team by talking with them. We had to point out that it was OK to stay focused, and that the nurses would still be part of the team. The nurses really had to be given permission to focus.

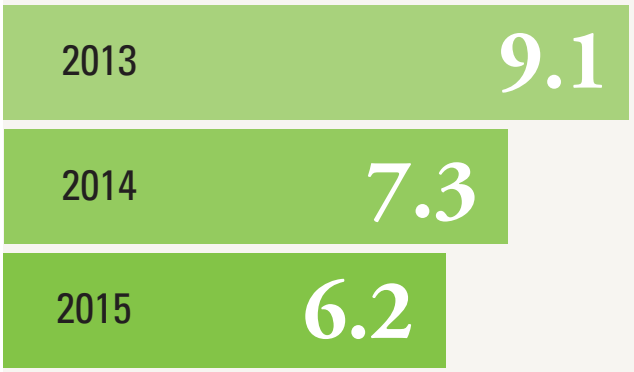
Achieving goals and sharing ideas

We have seen a decrease in medication errors attributed to interruptions. In January 2015, we had a medication error rate of .05 percent. In July 2015, we were down to .02 percent and in September 2015 it was 0 percent.

There's been a lot of interest in the changes. We presented them at a central shared-governance council. We're figuring out the best way for different units to roll out their own efforts to reduce medication administration errors, because those units might face different interruptions than the orthopedics unit did. We want the people providing the care to identify the specific issues on their unit and determine what might help resolve them. We know that nurses carry around a wealth of information and ideas, and we want to tap into that."

RESULTS:
Total Interruptions Reduced

SENTARA HOSPITALS INTERRUPTIONS PER HOUR*



The number of interruptions nurses experience while administering medications is decreasing on average as teams identify key interruptions and introduce ways to prevent them. A reduction in interruptions helps to lower medication administration errors.

* Includes ED, Med Surg/Int/ICU, and Women's Health

Source: Sentara Performance Improvement

Challenge 2

MOBILITY

Improve patients' mobility to decrease their loss of body strength and decrease the length of their ICU and hospital stay

According to a 2012 School of Nursing study at the University of North Carolina at Chapel Hill, patients can experience body deconditioning within a few days of inactivity, with some reports indicating that critically ill patients who are mechanically ventilated can lose up to 25 percent peripheral muscle strength within four days and 18 percent in body weight by the time of discharge. The study also noted that loss of muscle mass, particularly skeletal muscle, is higher in the first two to three weeks of immobilization during an intensive care unit stay.

Solutions presented by

Valerie Carroll, BSN, RN

Manager, General Intensive Care Unit

Sentara Norfolk General Hospital

"Mobilization affects the patient's length of stay in ICU and overall in the hospital. It also affects mortality. Several years ago we started focusing on getting even the most critical ICU patient to move.

We didn't have a true algorithm for mobility. Getting a patient to move depended on the particular nurse working with the patient and whether or not the physician wrote an order. It was hit or miss.

We wanted to develop an algorithm so everyone was on the same page. Even if the patient is on a ventilator, we want some type of mobilization. It should be something – maybe bedside PT (physical therapy); active turning; rotation modules or a change in chair position. There are many ways to mobilize a patient.

Developing an algorithm

We formed a team and created an algorithm for GICU (General Intensive Care Unit) in 2014. We took it to the critical care practice forum in 2015 and shared what we had accomplished. We worked through that committee and got system buy-in.

Instructing the nurses systemwide

Then we did systemwide education during the first quarter of 2015. We had developed an educational kit for the GICU staff, and it covered the need for mobility; the evidence; and how to get patients moving in some way. We shared that kit with the practice council, and the council members used it at their hospitals.

Starting mobilization efforts and setting goals

Second quarter, we rolled out mobilization efforts system-wide. Third quarter, we followed progress, and in the fourth quarter, we set the goal of three mobilizations in 24 hours for the patients.

Tracking progress

We also worked with IT to develop Clarity reports to show us how we're doing. The IT department spent a lot of time talking to us and asking what numbers we needed and how we'd get that information. Our reports needed to be different from the reports for other areas of the hospitals. We recognized that right away, and IT made it happen.

I was really pushing mobilization, and we had other 'pushers' in other hospitals. Because of those pushers, the reports and the nurses, we accomplished our goal systemwide. It's been an awesome process to be part of.

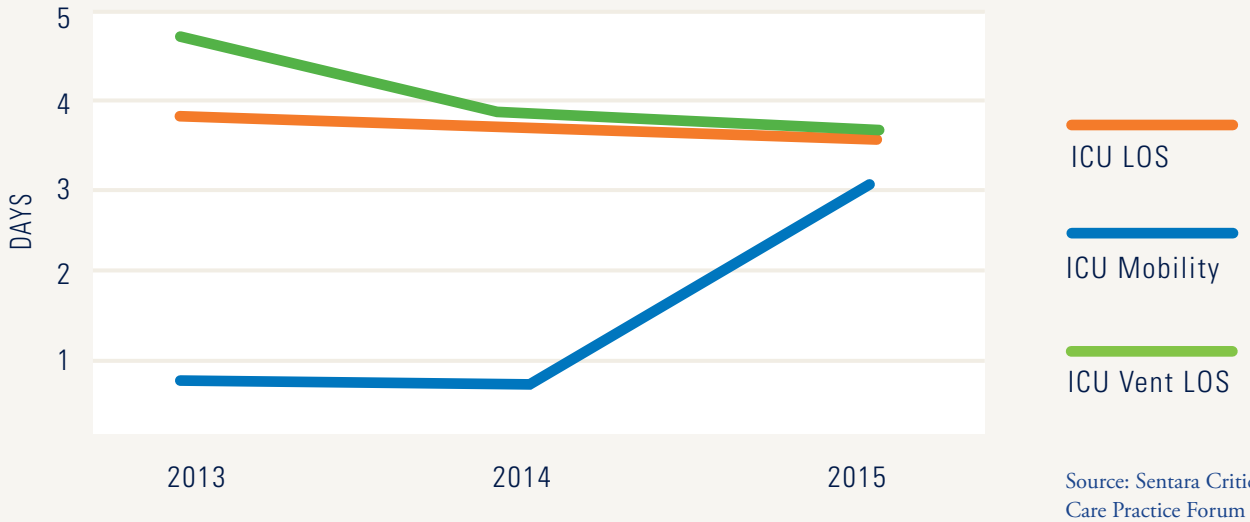
This has really been my favorite project. We brought the entire system of critical care together. For mobility to go from just about zero to three successful mobilizations every 24 hours, was amazing. We went from an average of .7 mobilizations in 24 hours in 2013 to 3.54 in 2014.

I think with more of the practice forums and the unit-based councils being introduced, we have a pathway for implementing projects systemwide. Projects like this used to be silos. Maybe others would hear what you were doing in your unit or your hospital, and they'd take on the project, too. Or maybe not. Now we're open to sharing at a system level and having discussions about why to make a change. We have more buy-in. We're sharing evidence, not just opinions."

RESULTS: Mobility Intervention

Nurses are working to increase ICU patient mobility in a number of ways so that patients spend fewer days on a ventilator and in ICU and experience a lower risk of pressure ulcers and death.

SENTARA ICU MOBILITY IMPACT ON ICU LENGTH OF STAY AND VENT LENGTH OF STAY



Source: Sentara Critical Care Practice Forum

Challenge 3

UNIVERSAL PAUSE

Reduce operating room errors

The Joint Commission documented 463 incidents of wrong-patient, wrong-site, wrong-side and wrong-procedure surgeries voluntarily reported to its database from January 1, 2010, through December 31, 2013. The national rate could be much higher (the Joint Commission has estimated as high as 50 incidents a week) as hospitals and their staffs unintentionally overlook vital steps in checking patients and procedure schedules.

Solutions presented by

Ana Campomanes, RN

Operating Room

Sentara Princess Anne Hospital

"It's part of my job to help prevent operating room errors. I prepare patients for surgery both physically and mentally. I make sure the labs are all in normal range. We don't want to do the procedure if they're not.

Reconciling the paperwork and reports: Step 1 in the stop-in pause

I also make sure we are doing the correct procedure. I start with the consent to surgery form. I compare the form to the schedule and have the patient verbally tell me what he's here for. I also double-check for the correct procedure by looking at his history information. I'm being an advocate by being sure we're doing the right surgery.

Marking the surgery site: Step 2 in the stop-in pause

One time, I went to the patient's room, and I had already confirmed where we were going to operate. The patient pointed to what he thought was the word 'wrong' on his foot. He thought the doctor was marking that foot as the 'wrong' foot. What had happened was the doctor had signed that foot with his initials – which looked like the word 'wrong.' The doctor is supposed to initial the correct site, but he had gotten mixed up this time. I called the doctor and had him come back, and we verified everything and he marked the correct foot.

