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Notable Nursing

Fall 2018 | A Publication for Nurses by Nurses

The Stanley Shalom Zielony Institute for Nursing Excellence



The MAGNUS Experience
Celebrating nurses' contributions
at the bedside
p. 10

Dear Colleagues and Friends,

At Cleveland Clinic, we promote a culture of continuous improvement by empowering caregivers at all levels to provide the highest quality of patient care.

With changes in the healthcare landscape, nurses increasingly are recognized as leaders in transforming the healthcare system. In addition to providing direct patient care, nurses are serving in a variety of roles, including as care coordinators, wellness coaches, healthcare navigators and leaders.

Through tiered huddles, nurses' voices are heard; the lines of communication are open — from clinicians at the bedside to executive leaders. The most critical issues brought to the table by nursing staff are escalated to senior levels within hours through these brief, focused conversations. The tiered huddle process empowers leaders — who are peers and colleagues — to perform at the top of their scope of work. (See story on p. 6.)

At Cleveland Clinic, we have a program called the MAGNUS Experience that shows clinical nurses how their contributions are valued. (See story on p. 10.) What I really like about this program is it allows time for reflection, and it showcases how indirect leader roles contribute to leader decisions. Meaningful recognition of the work nurses do positively impacts morale, improves engagement and fosters a team-building environment.

Treating patients in their last hours can be an intense experience for caregivers. Cleveland Clinic leaders recognize the efforts of caregivers while honoring a patient's life and journey, through "The Pause" — a moment of silence at the bedside of patients who have died. The Pause gives nurses a moment to reflect on the patient/family and their comfort-care needs. (See story on p. 14.)

Other programmatic opportunities discussed in this issue are our dedicated medical emergency teams and our admission unit to decongest the emergency department. These initiatives promote clinical nurse growth in nontraditional ways to enable nurses to realize their potential. Professional nursing is full of possibility. Effective nurse leadership comes from the ability to empower others to share creative ideas and speak up to optimize patient safety and quality.

I hope you find this issue informative. Please contact us anytime to share your thoughts and ideas. You can reach us at notablenursing@ccf.org.



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On the cover: The Magnus Experience: Celebrating nurses' contributions at the bedside.



Responding to **Medical Emergencies**

Dedicated medical emergency team nurses provide vital care during medical emergencies within the hospital

Although hospitals are designed to treat the sick and injured, sometimes situations occur within the walls of a healthcare facility that require rapid clinical intervention: an unresponsive patient in a post-anesthesia care unit, a fall by a family member in a waiting room or an employee experiencing new-onset chest pain (due to myocardial infarction). In these cases, rapid response teams are often used.

Cleveland Clinic main campus has two dedicated adult rapid response teams — the Adult Medical Emergency Team (AMET) and the Cardiac Medical Emergency Team (CMET). Other rapid response teams that also support the main campus are the Pediatric Medical Emergency Team (PMET) and Don Marten's Mobile Emergency Response Team (MERT). They can be activated by any employee, patient or family member when an individual is decompensating or becomes ill or injured while on main campus.



John Diemer, RN, and Jacqueline Westbrook, RN, are part of Cleveland Clinic's dedicated adult rapid response teams.

"Many hospitals do not have dedicated nurses and respiratory therapists on their rapid response teams; instead, nurses typically have other primary work responsibilities with emergency response added as a secondary/dual responsibility," says Rosslyn VanDenBossche, MBA, BSN, NE-BC, Assistant Director of Nursing for the Sydell and Arnold Miller Family Heart & Vascular Institute and Critical Care at Cleveland Clinic. "We are fortunate to have multiple emergency teams committed to providing world-class, immediate emergency care."

RNs are a critical part of METs

METs working at Cleveland Clinic main campus typically include a dedicated registered nurse, a dedicated respiratory therapist, and an attending physician or advanced practice nurse. There are 20 dedicated RNs on the AMET and CMET teams, with more than half working on both teams.

"In MET activations, the team provides rapid clinical assessments and interventions to individuals who are decompensating quickly, partners with the primary

team, assists with immediate tests or procedures, and expedites patient transfers to a higher level of care," says VanDenBossche.

The ultimate goal of METs is to intervene with urgent care before a patient experiences a cardiopulmonary arrest (CPA) by recognizing warning signs and rapidly activating the team when criteria are met. CPAs are best managed in the intensive care unit (ICU) where resources and equipment are more readily available.

