Cleveland Clinic

Notable NURSING

The Stanley Shalom Zielony Institute for Nursing Excellence

SPRING 2019

Smooth Operations

An inside look at perioperative nursing and training at Cleveland Clinic

p. 8

Dear Colleagues and Friends,

Nursing is a critical component of Cleveland Clinic's ability to carry out its mission to create the best place for healthcare delivery and the best healthcare workplace. In this issue are examples of our four cornerstones of care: Caring for Our Patients, Caregivers, Organization and Community.

Every spring our annual Patient Experience Summit showcases exceptional efforts to generate and exchange ideas, strategies and practices to improve and sustain a quality patient experience. In its 10th year, the focus will be on technology as we more deeply explore how healthcare must extend empathy into an increasingly digital environment to better care for our patients. We are excited to be partnering with the Healthcare Information and Management Systems Society on this year's summit as we welcome attendees and speakers from across the country.

You can reach us any time at **notablenursing@ccf.org**. I look forward to hearing from you.

K. KELLY HANCOCK, DNP, RN, NE-BC
Executive Chief Nursing Officer, Cleveland Clinic health system
Chief Nursing Officer, main campus

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Q: What are Cleveland Clinic's four cornerstones of care?

A: Caring for Our Patients, **Caregivers**, **Organization** and **Community**. These care priorities help keep our focus on caring for patients as if they are our own family, treating fellow caregivers as if they are family, maintaining our commitment to the communities we serve, and treating the organization as our home.

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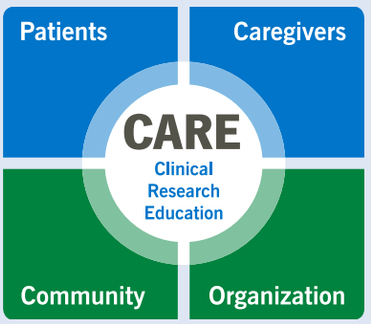
On the cover: Perioperative nurse Monia Blue, RN, Surgery Resident I, performing a count of the instruments before a surgical procedure.



Earning Magnet Recognition Requires the Right Culture and a Strong Commitment to Nursing Research

FIVE CLEVELAND CLINIC HOSPITALS HAVE ACHIEVED THIS CREDENTIAL

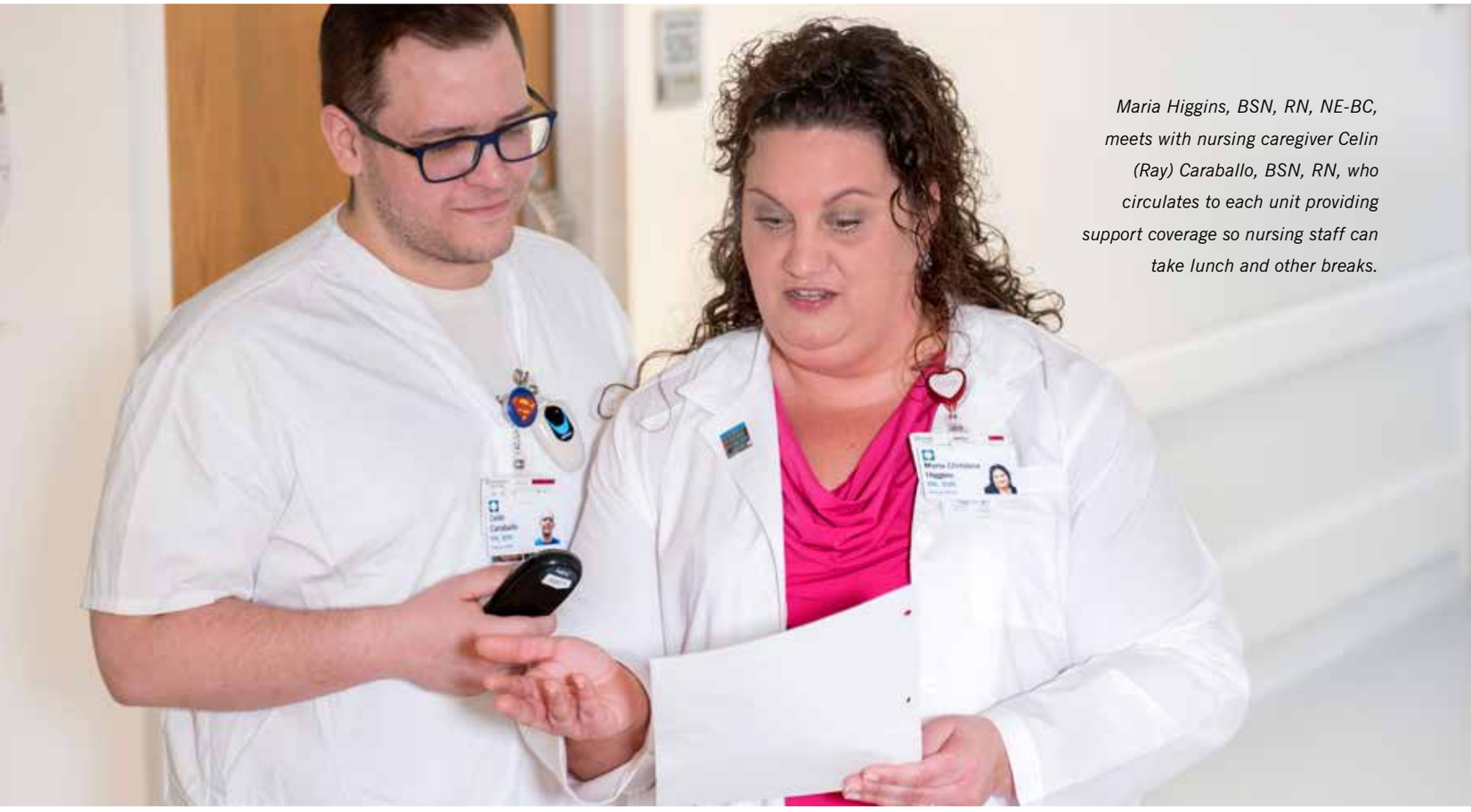
When Janet Schuster, DNP, MBA, RN, NEA-BC, CPHQ, HACP, Chief Nursing Officer at Cleveland Clinic Lutheran Hospital, learned in December 2018 that her staff was applying for Magnet® status, she was both excited and apprehensive.