After that I notified the OR team that both feet were marked and I confirmed that the right foot was the correct one. We call the whole process a stop-in pause.

Conducting an OR timeout and a stop-out pause

In the OR before an incision, we do a timeout with a safety checklist. We talk about the correct surgery site; allergies; and if we need a graft. We discuss fire safety, too. After the procedure, we do a stop-out or a post-procedure pause. We discuss blood loss; if counts are correct for needles, sponges, instruments; if specimens need to be put away and if they're labeled right. There are a lot of checks.

Before, we used to just do the timeout and the fire checklist. We added the stop-ins and stop-outs last year. We're doing the same thing in all of the Sentara hospitals. Before, we were doing different things in different places.

Double-checking details on a standardized board

In every OR, we have a standardized white board. We write the patient's name, procedure, allergies, antibiotics… everything about the patient. Everyone can look at the board and confirm details. We had different boards before; now they're the same everywhere.

I think the stop-ins and stop-outs are extra work, but we're safer, and we have documents on everything."

RESULTS: Steps in the Universal Pause

Sentara OR Safety Checklist

Black elements are required. Blue elements are required as applicable.

STOP-IN (Pre-induction)

Minimum nurse and anesthetist. Patient participating as applicable.

Validate against consent:

- Patient
- Procedure
- Site
- Site marked
- Allergies

TIMEOUT (Pre-procedure pause)

Surgeon initiates with all staff engaged. All other activity is stopped.

Validate against consent:

- Patient
- Procedure
- Laterality
- Allergies
- Antibiotic
- Fire Risk Assessment

Does Anyone Have Any Concerns?

- Introductions
- Non-routine elements
- Safety precautions/concerns
- EBL/blood products
- Relevant images displayed
- Special equipment/implants
- Specimen plan
- DVT prophylaxis

STOP-OUT (Post-procedure)

All staff and surgeon in room.

- Procedure performed
- Counts
- Specimen
- Key concerns
- Wound Classification
- EBL confirmed

Source: Sentara CPI Universal Pause Team

Challenge 4

CAUTI

Reduce the number of catheter-associated urinary tract infections (CAUTI)

An American Journal of Infection Control study in 2011 noted that more than 500,000 CAUTIs occur each year in the United States, accounting for more than 30 percent of all hospital-acquired infections. The CAUTIs lead to prolonged hospital stays (often up to four days) and increased healthcare costs. Close to 50 percent of surgical patients remain catheterized 48 hours after surgery and 50 percent of all patients with a Foley catheter do not have a clear need for one.

Solutions presented by

Kerstin Whiteaker, RN-BC

Medical-Telemetry

Sentara Williamsburg Regional Medical Center

"CAUTIs (catheter-associated urinary tract infections) can cause patients to have longer hospital stays, and it takes more treatment for them to recover. The cost is not reimbursed.

Establishing protocols for Foley insertion and use

A team here created new protocols with requirements for Foley catheter insertion and removal and for checks while they're in place. I helped implement them.

For Foleys to first be placed, the patient must meet certain indicators. There's a predetermined list we call the insertion protocol.

We discuss all of our Foleys during administration huddles, unit huddles and multidisciplinary rounds.

Removing Foleys earlier and conducting audits

With the nurse-driven removal protocols, doctors can write a protocol order, and the nurse must remove the Foley within 48 hours. The doctor can still write a 'do not remove' order if he chooses when the patient meets certain criteria.

We conduct audits to ensure everything is in place and checked. We check details about every stage of the care and ask questions like 'Are we doing Foley care every day?' 'Are we documenting it?'

Re-educating and tracking progress

We re-educated everyone on the staff about Foley care and the protocols, and then we tracked CAUTI rates and the number of days Foleys are used. We know that decreasing the device days decreases CAUTIs so we're putting a big emphasis on that.

Each unit needs to take responsibility for pulling the Foleys. The project is about creating a culture of accountability. We've had no CAUTIs for about two years. I truly believe having nurses be more aware about CAUTIs helped, along with really pushing to get the Foleys taken out early. In some places in the past, the Foleys were kept in for the nurses' convenience. Pushing to change that practice made a difference.

Comparing the protocols to national standards

The newest work we're doing is comparing the Sentara Foley protocol to the American Nurses Association's (ANA) toolkit. We've shared the ANA kit with our evidence-based practice forum, and we identified opportunities to further align the Sentara protocol with the national recommendations. We're in the process of revising the evidence-based indications for insertion, clarifying the cleansing agents used for Foley care and updating the post-removal algorithm.

I found the whole effort to reduce CAUTIs to be a great idea. When you can get information about why we're doing something and that it helps patients, I'm all for it."

Solutions presented by

Audrey Stiles, BSN, RN, CCRN, CEN

Intensive Care Unit

Sentara Williamsburg Regional Medical Center

"It can be hard to remind some of our staff about preventing CAUTIs because we haven't had a CAUTI at Williamsburg in a couple of years. People don't think there's still a concern when we're doing well.

Reminding the staff of best practices

Despite our good performance, we have to keep the topic top-of-mind, and I helped do that. Once or twice a month in 2015, I watched webinars about preventing CAUTIs and getting nurses engaged in preventing them. The webinars covered understanding the risk of CAUTIs and reducing the use of Foleys.

I would learn the information from the webinars and share it with my manager. Then I'd present the facts from the webinar at the staff meetings. My talks were to increase the staff's awareness, even if they already knew most of what I was talking about. My reminders just helped to reinforce what we're doing.

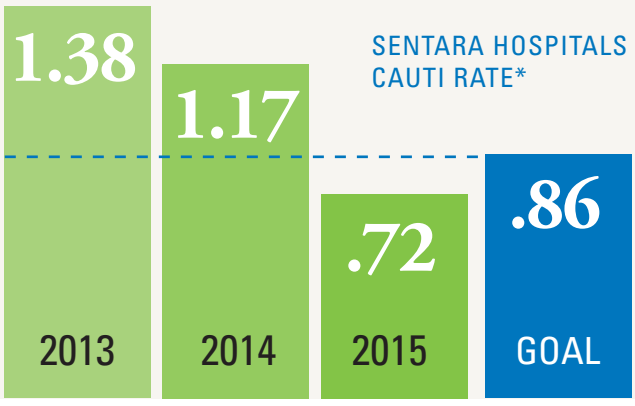
I serve as a preceptor for new nurses, orienting them, so it made sense for me to talk about Foleys. We want new staff to be aware of evidence-based research, and we don't want to slip with our CAUTI rates because of new staff.

Employing new tools and techniques

We started using the female urinal as an alternative to Foleys. We also sometimes do cathing every six hours, instead of straight cathing where the Foley catheter stays in. Learning that was a bit of a culture change.

We're focusing on urinary retention protocols at this time. It's a little bit vague how long you wait to use extra methods if the patient is struggling to urinate after the Foley is taken out. We start with cathing every six hours; we're looking for other methods beyond that. It might be that we change our urine measurements. We're investigating to find what is best. We continue to educate and research to keep improving."

RESULTS: CAUTI Reductions



To decrease the number of CAUTIs, nurses are seeking alternatives to Foleys, removing them promptly when used and improving care techniques. Due to these efforts, CAUTI rates are declining on average and we have exceeded our goal for 2015.

* SH CLABSI Rate CY 2013 excludes SHRH and SAMC; SH CLABSI Rate 2014 and 2015 excludes SAMC.

Source: Sentara System Infection Prevention

Challenge 5

CLABSI

Reduce central line-associated bloodstream infections (CLABSIs)

According to the Joint Commission, CLABSIs occur in up to 500,000 patients annually in the United States. They have up to a 30 percent mortality rate and could add up to $2.3 billion a year in costs for health systems.

Solutions presented by

Chandra Hubbard-Wright, BSN, RN

Manager, SCH IV Therapy and SNGH Outpatient Infusion Center, Hampton

Sentara CarePlex Hospital

"I'm the IV Therapy and Infusion Center manager. It's part of my job to deal with central lines daily. We had experienced a number of CLABSIs in 2014, so we started looking at what the concerns were.

It's a patient safety issue. We realize how important it is to properly care for the central line and make sure that it's only in place for a real good reason — and to make sure they're removed when that reason no longer exists.

It's the right thing to do for the patient. We don't want to cause any infections. If they have an additional infection, it can increase their length of stay, and they have to be placed on additional medication, an antibiotic, to clear that infection.