The strategy works, and the educational efforts have paid off: In 2017 there were 86 non-ICU codes at Cleveland Clinic's main campus, compared with 171 in 2010. "Every year, our goal is to decrease our CPAs outside the ICU and increase out MET activations," says VanDenBossche. In 2010, the team was activated 2,348 times. Last year, the team was activated 5,985 times.

AMET and CMET (established in 2007 and 2008, respectively) respond to the same types of emergencies, but differ by responding locations; CMET's primary response location is the Sydell and Arnold Miller Family Pavilion,

home to the Miller Family Heart & Vascular Institute, and AMET responds to all other locations on main campus.

A second AMET RN and response team is stationed in Cleveland Clinic's main campus outpatient building weekdays 7 a.m. to 7:30 p.m. to assist MERT with servicing the ambulatory population in that area.

"This second team was implemented as a response to the anticipated increase in activations due to the new Cancer Center building, increased concurrent activations and more inpatients traveling to these ambulatory locations for care," says VanDenBossche. "AMET in the ambulatory building reduces the time between activation and MERT arrival, which could range from two to 10 minutes or more, and bridges the distance gap for providers when an activation involves an inpatient."

RNs provide education, conduct research

"MET nurses are an incredible group who are highly engaged and committed to patient safety and to the development of our caregivers," says VanDenBossche. "They are informal leaders." As such, their role extends beyond helping out in rapid response situations.

Education is also a primary responsibility for the MET RNs.

Cleveland Clinic's MET nurses

are recognized as leaders in the field
of rapid response care.

Nurses and nursing students shadow the MET nurses and receive hands-on experience with defibrillators and crash carts. MET RNs also educate caregivers on the American Heart Association's Get With The Guidelines®.

Because of their vast experience and skill set, Cleveland Clinic's MET nurses are recognized as leaders in the field of rapid response care. They present at conferences, both locally and nationally, including the Ohio Association for Healthcare Quality State Conference and the Rochester Cardiac Nursing Conference. With recent institutional review board approval, AMET launched its inaugural nursing research study on the relationship between cardiopulmonary arrest rates and the use of a dedicated rapid response team. This is the team's first nursing study, which will serve as the foundation for additional research in rapid response care.

Email comments to notablenursing@ccf.org



Learning from Code Events

Code events that occur outside the ICU at Cleveland Clinic's main campus are carefully reviewed twice monthly by the Critical Response and Resuscitation Committee, which oversees all medical emergency teams (METs). In addition, Nursing holds Nursing Event Review and Educational Planning Sessions (NEREPS) monthly, attended by clinical nurse specialists, nurse managers, assistant nurse managers, an RN from the American Heart Association training center and MET RNs.

"We review all code events from the previous month, focusing on the 24 hours leading up to the code," says Kelly Lichman, BSN, RN, PCCN, Nurse Manager of the Heart and Lung Transplant Unit and co-chair of the NEREPS Committee. The committee reviews patient vital signs, lab work, medications, telemetry, physician notes and nursing notes. It examines how well caregivers followed procedures and escalation protocols.

Information gathered during NEREPS is relayed to nursing units to educate caregivers. "We discuss areas that were missed, good catches, and whether this was an unforeseen situation that, despite our best efforts, could not have been prevented," says Lichman. The data also guides continuous improvement initiatives.

Huddling Up for Quality Patient Care

Empowering leadership through focused discussions

In a culture of continuous improvement, empowering caregivers at all levels to provide the highest-quality patient care is taken to a new level at Cleveland Clinic through tiered huddles.

Tiered huddles are a series of brief, focused conversations that take place every morning across the health system hospitals, opening the lines of communication from our nursing staff all the way through to executive management. The most critical issues are escalated to senior levels within hours through different tiers, thereby identifying concerns needing hospital- and enterprise-level attention.

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The framework

Items brought to huddle are typically issues that cannot be resolved at the point of service, or involve system or process issues that need to be reviewed generally.

“Between 7 a.m. and 11 a.m., anything that happened to a patient or caregiver in the hospital in the past 24 hours is reported to the top level of the hospital system,” says Shannon Pengel, MSN, RN, NE-BC, ACNO, Clinical Nursing Director, Heart & Vascular Institute and Critical Care. She adds that tiered huddles allow concerns from the bedside to be escalated the same day, with many issues resolved within 24 hours.

Tiered huddles were piloted at Cleveland Clinic’s main campus in January, followed by Cleveland Clinic Hillcrest Hospital in February. Since then, huddles have been rolled out to all regional hospitals, with a goal of bringing family health centers and institutes into the fold in the coming months.