Only about 10 percent of hospitals in the United States have Magnet status awarded by the American Nurses Credentialing Center (ANCC). The credential is a sign of nursing excellence and requires that hospitals satisfy a set of criteria designed to measure the strength and quality of their nursing program.

"It's a big undertaking," says Schuster. "We're a small hospital. We have 100 inpatient psychiatric beds and 100 medical-surgical beds."

Hospitals that earn the Magnet credential are superior in that they have a culture of safety and high quality that translates into better outcomes. For example, in a 2010 study, Magnet-designated hospitals had a 10.3 percent lower fall rate than non-Magnet hospitals. Since each patient fall costs hospitals an estimated $35,000, in this example, lower fall rates were associated with costs savings. In the same study, authors found Magnet hospitals had significantly better outcomes for patient mortality, nurse safety, nurse burnout and patient satisfaction.[1]

Maryann Kaczor, RN (ambassador), and Christine Konopinski, LPN, discuss the Magnet journey.



Maria Higgins, BSN, RN, NE-BC, meets with nursing caregiver Celin (Ray) Caraballo, BSN, RN, who circulates to each unit providing support coverage so nursing staff can take lunch and other breaks.

THE PROCESS

Applying for Magnet status takes a team of nurses months of hard work that requires evidence of excellence in nurse satisfaction, patient satisfaction and clinical outcomes, such as two years of data showing low rates of patient falls and hospital-acquired pressure ulcers.

The process begins with the submission of an electronic application. Next, the applicant submits written documentation that demonstrates qualitative and quantitative evidence regarding patient care and outcomes. If scores from the written documentation fall within a range of excellence, ANCC representatives schedule an on-site visit to thoroughly assess the applicant. After this rigorous review, the Commission on Magnet analyzes the completed appraisal report and votes to determine whether Magnet recognition will be granted.

Having good outcomes alone is not enough, says Sheila Miller, DNP, MBA, RN, NEA-BC, Chief Nursing Officer for Cleveland Clinic Akron General. Until recently, Miller was the Chief Nursing Officer for Cleveland Clinic South Pointe Hospital, which received its first Magnet designation a little more than a year ago.

"As you work through the process of achieving Magnet status, you're looking at having the right environment and the right outcomes," she says. "Everyone does a gap analysis to see if they are not meeting certain standards, but it's really so much more. You need to have a professional nursing practice that demonstrates good outcomes."

STORIES OF EXCELLENCE

Documentation for the Magnet process is broken down into four categories: transformational leadership, structural empowerment, exemplary professional practice, and new knowledge, innovation and improvements. Within those categories, the team must include a description of the organization, the settings in which registered nurses practice, actions taken by nurses to support patient care, research projects, and the CNO's job description and resume.