Determining when a central line is appropriate and caring for it correctly

Our team built an action plan and started implementing that action plan.

The number one thing in our action plan was educating the bedside nurse.

We made sure that they understood when a central line was appropriate and how to care for that central line, from the dressing to caps we place on the end of the line to flushing it.

The other part that made the project successful was examining and updating the products that were available to care for patients with central lines. There was a ton of work done to make sure we had the right things for everyone across the system. The standardization means we can all say we're all doing the right thing, so hopefully we'll all have the same results, which leads to better patient care and keeping our patients safe.

Examining setbacks and reviewing central line insertions

The next thing we did was lots of communication. When we had a CLABSI, we reviewed the event and then we shared the event with the team so they could really get an understanding of where we could have done a better job. We saw it as an opportunity for improvement and that review helps us connect the dots.

The last, very important thing: we implemented a Central Line Safe Call. We huddle with the managers and team leaders Monday through Friday, and review every single central line — where it is; why it's there; when it was placed and when the dressing was changed. We discuss any complications; if it's been in too long; if the dressing is not quite right or if the site is bleeding. We have an opportunity to discuss, develop a plan and educate.

Teams like the CLABSI team and the supporting teams are common at Sentara. We recognize that to standardize, we need to get everyone's input; understand where everyone is in their journey; understand where everyone wants to go; and work together to get there. "

Solutions presented by

Angel Harper-Clarke, BSN, RN, CMSRN

Nurse Clinician, Education Department

Sentara Virginia Beach General Hospital

"Sentara's mission is to improve health every day. When we decrease CLABSI rates and the potential for CLABSIs, we put into action our mission statement.

According to the CDC (Centers for Disease Control and Prevention), CLABSIs can add $7,000 to $29,000 per case to a patient's medical bill. It can mean an increase in length of stay; a transfer to a higher level of care like ICU; organ failure; or dialysis.

I learned very quickly that nursing at Sentara is driven by evidence-based practices and providing a culture of safety for patients. Our work to prevent CLABSIs shows this once again.

I started on the effort by joining the PIV (peripheral intravenous) team in 2014. Then I moved onto the midline. Now I'm a midline site coordinator for Sentara Virginia Beach General Hospital.

Determining an algorithm and sharing it systemwide

With the PIV sub team, we developed an algorithm and had systemwide education about the securement of a PIV, so that nurses were less likely to struggle and then request a Peripherally Inserted Central Catheter (PICC) line as a substitute. You have to make the correct choice of catheter. You should only have a central line when it's the only way to deliver the medicine. We emphasized that one way to avoid infection is to choose the correct line.

Providing training and a new tool for easier line insertion

We had computerized training about initiating PIVs. We deployed vein finders, a newer piece of equipment that makes it easier to find a 'good' vein to insert the line, to each hospital to help the nurses.

Researching the most appropriate midline and selecting midline team members

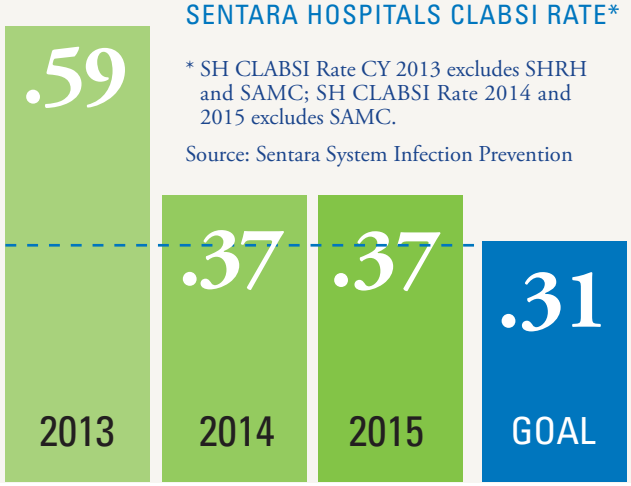
I became involved with the midline catheter team in February 2015. We conducted research and chose an appropriate midline and developed criteria for selecting nurses at each hospital to become midline team members. They became the team to receive special training on inserting midlines, a line with a lower risk of infection than a central line. I trained members, and those teams are all up and running.

At the same time, another team was working on central lines and proper care.

Our goal was to decrease CLABSIs at eight out of 11 hospitals, and I'm so proud to say we accomplished this goal."

RESULTS: CLABSI Decrease

Education on alternatives to central lines and proper central line care have helped nurses reduce CLABSIs so patients are treated with fewer antibiotics and experience shorter hospital stays.



* SH CLABSI Rate CY 2013 excludes SHRH and SAMC; SH CLABSI Rate 2014 and 2015 excludes SAMC.

Source: Sentara System Infection Prevention

Challenge 6

RESEARCH

Embrace research and process improvement to deliver patient-centered care

At every Sentara hospital and care site, members of the leadership team encourage nurses and other staff members to identify concerns and join forces to research evidence-based practices and then implement solutions that will be effective at their location and possibly others. By reviewing best practices, adapting them to a unique care setting and tracking progress, the Sentara staff members improve patient care and outcomes and inspire others to do the same.

Solutions presented by

Heather Galang, MSN, RN-BC, CNL

Clinical Performance Improvement Coordinator, Chair, Evidence-based Practice and Nursing Research Council

Sentara RMH Medical Center

"I used to be a case manager, and I kick-started my career as a clinical process improvement coordinator with a poster entitled 'Redesigning Care Coordination to Standardize, Streamline, and Improve Workflow Processes: A Lean Process Improvement Pilot and Patient Safety Initiative.' I presented the poster at VONEL (Virginia Organization of Nurse Executives and Leaders) and VNA (Virginia Nurses Association).

The project shows how nurses can use performance improvement and how the whole SRMH team, not just nurses, affects patients.

Creating a team to study the problem

We looked at redesigning care coordination to standardize and streamline our workflow process. It was absolutely a team effort. We had about 20 of us, from case managers and social workers to managers and process improvement engineers.

The way we had been designed before, we would have a case manager that would work on each unit and social workers would split up the units. There was a lot of duplicated work as patients were transitioning to a new care site. There was a lot of confusion as to who owned what. Bedside nurses didn't know who was doing what.

Defining responsibilities

We restructured, and we have two people, ideally a social worker and case manager, who split a unit. Each person takes half a unit with 18 patients, versus how it used to be and you'd have 36. Now each one does almost everything, with a few exceptions, to help the patient transition.

Case managers can spend more time explaining the transition to a skilled nursing facility to the patient and his family. The social workers can spend more time at the bedside, too. The case managers and social workers still communicate, but there isn't a delay or confusion. It is much more streamlined.

Reducing avoidable days and solidifying teamwork

Our goal was to reduce avoidable days (days patients didn't have to spend in the hospital). We've seen improvement most months. We also looked at key benefits, such as the staff's perception of teamwork increasing. They felt like they could complete their work better; their work didn't feel as overwhelming. The bedside nurses found it was helpful to know which case manager or social worker was helping her side of the unit, so the nurse knew who to go to for help.

Reducing avoidable days and improving teamwork were great benefits to the project, and the process emphasized to me what is possible when you gather as a team, review the research and create solutions. Nurses across Sentara are taking the same steps and that's the most important lesson."

"The case managers and social workers still communicate, but there isn't a delay or confusion. It is much more streamlined."

– Heather Galang, MSN, RN-BC, CNL

RESULTS:
Sentara Scholarly Work

	2014	2015
Manuscripts	**12**	**18**
Presentations	**13**	**29**
National	7	11
Regional	3	7
Local	3	13
Posters	**88**	**101**
National	41	22
Regional	26	52
Local	28	68
Grants	**1**	**7**

Source: Sentara Clinical and Business Intelligence

As Sentara reaffirms its commitment to evidence-based research, a growing number of nurses from all care sites and all levels are investigating ways to improve patient outcomes. They are then sharing their findings locally and nationally.