“It’s a huge win for our teams,” Pengel says. “Caregivers are getting their concerns heard, and managers feel a sense of empowerment in resolving issues quickly. From a leadership perspective, it’s a timesaver.”



Focus on safety

“There is now a laser focus on safety, as every day we hear through these huddles what didn’t work well and what we could do better,” says Sue Collier, DNP, RN, NEA-BC, Vice President, Nursing, and Chief Nursing Officer at Hillcrest Hospital. “Issues are shared transparently, with the goal of learning quickly from each other. This really puts the focus on what we are doing clinically to support our patients and enable caregivers to provide the best quality care.”

Accountability

Pengel says tiered huddles create a different way to lead.

“I’m not constantly trying to follow up on issues. Everyone is bringing issues to one forum,” she says. “As a leader in a room with 10-15 managers, it forces me to delegate to make the follow-up happen. For some new leaders, observing an expert leader delegating responsibilities to others during

Tiered Huddle Structure

All huddles follow the same priorities:

- **Care for Patients** focuses on potential serious safety events, central line-associated bloodstream infections, catheter-associated urinary tract infection, *Clostridium difficile* infections, falls, clinical/nonclinical codes, other safety risks and patient experience.
- **Care for Caregivers** focuses on the caregiver experience.
- **Care for Organization** looks at occupancy rate, operating room volume/target, emergency department volume/target, transfers/target, crucial staffing issues, sitter cases and environmental safety.

Tier Participants:

Tiers 1-4 focus on hospitals:

Tier 1 Caregivers at the unit level and managers/supervisors

Tier 2 Managers and directors

Tier 3 Nursing directors and ACNO/CNO and Operations President, COO

Tier 4 President, COO, ACNO/CNO

Tiers 5 and 6 focus on the enterprise:

Tier 5 Hospital system presidents, COOs, CNOs and ECNO

Tier 6 CEO and Operations Council

ACNO Kim Hunter, DNP, MBA, RN, participates in tiered huddles that open the lines of communication from nursing staff up through executive management.

huddles provides a model they can replicate; it may be a growth opportunity in their leadership journey.

“Delegation in problem-solving forces accountability. The next day we ask managers and leaders about follow-up. The tiered huddle process empowers leaders who are peers and colleagues to perform at the top of their scope,” says Pengel.

She explains that Cleveland Clinic is continuing to refine the process, including the questions asked. An early discovery was that events have to be analyzed the same way at all levels to make an impact on quality and safety.

“We’re in the process of hardwiring those questions we ask each time to drill down to a root cause,” she says.

Email comments to notablenursing@ccf.org

BEST Practices

Testing Technology that Improves Patient Data Accessibility

Cleveland Clinic nurses are piloting technology that eliminates the need to print heart rhythm strips onto paper, saving time and improving patient care.

During the past year, nurses in the heart failure and stepdown units of the Heart & Vascular Institute have been using AirStrip ONE® technology. The technology is integrated into the Epic electronic medical record (EMR) system, alleviating the cumbersome manual process of printing and filing electrocardiogram rhythm strips.

Integrating technology

The AirStrip technology wirelessly transmits patient waveforms, allowing nurses and clinicians to view live streaming and historic patient waveforms. Nurses and clinicians can also easily select and capture a waveform, and then post it to a patient's EMR, where it can be viewed by all members of the patient's care team in real time, either on-site or remotely.

"Once it is in Epic, it's always accessible — even from a distance. Physicians can look at it from anywhere, so it really streamlines communication," says Jason Heiss, BSN, RN, a nurse manager of a cardiac progressive care unit who is testing the technology. He says it allows nurses to interpret the telemetry strips of their patient assignment (typically four to five patients) in about 10 minutes, making it more efficient than the previous workflow.

George Rouse, BSN, RN, another nurse manager on two cardiac progressive care units, says being able to quickly capture the data electronically encourages nurse compliance with recording rhythm strips. Previously, the central monitor printer was often in use when nurses were ready to obtain and assess rhythm strips. Waiting for the

printer meant less time for direct patient care and also led to failure to return later to input the data.

Cutting through the noise

AirStrip also is a valuable tool for the eCentral Monitoring Unit's (eCMU, which provides 24/7 cardiac telemetry monitoring for patients) monitor technicians to identify and prioritize patients at risk. Monitor technicians can quickly pull up the live patient monitor through AirStrip and communicate information to nurses caring for patients. Because each monitor technician is tuned in to patients with active problems, it reduces the general noise from multiple alarms that cause desensitization and "alarm fatigue."

"The eCMU leverages the AirStrip technology so we can manage critical alarms," says Laura Idzior, MBA, RN, NE-BC, Assistant Nursing Director, Miller Family Heart & Vascular Institute and Critical Care.

The AirStrip technology for posting strips to the EMR will be tested at additional locations throughout the Cleveland Clinic health system.

Email comments to notablenursing@ccf.org

Navigating Patients Through a Complex Care System

The right care in the right place at the right time

Cleveland Clinic is at the forefront of creating a model of care that optimizes the patient experience by connecting patients to the right care in the right place at the right time.

Cleveland Clinic's Quality Alliance Network Navigation Team was assembled in January to advocate for patients in an increasingly complex healthcare system. Navigation team members use relationships with primary care providers, home care nurses, and case managers at the payer level to connect patients with the services they need within the insurance network.

"It's a very new way to partner with insurance companies," says Program Manager Margaret M. Cole, MSN, RN, CCM, who leads a team of three lay navigators and three RN navigators. "This is a shift to a value-based care model that aims to optimize patients' status and improve their quality of life. When patients are satisfied with the care they receive, they may be more likely to proactively stay within Cleveland Clinic's system."

The concept was born out of a narrow network business growth strategy to design onboarding and navigation for Medicare and commercial patients new to Cleveland Clinic and/or cobranded insurance plans.

Mitigating risk

"We help patients get where they need to be," Cole says. "We help mitigate risk by making sure patients are registered correctly and are receiving care within their network versus care outside the network."

The care model, Cole says, links patients to in-network primary care providers to identify needs, interventions and services.

Cole calls the model patient-centric. Navigation team members help connect patients with physicians and services in their insurance network, facilitating appointments if necessary. The navigation team also serves as a liaison to insurance providers and nursing care providers. With information from the payers, the navigation team can work with nursing care providers to optimize a patient's benefits.

The team serves about 2,000 members in Cleveland Clinic's Medicare narrow networks (which limit choices of doctors and hospitals) and also patients in the commercial narrow networks — a population in which some are unmanaged patients who are not connected or aligned with a Cleveland Clinic primary care provider. The service is now expanding in more at-risk contracts.

A new frontier

Cole says the program is new and undefined, challenging navigators to use their highest level of judgment, be innovative and put their experience to work building relationships across different care venues.

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MAGNUS Program Nurtures and Empowers Nurses to Thrive at the Bedside

Celebrating nurses' contributions at the bedside

10

Clinical nurses who serve on the front lines of healthcare shoulder a great deal of responsibility caring for others. They plan and evaluate nursing care, coordinate care of multiple patients, provide patient education, and carry out usual care processes such as administering medications, monitoring patient conditions, maintaining records and communicating with multiple healthcare providers to ensure high-quality, safe patient care.

Yet too often, clinical nurses do not recognize their own clinical leadership potential or understand their crucial roles in leadership within the healthcare system.

The MAGNUS Experience, administered through Cleveland Clinic's Office of Advanced Practice, offers a unique opportunity for clinical nurses to participate in rich and thought-provoking discussions centered on uncovering each participant's leadership potential. Each nurse is challenged to "lead from the middle."

MAGNUS (formerly the LEAD Program) is a three-month professional enrichment experience. The Latin word *magnus*, which means "great" and "important," was selected to convey the scholarship that is required to explore contradictions in healthcare, and the meaning of and complexities in building relationships. The experience challenges nurses to read more, obtain certification and

become active members of their respective professional organizations. Mary Beth Modic, DNP, APRN-CNS, CDE, Clinical Nurse Specialist, Diabetes, Cleveland Clinic, designed the program and facilitates the course with other advanced practice colleagues.

"Rarely are clinical nurses afforded an opportunity to examine their profession and dream for the future," Dr. Modic says. "We want nurses at the bedside to revel in what they do. I want them to realize that one doesn't have to have a formal leadership position to impact care."

Transitions

The program was initially offered to assistant nurse managers, but Dr. Modic realized that the audience best suited for the experience was clinical nurses. Many of the participants do not have managerial aspirations but are seeking learning opportunities where they can be challenged intellectually and professionally and appreciated for their commitment to thriving at the bedside.

Over time, Dr. Modic expanded the course content to include more readings on topics that are essential for clinical leadership — communicating empathically, expressing appreciation and harnessing the science of stamina (through physical and mental nurturing) to remain resilient.



The MAGNUS Experience offers a unique opportunity for clinical nurses to participate in rich and thought-provoking discussions centered on uncovering each participant's leadership potential.

Pictured from left to right:
Nurses participate in a group discussion on shared experiences.