Challenge 7

PALLIATIVE CARE

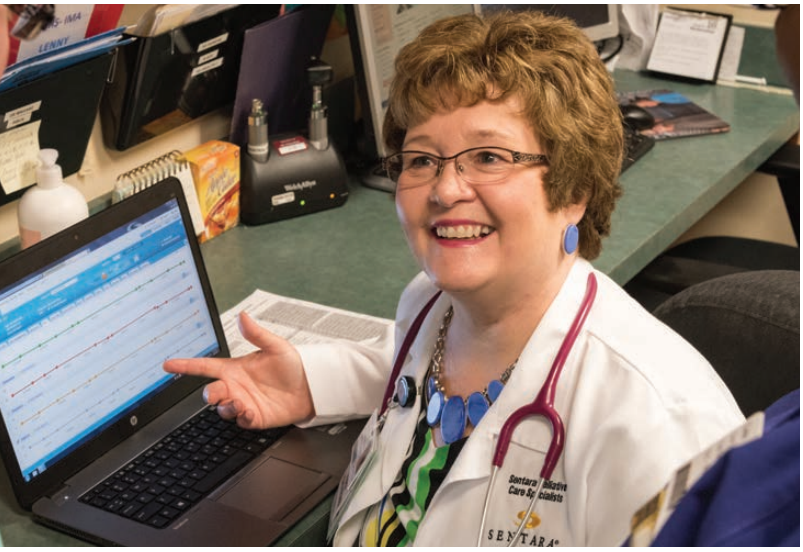
Increase the use of palliative care for appropriate patients to lower 30-day readmission rates and death-in-hospital rates

Patients facing life-challenging illnesses benefit from care delivered at a site best suited to address their physical and emotional needs, along with their families' needs. Nurses in all settings are learning about a variety of solutions that can often be best delivered through palliative care staff in hospitals, skilled nursing facilities and hospices.

Solutions presented by

Denise Miller, MSN, RN, FNP-BC

Sentara Medical Group



"From August 2014 to January 2015, we built a program of integrating palliative care referrals into skilled nursing facilities. We obtained our software; worked with IT; consulted with the processing people to create a flow map and developed survey questions. We got off the ground in February 2015.

It was a collaborative effort between Sentara Virginia Beach General Hospital (SVBGH), Life Care and Sentara Medical Group Palliative Care Medicine. Our goal was to determine if palliative care in a skilled nursing facility could reduce 30-day hospital readmission rates.

My role was to evaluate the facilities; look at readmission rates; educate staff on palliative care and how it can be utilized; and coordinate care between the Sentara palliative care team and myself.

Providing smooth transitions between care sites

Coordinating care means there's no drop in service from palliative care at Sentara Virginia Beach General Hospital to Sentara Nursing and Rehabilitation Center - Virginia Beach, our first care site. We also expanded to provide the same support between Sentara Princess Anne Hospital and Sentara Nursing Center - Windermere and then Sentara Leigh Hospital and Sentara Nursing Center Norfolk.

We want to secure continuity of care and to support patients and their families. After the patient is referred to us, we follow up to make certain that the patients' goals are honored and met. We provide pain and symptom management and support families through complex discussions. While we're striving to reduce 30-day readmission rates, we're really trying to reduce the burden on the patient and the family.

Reviewing our results

Tracking our metrics is important. We look at why we're consulted; the diseases patients face; outcomes such as hospital referrals, number of deaths and numbers of readmissions; and numbers of advanced directives that are signed.

Nurses have recognized patients who are appropriate for palliative care referral earlier because of the education efforts we have in place. Two nursing centers nurses were recently honored by us because they've really embraced what palliative care can do.

In 2015, we avoided 49 potential hospital deaths through hospice admissions; avoided 22 hospital readmissions and 17 hospital admissions; and followed 32 patients through death in a nursing center.

In December we submitted our outcomes to the Case in Point Platinum Award contest sponsored by Decision Health. The award recognizes success in the healthcare continuum through programs that educate and empower patients, manage quality care and contain healthcare costs. We're a finalist in the transitions of care category.

I'm also thrilled that a survey of our discharged patients showed 100 percent of them would recommend palliative care."

Solutions presented by

Courtney Newton, BSN, RN, ACM

Care Coordination

Sentara Leigh Hospital

"We work closely with palliative care by identifying patients who are appropriate referrals for them. Care coordinators talk with physicians during multidisciplinary rounds to identify those patients who could benefit. If the physician chooses to refer the patient, palliative care helps with services and advanced care planning.

Patients with chronic diagnoses and advanced age or patients who are requesting end-of-life services and families looking for support are all good candidates for referrals to palliative care.

I like being able to help patients and families who have complex needs. I like to hear their stories and match them up with resources they can benefit from.

Leading the patient and family to better outcomes

The palliative care team is filled with helpful people, so with the consults they can then build rapport and trust with the patient and family. We have better outcomes with their assistance.

Palliative care is always on board with our hospice patients, whether we transition them to their home or to a hospice home. We work hand in hand.

Once we consult on a case with palliative care, we'll talk back and forth about what the patient and family decided. If it's a really complicated case, we talk with the family together and then can all work together. That way, sometimes we can avoid duplicate work and asking the same questions."

Challenge 7

Solutions presented by

Sandy Allen-Dansby, RN

Sentara Hospice House

"I've been gifted with the ability to talk about end of life and to help people make peace with end of life. If you wait and listen, you can be ready to help the patient at the right time.

For one patient, I reached out to our chaplain who then came and talked to her. She had been moaning and moaning but wasn't in pain. Her worry was that she had done something so awful that God could never forgive her. Her comfort came from being reassured by the chaplain. You can make a huge difference if you identify what the patient is struggling with, whether it's pain or a spiritual issue.

Reaching across Sentara and making suggestions

We have interactions with case managers at our hospitals and the floor nurses as patients are transferred to us. We review the referrals and can help with the assessments of patients before they transfer to us.

Our team is growing with a new member, and soon, we're changing the way we chart. It's the same system but upgraded. We had input into that by looking at the format and giving our ideas for improvements. My manager and our physician are open to suggestions. They really listen to us about our patient concerns or the staffing. We're all trying to deliver the best care to every patient."

"My manager and our physician are open to suggestions. They really listen to us about our patient concerns or the staffing."

– Sandy Allen-Dansby, RN

Solutions presented by

Anne Reddy, MD

Medical Director

Sentara Hospice House

"Hospice House nurses help with whatever needs the patient has. We operate as a combination of a home for people who may come to us and die and as almost a mini hospital where a patient comes to us to get his symptoms under control and then he returns to his home. The nurses are involved in the total management of the patient in both cases.

The nurses here offer the type of care I strive to give. I always say I practice '1950s medicine.' We had to spend time with patients, interact more and figure out what was going on.

Our nurses do that at Hospice House and beyond. They go the extra mile and visit patients at home. They provide the families with their cell phone numbers. The family will call in an emergency, and the nurse offers guidance.

In the last two years, we've gone through changes, and we talk with the nurses and listen to them. We brainstorm the best ways to do case management."

Sentara Hospice House team

Challenge 8

NURSE-RUN CLINICS

Provide proactive, ongoing care through nurse-run clinics and nurse-run care management

As the field of medicine is overwhelmed with more patients facing serious health concerns, nurses are taking on new and expanded roles. They're initiating patient education, following medicine protocols independently and consulting as true care partners with pharmacists and physicians. Patients look to nurses as experts they can trust with both problems and solutions.

Solutions presented by

Alverta H. Robinson, MSA, BSN, RN, LNHA, RN-BC

Sentara Medical Group

"In 2015, Sentara received the ACMA (American Case Management Association) award for most innovative project. The award honors something cutting edge in patient management. Usually the projects are developed by hospitals, workers' compensation and health plans. What made us different is that we have patient management run by nurses in physician practices.

We developed our program with a targeted population of high-risk, high-utilizer patients. We matched patients with nurse care managers who followed their progress, hospital admissions and recovery.

Decreasing ED use and hospital admissions and readmissions

We were able to do some significant things since we started in 2012: We had a 42 percent decrease in ED (emergency department) visits; a 46 percent decrease in all-cause hospital admissions; a 26.5 percent decrease in 30-day hospital readmissions.

We're the linchpins for our patients in that whatever type of care they're in, be it the hospital or home care, they can still reach out to us, their care manager. We even do home visits.

What really works for us is establishing that relationship with the patient. Our patients call us and say, "I'm not feeling well; I want to go to the ED." We give him direction. Maybe it can wait until tomorrow; we can get him in to see the physician in the morning. Or we may have to give him the advice to go to the ED. It's a matter of being there for the patients and them knowing there's someone from their physician's office for them to talk to.

Advocating for the patient and sharing their needs

One of our success stories is a man who didn't know he was diabetic. He found out and immediately heard that he 'must go on insulin.' The doctor was insistent. We have a good relationship with the nurses on staff, and one called into care management and told us about the situation. Our care manager talked with the physician, who agreed to give her 30 days. She worked with the patient on diet and exercise, and he lost weight. When the patient went back to the physician after 30 days, his glucose level had gone down, and he didn't have to go on insulin. When you can make a difference like that, it makes it all worthwhile.

We do a lot of transition work to stop patients from being readmitted. We call the inpatient care coordinator and say 'Please make sure this patient has Home Health; her husband can't care for her.' We call the patient 48 hours after discharge. We review discharge instructions with her and see if her prescription got filled. Sometimes the patients can't afford the medicine; we intervene to get a different medicine at a lower cost."

Solutions presented by

Mary Didier, RN

Sentara Anticoagulation Services Clinic-Kempsville

"In December 2012, we were just three clinics helping patients who took anticoagulation drugs; now we have 17 all nurse-run clinics. When we started expanding, we could reach more patients, and it's just been a needed change.

All blood thinners run a risk of causing patient bleeding. We need to be sure the INR (international normalized ratio) level, the amount of medicine in the blood, is just right. If it's too high, you get bleeding. We tell patients to call if they're bleeding and don't have an injury. There's also the risk of the INR level being too low. Then the patient can develop a blood clot in his leg or lung or have a stroke.

Educating the patients

We found some patients weren't getting educated on why they needed to be monitored regularly while they took the anti-coagulation drug. We've standardized the education process, the monitoring process and the system for sharing information with the referring physicians.

We have nurses who see patients in our clinics. We review their medications, and pay close attention to any new drug that they've started taking that could interact with the blood thinner. We do a finger stick to check the INR. Based on the patient's INR, we adjust the medicine dose up or down according to our protocol.

Our nurse-run clinic system is called an RN to PharmD model. If we have an issue with our protocols or the patient has an infection, we consult with the pharmacist. If a patient goes on an antibiotic, we also call the pharmacist because antibiotics tend to interact with anticoagulants.

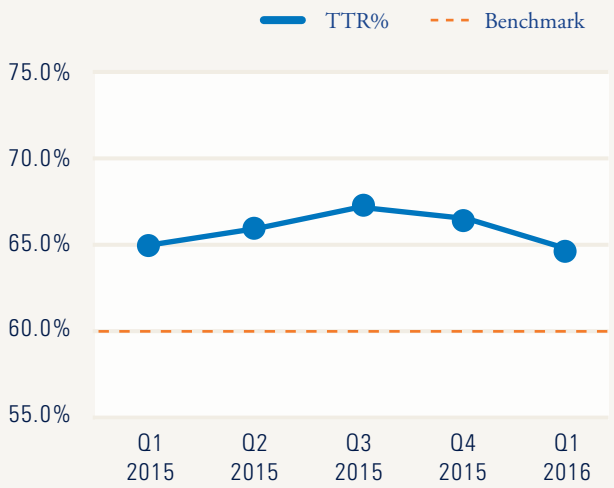
Offering options to less-mobile or busy patients

We're part of a virtual group, too. We have a lot of patients who aren't well enough to come into the clinic, so we have Home Health helping them. Home Health does the finger stick, and we do the dosing. We also offer home testing, where the patient does a stick at home and reports the number to a third party. The third party calls us, and we call the patient for changes. The at-home testing patients can call and come to the clinic, too, if they need extra help.

In the future, we'll be introducing group education classes, and we're bringing in a representative from the third-party reporting company. Patients will be able to come and learn about why testing is so important and how they might be able to do it at home."

RESULTS:

SENTARA ANTICOAGULATION SERVICES & CLINICS (SASC) TIME IN THERAPEUTIC RANGE (TTR)



Source: Sentara Medical Group

Challenge 9a

Achieve a BSN rate of 80 percent

Understanding that quality patient care hinges on having well-educated nurses, the Robert Wood Johnson Foundation in 2010 called for 80 percent of all nurses in the United States to have a minimum of a bachelor's degree in nursing by 2020. The Foundation, along with the Institute of Medicine, pointed to research that has shown lower mortality rates, fewer medication errors and positive outcomes are linked to bachelor-prepared nurses. Sentara nurse leaders are paving the way for nurses to earn bachelor's degrees by offering scholarships and tuition reimbursements and revamping the Sentara College of Health Sciences RN-to-BSN degree.

Solutions presented by

Sheryl Arrington, RN

Step-down Stroke Unit

Sentara Obici Hospital

"I started working on my bachelor's degree in 2015. I'm studying for my certification in progressive critical care nursing, too, and I carry around that book all the time as well. I'm working full time on my degree and certification and full time at work. I decided to do this even before Sentara encouraged nurses to get their BSN and certifications. I wanted to further my education.

When I first came to Sentara, I was a certified care partner; when I saw other nurses interacting with patients, I liked what I saw and knew I had to pursue my dream of being a nurse. I went to school and became an LPN and then I returned to become an RN.

My ultimate goal is to become a DNP, a nurse practitioner with a doctorate. My bachelor's is my first step toward that. I want to show my kids – ages 14, 11 and 2 -- that everything is possible. Learning more and becoming a nurse practitioner will help me and patients. The nurses see more and more and are responsible to help patients more, so all the education helps.

Making the money and schedule work

I applied for the Sentara Foundation scholarship. I was already in school, and I met all the requirements. The $5,000 made me excited, and it gave me a little relief from finding other ways to pay for my education. I try to avoid loans so my only other option would have been to work more. That would mean more time away from my family.

My manager told me about the scholarship. Tuition reimbursement is also a huge help. You can get more the longer you've been at Sentara. I've been here 10 years, and I receive $2,300 in reimbursement annually.

My manager works with me on my schedule, too. She knows that I prefer to work Wednesday, Friday and Saturday. School puts the assignments out on Sunday, and I tackle those at the start of the week so that at the end of the week, I'm focused on my job."

Solutions presented by

Alexandria Hill, LPN

Sentara Life Care

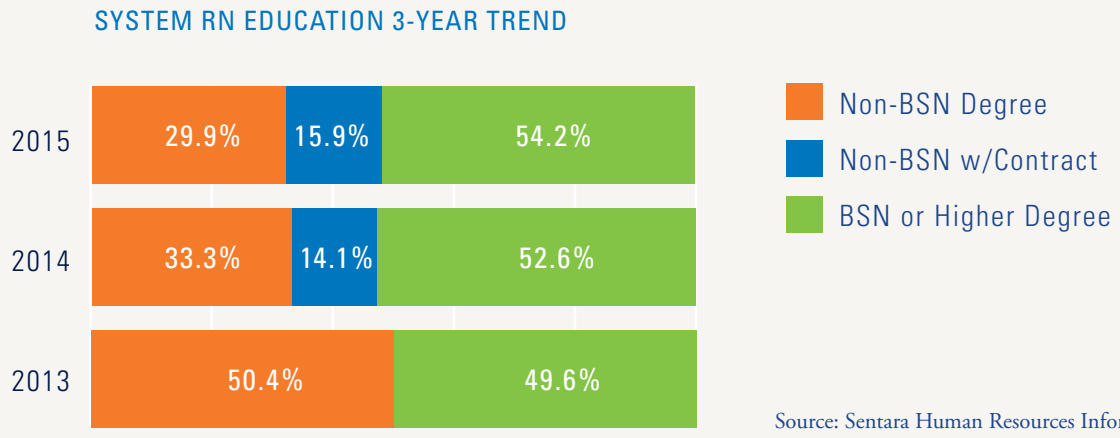
"I started my education journey in 2011 at Chesapeake Center for Science and Technology working on my LPN as a 'stepping stone' to becoming an RN. In 2012, I began working on my bachelor's degree in nursing.

Upon graduating with my LPN, I briefly worked in a behavioral health group home before joining Sentara Life Care Chesapeake as a 3-11 staff nurse. Once I started back in school, my schedule became more demanding and I transferred to the Resource Pool. I then became a Subject Matter Expert (SME) with HealthMedx Vision project. This gave me the ability to see long-term care from a leadership perspective and gain experience in staff education. During this time, I also took care of my grandparents throughout their journeys as residents in Life Care facilities.

My work experience, clinical rotations, and being a family member with loved ones in our facilities led me to realize that education is vital into improving our patients' health every day. Healthcare is always changing and it is our duty as healthcare professionals to learn about these changes. Also, whether we realize it or not, nurses are teachers too! I believe the key to being an advocate lies in patient education and health promotion.

When I was presented the opportunity to become a part of the Household Model culture change at SNC-Chesapeake, I instantly knew this was my reason 'why' all along. Obtaining my BSN has given me the opportunity to grow as an educator and leader in order to become a positive influence in long-term care."

RESULTS:



Source: Sentara Human Resources Information Systems

Challenge 9b

Earn Magnet certification

The American Nurses Credentialing Center developed Magnet certification to recognize healthcare organizations for quality patient care, nursing excellence and innovative nursing practices. Nearly half of Sentara's hospitals – Sentara Martha Jefferson Hospital, Sentara Norfolk General Hospital, Sentara Williamsburg Regional Medical Center, Sentara RMH Medical Center and Sentara Leigh Hospital – have journeyed through the years-long process of applying for and securing Magnet certification. The other hospitals are continuing to take big steps toward the same honor by consistently engaging nurses in decision making and initiating innovative programs that improve patient outcomes.