Louis Zamudio, RN, recounts a moment in his profession that impacted his outlook on nursing.

Kristen Petro, RN, writes about the people and experiences in nursing that shaped who she is today.

In one article that always surprises participants, the author points out Florence Nightingale's imperfections — she was difficult to work with and often took credit for others' ideas.

"They're stunned by that portrayal," Dr. Modic says. "But the article illustrates that we are all flawed, and it also provides reflections of the time in which we live."

In addition to the required reading list, group discussions are designed so that time is spent in small groups to accommodate those "individuals who may be hesitant to speak up in a large group, but amaze and enchant their colleagues with their opinions in small groups."

"Appreciative check-ins and checkouts" encourage empathy and foster relationship building. Participants get to know each other on a personal level and offer examples of what they appreciate in each other.

A popular exercise called "Stepping Stones" requires participants to select from a bowl of six stones in assorted sizes, colors, shapes and textures. Participants choose stones representing individuals who have been instrumental in their careers and share with others in their small groups the impact of these individuals on their formation and growth. Many participants shared the experience of reconnecting with individuals who had been instrumental and with whom they had lost touch.

"One nurse was nominated for a March of Dimes award," says Dr. Modic. "At the awards ceremony, accompanied by his parents, he called his former nursing professor and said, 'I want you to know that I would not be here without you.'"

Focus on clinical nurses

Most participants in MAGNUS are clinical nurses who work directly with patients. "The whole purpose of this experience is to cherish and challenge clinically based nurses," Dr. Modic says.

To reinforce the idea that clinical nurses are leaders, Dr. Modic is mentoring MAGNUS alumni to facilitate future cohorts.

"What better way to sustain the program than to mentor clinical nurses who embody that experience?" she asks. "They're living this work and can appreciate the challenges these nurses confront on a daily basis."

Dr. Modic adds that feedback she and the other facilitators have received about MAGNUS validates its intent. Many have expressed that the experience has been "professionally life-altering." This sentiment applies to the facilitators as well. "To have the opportunity to interact with such incredibly dedicated, curious and amazing nurses is a privilege beyond measure and a professional dream come true," she says.

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Dealing with Patients' Passing: Comfort Carts and 'The Pause'

Nurses champion new concepts in end-of-life care

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Cheryl Mooney, RN, holds a fleece blanket from a comfort cart, an initiative she developed with her team to help patients at the end of life.

After Cleveland Clinic Avon Hospital opened in 2016, its staff of seasoned nurses began noticing something different from their previous hospitals. Because of the community's older population and numerous skilled nursing facilities, Avon Hospital was caring for more patients at the end of life.

Death and dying was a recurring phenomenon — particularly in the ICU setting, where Cheryl Mooney, RN, (pictured here) set out to enhance care for end-of-life patients and their families. Inspired by an article that featured hospital staff who presented blankets to grieving families, Mooney envisioned a whole cart of comforting items.

Avon Hospital's nursing leaders encouraged Mooney to recruit members of the ICU Shared Governance team to make her cart a reality. The comfort cart was rolled out in Avon Hospital's ICU in early 2018.

In addition to the beverages and snacks found on standard “bereavement carts,” Avon Hospital’s comfort cart offers items of support donated by community groups and staff, including:

- Keepsake blankets tagged with the message “Wrap your loved one in warmth. Take it with you for comfort in the moments to come.”
- Meditation stones painted with inspirational words.
- Multicultural spiritual literature, books of prayer and meditation materials.
- Poems.
- Scented lotion for massaging a loved one’s hands.
- A CD player with music.
- Information about the dying process and its stages.
- Information on grief and bereavement counseling services, local support groups, and hospice care.
- The American Medical Association’s “Caregiver Self-Assessment Questionnaire” for caregivers dealing with feelings of loss and grief.

Relieving mental anguish

“Before comfort carts, nurses would provide support, but we had nothing tangible for comforting families,” explains Sara Novicky, BSN, RN, Nurse Manager, Critical Care and Step Down.

The effect of the comfort cart has been powerful.

Novicky remembers the daughter of one patient who, as a child, had collected rocks and proudly presented them to her parents. As an adult, when her father was removed from life support, she took meditation stones from the comfort cart and laid them on his chest. The symbolic gesture was moving for the family as well as the caregivers present.

“The cart and its contents have eased the spiritual and emotional adjustment associated with imminent death for everyone involved, including nurses,” says Jacquie Nowlin, DNP, MBA, RN, NEA-BC, Director of Nursing, Acute and Critical Care Services at Avon Hospital.