Solutions presented by

David Vendt, BSN, RN

Team Coordinator, Emergency Department

Sentara Obici Hospital

"I'm part of several teams that support the team championing our first Magnet application. It's being submitted soon and we hope to have a site visit from the Magnet certification committee in the future. The certification will tell everyone that we meet a standard that exemplifies excellence.

I'm part of the early-hire BSN, systemwide program. We visited 12 colleges and universities; presented to BSN students so they could learn about Sentara; and then a few days later, we interviewed students.

It's kind of like a combine for football; we're reaching out to the best recruits. We're looking for the leadership skills that come from a BSN, and we need nurses who understand the value of evidence-based practices.

Educating the newest nurses

We're also launching new-graduate classes that will boost retention. The new nurses will learn about stress management, time management, wound care and advanced care planning. We'll have simulation classes and hands-on training with equipment.

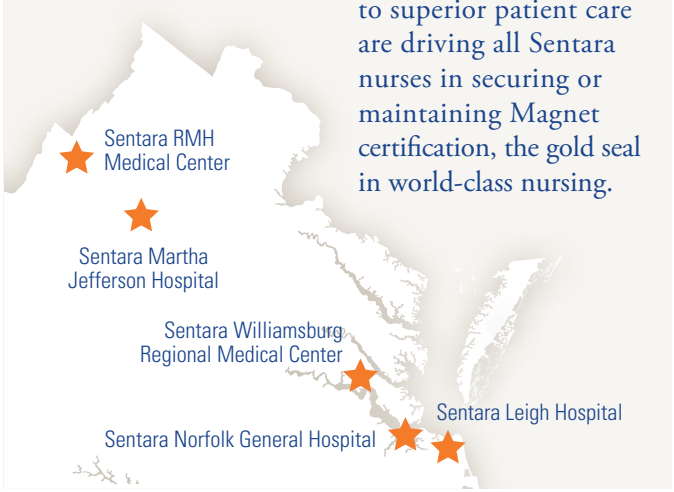
Good retention brings consistency to our team. It's nice to come in and have the same players and know who will be on your left, who will be on your right, who is your wingman. Teamwork is what I like best about Sentara.

Improving patient safety and patient satisfaction

In addition to also working on the CLABSI and CAUTI committees, I'm on the patient satisfaction committee. I round the ED and check on patients and their families. It's a scripted evaluation; I ask if a nurse has been by in the last hour; if the doctor is keeping them up-to-date on their care plan; if I can do anything to help."

RESULTS:

SENTARA'S 5 MAGNET DESIGNATED HOSPITALS



Evidence-based research, innovation and dedication to superior patient care are driving all Sentara nurses in securing or maintaining Magnet certification, the gold seal in world-class nursing.

Journey Towards Pathways to Excellence

Solutions presented by

Ashley Riffe, BSN, RN

Staff Development Coordinator

Sentara Life Care

"The Pathways to Excellence credential is a high honor to receive through the American Nurses Credentialing Center (ANCC). A facility must meet several requirements to obtain this reputable credentialing, which in turn will improve working conditions for staff. The Pathways to Excellence program ensures that a facility's decisions are employee oriented. This leads to increased retention and job satisfaction. As a previous bedside nurse, when given the opportunity to have my voice heard, the feeling of involvement always improved the working conditions. The involvement of nurses and aides in the decision-making process will improve work flow and morale, ultimately leading to improved patient satisfaction."

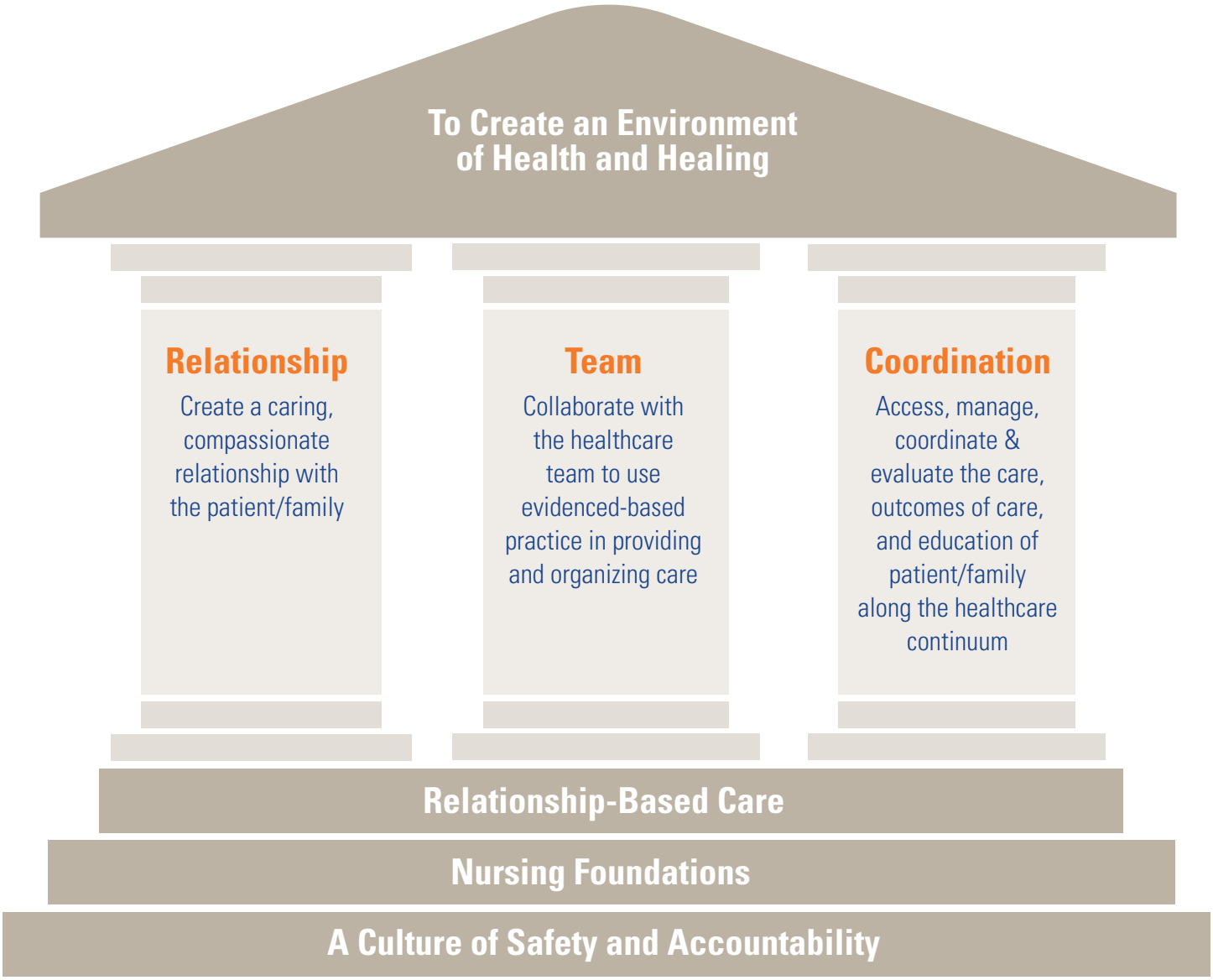
Sentara Life Care Team

Challenge
10

Embrace the Sentara Professional Practice Model's team principle by collaborating on practice forums

Sentara Healthcare nurses designed the Professional Practice Model (pictured) as a blueprint of Sentara's guiding nursing principles. The building blocks of a culture of safety and accountability, nursing foundations and relationship-based care provide stability and support for the solid pillars of coordination, relationship and team. Shared decision making, driven by evidence-based practices, is a key element in strengthening our teams. Through our practice forums, whether on the unit, hospital or system level, shared decision making is a regular and welcomed part of Sentara nurses' work. Bedside nurses and leaders collaborate to analyze research and implement best practices to create an environment of health and healing for patients.

Sentara Healthcare Professional Nursing Practice Model



Solutions presented by

Gina Black, RN

Member, Critical Care Nurse Practice Forum (CCNPF)

Sentara Albemarle Medical Center

"I'm a new member to the CCNPF committee and so far, I've been listening in and reading the minutes.

One thing I read about is CHG (an antibacterial). We were using it on our ventilator patients at Albemarle, as part of our ventilator-associated pneumonia protocols. We haven't had a case of ventilator-associated pneumonia in a long time, which is a really big deal. I read in the minutes, though, that CHG is not making a difference. A study showed it doesn't affect anything. So we were able to do away with the expensive packages of CHG. It's no longer part of our protocol, and we're saving money.

The CCNPF committee also shared that Sentara hospitals are getting ready to study using disposable EKG wires. We've been using those at Albemarle for about two years, so I'll be talking to the committee about our experience. We find them much better and easier to clean.

The more I can learn and share about Sentara with others here helps to calm their nerves. We've been part of the system for two years. The more we know, the more everyone here feels secure."

Solutions presented by

Mona Buck, BSN, RN

Member, System Falls Collaborative

Sentara Halifax Regional Hospital

"The falls committee welcomed me as a new member in 2016. We'll be able to do a lot to keep our patients safe. Not only can everyone share their ideas through the committee, they can engage in a little friendly competition as we improve our fall rates.

As a new member of the team, I'm standing on the shoulders of giants and learning from their best practices.

Analyzing data and perfecting reporting practices

Conference calls are held monthly, and meetings quarterly. Members report their hospital fall rates regularly, and we look at them. One hospital was reporting falls at a significantly higher level of resulting injury. We wondered, 'if the rooms were smaller or if there was something different about the design of the rooms.' Turns out they were considering any type of impact as an injury, even if it was a slight bruise. They were coding the fall more aggressively. The staff realized that they weren't in that bad of a situation with falls. We were happy to find out we didn't have horrific falls at that hospital.

Sharing solutions to reduce falls

We have managed falls before largely with bed alarms and restraints. A lot of evidence-based research has shown that the restraints can increase falls. After Sentara came, we looked for non-restraint ways to address falls.

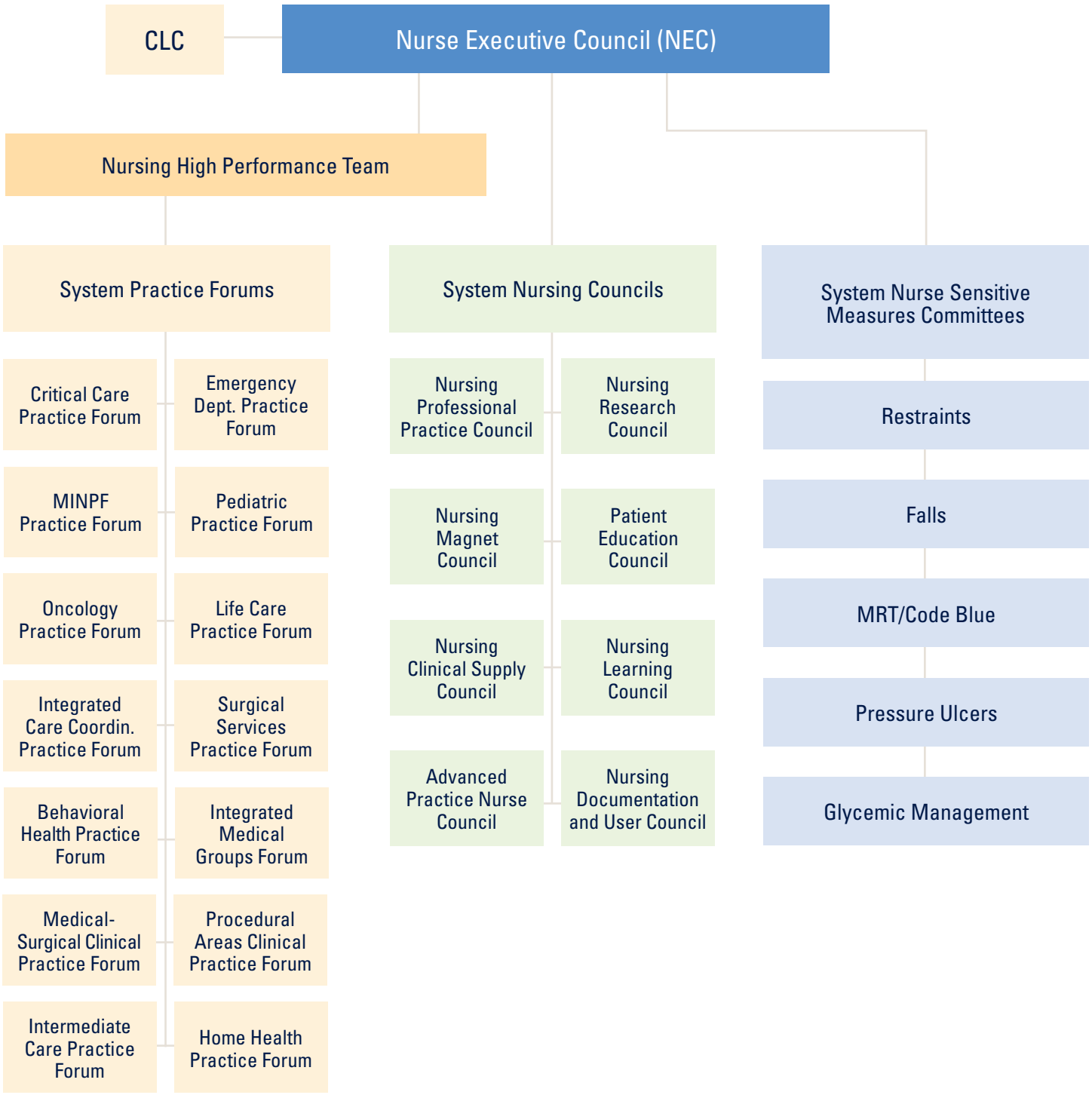
We use sitters, especially for our dementia patients. Another solution has been chair alarms. If a patient has orders to be out of bed and in a chair, we're helped by the alarm. We've used Envision® mattresses, too. They're soft, fluffy mattresses that we usually have for people with skin breakdowns. The beds benefit potential fall victims, too, because patients nestle down in the mattress because it's so comfortable. When they're nestled down, they don't fall out of bed.

Some of the other hospitals are using a placard that says, 'don't pass.' It means don't pass this room without checking on this patient. The patient is a fall risk and needs to be checked regularly. I'm looking into getting those placards."

Challenge
10

Forums at a variety of levels – unit, hospital or system – encourage nurses to present ideas and act upon them to deliver exceptional patient care.

2016 Sentara Healthcare Nursing Committee Structure



Challenge 11

Recognize nurses who excel at delivering compassionate and competent care with DAISY Awards

The family of J. Patrick Barnes, who died from an autoimmune disease, created the DAISY Award for Exceptional Nursing in honor of the nurses who cared for Patrick during his final days in 1999. DAISY stands for Diseases Attacking the Immune System, and the award recognizes nurses who skillfully and compassionately care for patients and their family members. It is now presented to nurses in over 2,000 healthcare facilities throughout the United States, including all Sentara care sites, and 15 other countries.

Solutions presented by

Bridget Rasmussen-Trotman, LPN

Pre-op, *Sentara Northern Virginia Medical Center*

"I work in pre-op; I make sure patients are ready for surgery. I tell people that I have the most fun job in the hospital because I can ease patients' tension.

I won the first DAISY Award at our hospital. They said I was nominated because of my bedside manner. I would describe it as caring and compassionate with a side of humor. You can't be a good nurse without humor. It keeps the stress level down for your patient.

When I received the award, I thought I was going to talk about a flow process between pre-op and OR. I had no idea. I was pretty shocked. Everyone said it was great because it was the first time ever that I was speechless! I felt very honored; I mean, I cried.

Selecting the nurses for a DAISY Award

There's a lot of support for the DAISY Award, because it's a team-builder. We're hoping it's taking off Sentara-wide. You're recognizing co-workers. The DAISY Award here is given every three months. I'm on the nurse committee who helps select the winners. I have a stack of about 250 nominations right now. I prepare the packet, blacking out the names. Our committee reviews them first and then we forward the three finalists to our leadership for their decision.

It helps when a patient is real specific on the nominating form. For example, say that you saw a nurse working with a man who had a stroke and was panicking. The nurse found out that the man liked dogs and started to talk to him about different kinds of dogs so he could calm down. The nurse's actions helped the patient feel like a person in that moment and not a diagnosis. If a patient can write those details, it's so much more helpful than saying 'Jane was good.'

Sometimes you wonder if you really make a difference, and with a DAISY Award, you know that you did."