After testing the comfort cart, Mooney and her team applied for and received a grant to replenish the cart and to buy carts for other units, including Avon Hospital’s Emergency Department.

“Historically, in a critical care environment, providers were trained to accelerate treatments (to do everything possible) to maintain the life of clients,” says Chief Nursing Officer Mary Sauer, DNP, MBA, RN, NEA-BC. “Comfort carts offer a different type of patient- and family-centered care and help lessen the mental anguish and fatigue that are prevalent in a critically charged, fast-paced environment.”

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The Pause

Cleveland Clinic also introduced another innovation in end-of-life care: “The Pause” — a moment of silence and the reading of a special script at the bedside of a patient who has died — to honor a patient’s life and journey and recognize the efforts of caregivers.

The concept was developed at the University of Virginia Medical Center and was introduced to Cleveland Clinic clinicians and providers by a cardiology fellow in the Coronary ICU.

“I was amazed by how powerful it was for me as a caregiver,” says Clinical Nurse Specialist Debbie Klein, MSN, APRN, ACNS-BC. “It gave me time to honor the person who had just died.”

Klein became passionate about instituting The Pause throughout Cleveland Clinic and now co-chairs the Center for End-of-Life Care Pause Committee.

“Treating patients in their last hours can be an intense experience,” she says. “We need to remember to take care of ourselves as well as the patients in our care.”

Closure for caregivers

Although it is designed for caregivers, the patient’s family and loved ones are invited to participate in The Pause. Participation is voluntary for everyone and occurs as soon as possible after the time of death.

A physician or nurse leads The Pause with this suggested script:

“Let us take a moment to pause and honor [patient’s name]. He/she was someone who loved and was loved — was someone’s family member and friend. In our own way and in silence, let us take a moment to honor [patient’s name]. Let us also honor and recognize the care provided by our team.”

[15–30 seconds of silence]

“Thank you, everyone.”

Cleveland Clinic is in the process of placing cards with The Pause suggested script on all emergency carts in the health system. Cards are available in English, Spanish, Arabic, Russian, Mandarin and Cantonese.

Donielle Finding, MSN, MBA, RN, Assistant Nursing Director at Cleveland Clinic Medina Hospital, says The Pause provides closure, giving caregivers a moment to collect themselves before walking into another patient’s room.

Culture change

“So often, nurses’ interactions at the bedside become routine. But a death should never be routine,” says Novicky.

“Nurses may not realize the burden they carry when witnessing a patient’s death,” she says. “We used to just go about our business, but now comfort carts and The Pause are helping us cope in a healthier way.”

Email comments to notablenursing@ccf.org

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An Improved Model for Moving from the Emergency Department to an Inpatient Unit

A NEW ADMISSION UNIT AT CLEVELAND CLINIC'S MAIN CAMPUS ALLEVIATES GRIDLOCK IN THE ED AND STREAMLINES PATIENT CARE



In May, Cleveland Clinic's main campus opened an eight-bed inpatient admission unit (E17) within its Emergency Department (ED), designed to help alleviate issues faced by nearly all hospitals — extended patient length of stays and bottlenecks in the ED.

“We really want to make our ED as efficient as possible so patients spend the least amount of time there,” says Kimberly Hunter, DNP, MBA, RN, NEA-BC, Associate Chief Nursing Officer, main campus. “There are times when physicians decide to admit patients to the hospital, but the patients must stay in the ED waiting for a bed to open up on an inpatient nursing unit. Having an admission unit allows patients to be transferred from the ED before moving to a medicine unit.”

E17 serves new admissions coming into the hospital from the ED under the medicine service line. It is open on Mondays, Tuesdays and Wednesdays from 11 a.m. to 11:30 p.m. and staffed by an advanced practice provider, two full-time registered nurses, a nurse leader, a clinical technician and a health unit coordinator.

“Part of the beauty of E17 is that an advanced practice provider reviews the ED events and medical history of patients as soon as they come into the unit and writes the admission orders,” says Dr. Hunter. “Then nurses can immediately do an admission assessment, start the patient on different therapies and implement the ongoing plan of care — that all starts before the room on the regular nursing floor opens up.”

Building on the model established at a regional hospital

Cleveland Clinic Hillcrest Hospital piloted the concept of an admission unit near its ED. Opened in June 2017, the 10-bed West Center Admission Unit serves adults, including geriatric adults, requiring medical-surgical and progressive



Assistant Nurse Manager
James Durkalski, RN, completes
patient admission assessments in
the new admission unit.

care for a variety of diagnoses, including cardiovascular, gastrointestinal, metabolic, neurological, orthopaedic, pulmonary and renal conditions.

“After the admission unit’s implementation, patients’ ED length of stay was reduced by 30 minutes,” says Amy Berardinelli, DNP, RN, CPAN, NE-BC, Nurse Manager of the Surgery Center at Hillcrest Hospital.

Prior to opening the admission unit at Cleveland Clinic main campus, several nurse leaders visited the admission unit at Hillcrest Hospital. “We asked questions about patient flow, processes and what’s important to start a unit,” says Dr. Hunter.

One of the key priorities was having a dedicated advanced practice provider present in the admission unit at main campus.

“Immediate attention to meeting patient treatment needs is critical to patient-centric care, and a primary early goal

of moving patients from the ED environment,” says Josalyn Meyer, MSN, RN, NE-BC, Director of Nursing, Medicine and Endocrinology & Metabolism institutes. “There’s no delay in caring for very ill patients, because we have a provider available at all times.”

Meyer says nurses had a seat at the table for all decisions and “it truly felt like Nursing’s voice was heard.” For example, nurses offered suggestions on unit innovation, required equipment, hours of operation, different staffing patterns and collaboration with other disciplines, such as environmental services, transport and pharmacy.

Reaping benefits beyond shorter ED lengths of stay

The advantages of the admission unit extend beyond the unit’s initial purpose. “The original intent was to free up beds in the ED, but the trickle-down benefits have been very impactful on patient experiences,” says Meyer. “Since patients aren’t waiting in the ED for their inpatient admission, and since their care plan is initiated earlier in the hospital stay and continues when they are transferred

to the hospital unit, patients may be less anxious, and they receive meals and chronic care medications more quickly.” Family members benefit by receiving communication about the care plan earlier in the process. And clinical unit nurses benefit by having the workload of an admission essentially removed, allowing them to focus on implementing the plan of care.

Anecdotal feedback from both patients and unit nurses has been positive, and Cleveland Clinic will track metrics on patient experience and nurse satisfaction. Preliminary numbers show E17 is meeting its length-of-stay goal of three hours or less: As of the end of June, the average time from transfer into the admission unit to transfer to a medicine unit was three hours and four minutes.

“It’s so important that we have a good plan for the day because we are not open 24/7. It’s up to us to anticipate patient transfer out of the unit,” says Meyer. “We’ve not had a situation where the unit was ready to close and a patient was still occupying a bed, which speaks to our relationships and communication with fellow healthcare providers. The main campus admission unit is a well-oiled machine.”

Due to its success, there is discussion about extending the unit’s hours and adding more service lines, such as orthopaedics, digestive disease and cardiovascular medicine.

Email comments to notablenursing@ccf.org



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Research

Can Delaying the Newborn Bath Increase Breastfeeding?



Heather DiCioccio
DNP, RNC-MNN

Bathing a newborn just after birth has long been standard practice; however, a new Cleveland Clinic study found that waiting to bathe a healthy newborn 12 or more hours after birth increased the rate of

breastfeeding exclusivity during the newborn hospital stay.

Heather DiCioccio, DNP, RNC-MNN, Nursing Professional Development Specialist for the Mother/Baby Unit at Cleveland Clinic Hillcrest Hospital, led the study.

“We wanted to conduct research on this topic because more mothers were asking us not to bathe their baby right away,” Dr. DiCioccio says. They were reading on mom blogs that it was better to wait to bathe their baby the first time, since amniotic fluid has a similar smell to the breast — which may make it easier for the baby to latch.

“When we went to the literature to learn more about the link between delaying the first bath and breastfeeding exclusivity, we learned that data were scarce — we found only one study in the published literature,” she says. DiCioccio knew that for a new standard of care to take hold, she and her team would need rigorous data.

Study design and results

Beginning in April 2016, nurses at Hillcrest Hospital’s Mother/Baby Unit began delaying the first bath for healthy newborns until at least 12 hours post-birth, with a goal of reaching 24 hours. After three months, they compared post-practice-change data with data from February 2016 (prior to practice change). The two data sets comprised about 1,000 mother/baby couplets.

Breastfeeding exclusivity increased significantly when post-practice change was compared with pre-practice change. The effect was stronger in mothers who delivered vaginally, compared with those who delivered by C-section.

Staff and family reactions

“When the practice change began, some nurses resisted making the change,” Dr. DiCioccio says. Their resistance lessened once they saw how much parents liked it. “The staff really took ownership of the process and made it their standard.”