RESULTS: DAISY

The DAISY Award

FOR EXTRAORDINARY NURSES

Reach out to your leader to nominate a deserving nurse for a DAISY Award or to learn more about encouraging patients and their families to do so.

www.daisyfoundation.org/daisy-award

Challenge
12

Preparing today's nurses to exceed tomorrow's goals

As the healthcare industry grows and changes, so do the daily challenges faced by all nurses. Sentara nurse executives set the standard for excellence that must be achieved, regardless of the growing demands. At the core of the nurse executives' efforts to ultimately deliver quality patient care is a desire to first engage every interested nurse in decision making. The Nurse Executives strive to provide each nurse with an opportunity to be heard and to make a difference in patient outcomes, driven by best practices. Through listening to nurses, the Nurse Executives pave a pathway to those proven practices.

The Nurse Executives are also committed to supporting current staff members with ongoing education through certifications and degrees and to ensuring that Sentara has a full staff of well-qualified and dedicated nurses. The executives are expanding their reach outside of standard recruitment efforts and into area colleges and universities, where they look for new nurses dedicated to excellence and compassion, similar to those who are already part of Sentara.

Solutions presented by

Grace Myers, MSN, RNC-OB, CNS, NE-BC

Vice President, Nurse Executive

Sentara Norfolk General Hospital

"Each of our clinical units has unit practice councils made up of the bedside nurses and chaired by them. That's a foundational area for our nurses to have a voice with problem solving and issue resolutions. The council members let fellow nurses know of upcoming meetings and see if they have issues to discuss.

In addition to participating with the regular council meeting, the unit practice council chairs also attend an annual meeting that I lead. I give them an overview of all of our objectives and goals for the year. I do that with our unit coordinators as well, and I talk with the unit coordinators at meetings every other month, too. I share what we're working on, and they talk with me about things they'd like to do. I like to hear from the nurses at the bedside. They also have excellent suggestions about recruiting and retaining nurses. Who better to talk with about what we could do to improve the environment than the nurses themselves?

We're also working with our 'Magnet champions' to improve our overall nursing efforts. We decided to revise our nursing theory model, and we implemented a new model of relationship-based care. The Magnet champions are helping us embed the relationship-based care into the care of our patients, and we're starting to see an improvement in our customer satisfaction score. On a recent report, we were up to 80.6 percent, which was higher than we had seen in 2015.

Another change that nurses will be part of and that should have a good impact on our customer satisfaction scores is our site improvements. We just kicked off a five-year effort to update the facility. The patients and their families will have better rooms; we'll have family sides of the room with sleepers so they can spend the night. We'll have nourishment areas that are welcoming and more open. Anytime we provide a more welcoming and friendly environment for patients, it helps nurses because their goal is to care for the patient and his family. It'll also be an easier environment for the nurses to do their job."

Solutions presented by

Kim Bradley, MSN, RN, NE-BC

Nurse Executive, Director of Clinical Services

Sentara Enterprises

"We're involved with many of the performance improvement initiatives throughout the system. So much is related to the hospital readmissions that we work to keep down. We're part of the creative thinking and problem-solving efforts with patients and on the system level.

We are represented at numerous system committees. Before, we didn't always get information at the right time, and it wasn't always tailored to our care setting. We've really worked to be at the table. With our big focus on reducing CLABSIs, our staff was trained on the same protocols at the same time as other caregivers, but with some changes to apply it to our care setting. Being there as protocols are developed and being able to speak up is huge.

Beyond the systemwide committees and their education efforts, we're providing training for our nurses. With home care nurses, because they have so much influence on patients remaining at home, we're spending a lot of time teaching them about medication reconciliation and bundle payments. For wound care, we want nurses at the top of their license to assess and manage wounds at home. We're helping them gain the needed skills by working with vendors and subject specialist nurses. Nurses need to be very current with their skill sets."

As well as always being open to training, our team realizes we're regularly tweaking our process. Part of last year, we focused on the infusion nursing team, which had been collapsed into the general nurse population. We identified that you do need a more specialized nurse in a post-acute setting for doing patient IV. We worked on building that specialized, albeit collaborative, team.

Another change is our new hospice nursing director. She has worked with the team to expand some basic hospice nursing capabilities to a level we haven't seen before. We want to ensure nurses can take patients requiring a higher skill level, such as cardiac patients with strong medications. The staff is getting education on how to deal with a more acute population."

Challenge
12

Solutions presented by

Mark Beck, MSM, BSN, RN, NE-BC

Vice President, Patient Care Services, Nurse Executive

Sentara CarePlex Hospital

"Overall, we face a challenge recruiting and retaining nurses. We're excited to have started a new program to recruit and retain new graduates. We're able to get the 'first dibs.' We're not waiting for them to come to us. We're actively pursuing the cream of the crop.

We have a residency program that also just started and that can help retain the nurses. We heard from the employees and from HR that this is something we really need to focus on. It offers classes, and it couples them with a mentor for the whole year. We launched it in early 2016.

We're working more closely with the schools, too. We're finding a disparity between what they're producing and what we need. The students are sometimes not completely prepared. We're trying to close that gap.

Once nurses are on staff at Sentara, it's vital for them to continue their training and to continue to improve their care skills through that training. We're focused on raising our certification rates. Our nurses need to stay on the cutting edge. Some can say 'I have 20 years experience.' But it could be that they earned five years of experience, and then for 15 years their experience stayed the same. With certifications, you're putting a lot of work and effort into learning the latest and greatest. We have goals at each facility, and we're really pushing our nurses. It makes a difference in nurses' critical thinking skills and patient outcomes.

Across the system, we continue to be determined to have 80 percent of staff with BSNs. We're offering lots of different scholarships. We have matching scholarships for those who have signed contracts that require them to earn a BSN. We have worked with the schools to try and get good prices for the nurses to go back."

Solutions presented by

Valerie Keane, MHSA, BSN, RN, FACHE

Vice President, Nurse Executive

Sentara Northern Virginia Medical Center

"Our nursing team is incredibly dedicated. They're very resilient. They're willing to do whatever it takes to elevate the level of care we provide. Folks are willing to pitch in. The team here has really pulled together, and they partner well with physicians, pharmacists, dietitians, housekeepers and administrators. We've had some challenges around staffing, and our nurses persevere through the heavy workload and keep a great attitude.

I'd really like to see us be the employer of choice in Northern Virginia and attract more excellent nurses. I think to do so, it's a matter of bragging about what we do and getting the Sentara brand out there and talking about the resources we have.

We've partnered with colleges and universities, too. They understand what we're looking for in new graduates, especially in terms of the patient experience. Back when I graduated, I was judged on my technical competency. Nurses coming out of school now need to have that technical competency, but they also need to understand the patient experience and what drives that. There's cultural diversity to consider, and they need to be very compassionate. As much as you'd think, well, of course, that's why people go into nursing, we find that being compassionate isn't always a component new nurses have had a lot of training in. If you're not able to be nice to the patient, and his family, you're not a great nurse.

Having a consistent and caring staff of nurses who are engaged with patients and dedicated to solving problems will make a difference as we continue on our journey for Magnet certification. We're about two years away from submitting an application. We've started with our shared-governance by getting committees and forums in place. As opposed to a top-down model for decision making, we're engaging the staff in decisions. There's involvement, so we have staff buy-in. The staff are the folks at the bedsides, and they can say what is happening. They've got a voice and are at the table when decisions are made."

Challenge
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Solutions presented by

Joani Brough, MSHA, BSN, RN, NE-BC

Vice President, Nurse Executive

Sentara Princess Anne Hospital

"For nurses to have autonomy and satisfaction, they need to drive nursing practices. They are the best judge of what's going to work because they're closest to the patients. They feel a lot of ownership in the change they're going to make.

There are many venues where our nurses have a voice. You see it in our shared governance model. They get together in committees, especially on the unit level. They problem-solve issues related to their patients. That committee is really given the authority to implement best practices based on evidence. We encourage them to look at the evidence-based, best practices and determine how we can implement those.

All the chairs of the unit committees meet at a facility level as part of the hospital partnership council. They discuss practices other units might want to adopt.

I've seen the nurses make a difference in many ways. One is in the OB department where they completed a project related to placing the baby on the mother or father's chest immediately after birth. That has made a difference in the bonding experience.

Another nursing unit had a problem with UTIs (urinary tract infections). They put together a plan for a two-person catheter insertion. The person inserting the catheter has an assistant to help. That has made a difference in the rate of UTIs; we've cut the rate in half.

Beyond being sure that we have great committees where nurses can participate, one of my expectations is that the leadership team is visible and approachable so staff can talk to us on a regular basis. The nurses have direct access to nursing leadership. It's not a rarity for them to see us.

The greatest joy I have is interacting with staff. They know what matters to me, and they hopefully think about that when they care for the patients. I want them to do their best every day. I ask, 'What's going on today?' 'Is there anything I can do?' 'What is your staffing like today?' I try to let them know I want to make their day better."

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