“It is now our policy to delay the bath at least 12 hours, unless the mom refuses to wait. In that case, we ask for two hours,” she says.

Dr. DiCioccio and her team are pursuing publication of the study and hope it spurs more research and ultimately changes the practice nationwide.

Email comments to notablenursing@ccf.org

Why Does Delaying the First Bath Increase Breastfeeding?

The answer is unclear, but research findings (Cleveland Clinic’s and that of others) point to a few factors:

- **Skin-to-skin time:** “By not bathing babies, there is more skin-to-skin time with mom, so that can play a role,” Dr. DiCioccio says.
- **Smell:** The similarity in smell between the amniotic fluid and the breast may encourage babies to latch.
- **Temperature:** Babies in DiCioccio’s post-practice-change group were more likely to have stable/normalized temperatures post first bath. They weren’t as cold as pre-practice-change babies after their first bath, so they weren’t too tired out to nurse,” she says.

Simulation Research Helps Patients Learn to Avoid Falls at Home

A Cleveland Clinic Hillcrest Hospital nursing team's study on the effect of simulation education on fall risks resulted in delivering routine patient education on fall risk prior to discharge.

Falls are the No. 1 injury for U.S. geriatric patients, and the leading cause of fractures and death in the elderly, according to Nancy DeWalt, BSN, RN, PCCN, NE-BC.

"Hospitals do many things to prevent patient falls, such as having patients wear skid-resistant socks and having nurses post signage that warns the healthcare team about fall risk. But after we looked into fall risks further, we realized that we did not educate patients on how to be safe once they go home," says DeWalt, lead researcher on the study.

After attending a research-education program on simulation education, DeWalt worked with her team and the hospital's engineering department to convert a sleep study suite into a temporary (two years) simulation classroom.

The classroom had a bedroom and bathroom — two of the most common places for falls — complete with potential fall hazards, including a lip on the shower, throw rugs, oxygen tubing on the floor and a nightstand too far from the bed.

Study design

Ninety patients who were hospitalized after a fall event were divided into two groups to receive education on potential fall hazards in the home: (1) written handout or (2) simulation delivered in the temporary classroom. Before and after the education, members of both groups answered test questions based on pictures of fall hazards in a bedroom and bathroom. Following discharge, participants were tracked at two weeks and three months to learn about changes made in tripping hazards and about new fall events and rehospitalizations.

Both education methods (handout and simulation) helped participants better identify potential fall risks on the test (post-vs. pre-education), and there was no statistically significant difference

in scores between groups. Post-discharge, a 10 percent difference between groups was identified, favoring the simulation group, in sustainably reducing fall risks in the home. Additionally, the number of hospital readmissions due to falls during this time (fall rate) was 15 percent lower in the simulation group, although this was not a statistically significant rate of difference between groups.

DeWalt concluded that both groups benefited from fall risk education and that simulation may be an effective teaching method for some patients, but more research is needed with a larger sample size.

Next steps

Nonlicensed nursing personnel now use a series of photos, based on the simulation room used in the study, to provide short education sessions with patients ready to be discharged. DeWalt joined Cleveland Clinic's enterprisewide Falls Committee and will present the study findings to other hospitals and home health agencies in the health system.

Email comments to notablenursing@ccf.org



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Awards and Honors

K. Kelly Hancock, DNP, RN, NE-BC, Executive Chief Nursing Officer, Cleveland Clinic health system, was named to *Crain's Cleveland Business* Notable Women in Healthcare 2018.

Nancy Albert, PhD, CCNS, CHFN, CCRN, NE-BC, FAHA, FCCM, FHFS, FAAN, Associate Chief Nursing Officer, Office of Research and Innovation, Cleveland Clinic health system, and Clinical Nurse Specialist, Kaufman Center for Heart Failure, Heart & Vascular Institute, was elected to the Heart Failure Society of America Executive Board as secretary. The organization also awarded Dr. Albert the 2018 Nursing Leadership Award for her contributions to improving the care of patients with advanced heart failure. She is the first past president of the American Association of Heart Failure Nurses and is on the leadership team for the Council of Cardiovascular and Stroke Nurses of the American Heart Association.

Esther I. Bernhofer, PhD, RN-BC, CPE, was named to the American Society for Pain Management Nursing (ASPMN) Board of Directors.

Kathleen Burns Mau, DNP, APRN, ACCNS-AG, ACNS-BC, CEN, was recognized as America's Best Nurse by the American Health Council for her outstanding contributions to the nursing field. Dr. Mau is the Senior Director of Nursing Education for Cleveland Clinic.

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