At Lutheran Hospital, in order to illustrate **exemplary professional practice**, Schuster and her team will include a recently created narrative describing how nurses developed a multidisciplinary treatment plan for a psychiatric patient with acuphagia — a rare disorder that causes the sufferer to eat sharp objects.

To illustrate **transformational leadership**, they'll describe how a nursing director came up with the idea of having a nursing caregiver go to each unit to support coverage so that the nursing staff could take lunch and other breaks. They will also explain how the nursing units gave up a portion of their budgeted direct hours in small increments to pay for this additional position.

And to illustrate **structural empowerment**, they'll write about the hospital's shared governance committee, where nurses are involved in decision-making and feel comfortable bringing forth ideas to improve care.

"We have teams that are very active in writing these stories or in reminding the writing team of the many activities and outcomes previously achieved," says Schuster. "I have a Magnet ambassador for each area. That's how we're building excitement for this from the top down."

GREATER EMPHASIS ON RESEARCH

In its most recent evaluation of Cleveland Clinic main campus, ANCC officials noted it will be elevating nursing-led research as a necessary component of Magnet to promote new knowledge, innovation and improvements. "The idea is to get nurses at all levels of the organization involved in research for the betterment of patient care," says K. Kelly Hancock, DNP, RN, NE-BC, Executive Chief Nursing Officer for Cleveland Clinic health system, and Chief Nursing Officer for Cleveland Clinic main campus.

Cleveland Clinic already has a robust nursing-led research program. Five nurse scientists with PhDs serve as mentors to nurses interested in research, and the mentor team is supported by resources that include a budget for educating nurses, statistical analysis, internal grants for literature review of current evidence, nurse-led research and writing for publication.

"Typically nurses come to us with an idea or a clinical problem," says Sandra Siedlecki, PhD, RN, CNS, senior nurse scientist, Office of Nursing Research and Innovation. "We help them understand the issue and brainstorm with them to arrive at a focused question that can be addressed through research."

The team at Lutheran Hospital found that the area of research was lacking and contacted the Office of Nursing Research and Innovation. Soon they had two studies in the works — one on psychiatric patient acuity, measuring the intensity of nursing care required by a psychiatric patient, and a second examining the effect of postoperative laxatives on constipation.

"With that piece of the puzzle in place," Schuster says, "I'm confident that we'll have the application in by October 2020."

Email comments to **notablenursing@ccf.org**

1 *Lake ET, Shang J, Klaus S, Dunton NE. Patient falls: Association with hospital Magnet status and nursing unit staffing. Res Nurs Health. 2010;33(5):413-25. doi: 10.1002/nur.20399.*

FIVE Cleveland Clinic hospitals have achieved the distinguished Magnet recognition:

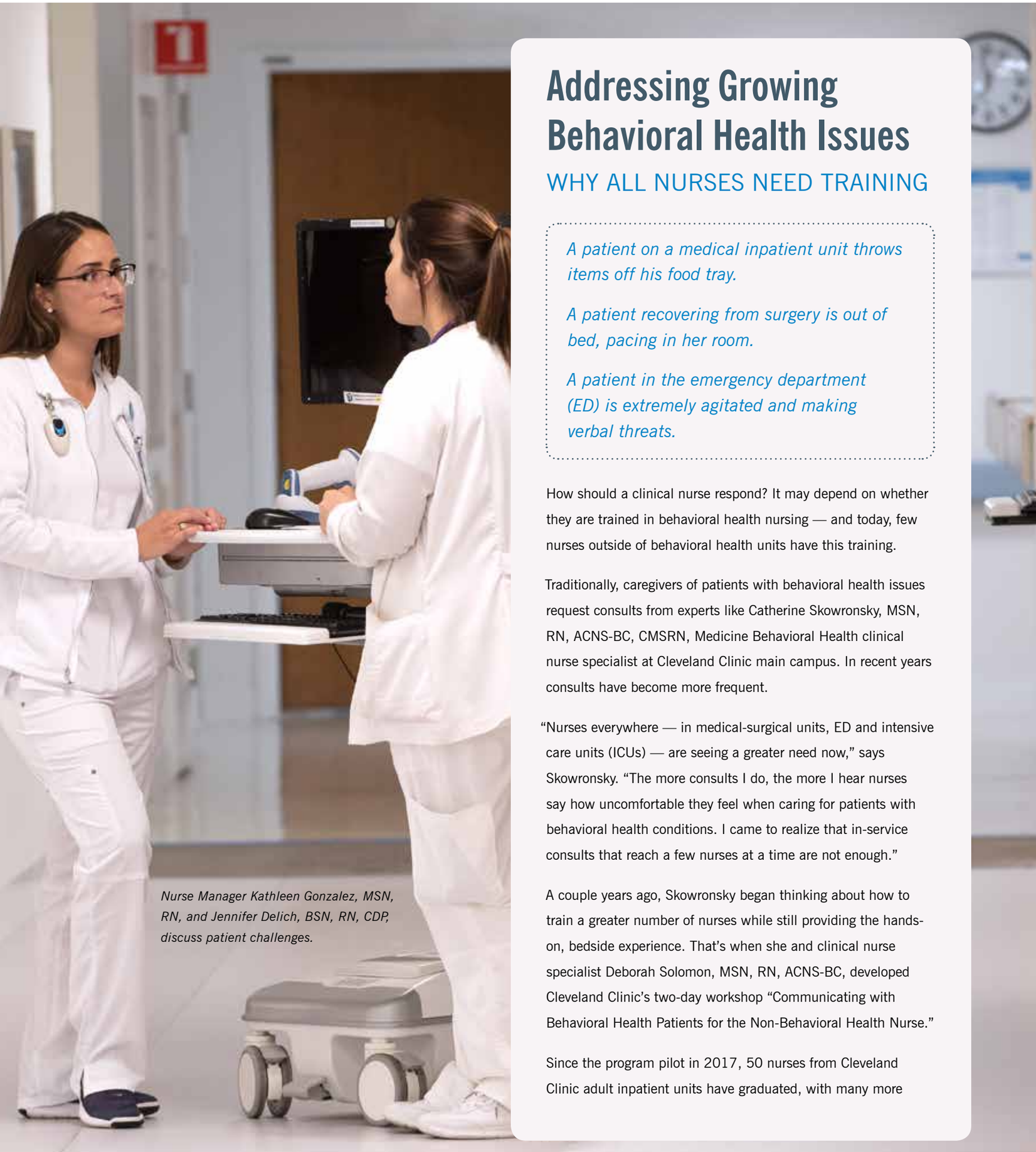
Cleveland Clinic main campus has been recognized as a Magnet organization since 2003.

Fairview Hospital achieved Magnet status in 2009.

Akron General achieved Magnet status in 2013.

Hillcrest Hospital achieved Magnet status in 2014.

South Pointe Hospital achieved Magnet status in 2017.



Nurse Manager Kathleen Gonzalez, MSN, RN, and Jennifer Delich, BSN, RN, CDP, discuss patient challenges.

Addressing Growing Behavioral Health Issues

WHY ALL NURSES NEED TRAINING

A patient on a medical inpatient unit throws items off his food tray.

A patient recovering from surgery is out of bed, pacing in her room.

A patient in the emergency department (ED) is extremely agitated and making verbal threats.

How should a clinical nurse respond? It may depend on whether they are trained in behavioral health nursing — and today, few nurses outside of behavioral health units have this training.

Traditionally, caregivers of patients with behavioral health issues request consults from experts like Catherine Skowronsky, MSN, RN, ACNS-BC, CMSRN, Medicine Behavioral Health clinical nurse specialist at Cleveland Clinic main campus. In recent years consults have become more frequent.

"Nurses everywhere — in medical-surgical units, ED and intensive care units (ICUs) — are seeing a greater need now," says Skowronsky. "The more consults I do, the more I hear nurses say how uncomfortable they feel when caring for patients with behavioral health conditions. I came to realize that in-service consults that reach a few nurses at a time are not enough."

A couple years ago, Skowronsky began thinking about how to train a greater number of nurses while still providing the hands-on, bedside experience. That's when she and clinical nurse specialist Deborah Solomon, MSN, RN, ACNS-BC, developed Cleveland Clinic's two-day workshop "Communicating with Behavioral Health Patients for the Non-Behavioral Health Nurse."

Since the program pilot in 2017, 50 nurses from Cleveland Clinic adult inpatient units have graduated, with many more

requesting training. In 2019, the workshop will be available to all nurses across Cleveland Clinic's health system.

GROWING NEED

Nearly 1 in 5 U.S. adults lives with a mental illness, according to the National Institute of Mental Health. Based on research findings, these individuals are more likely to have chronic conditions and a greater symptom burden than those without a mental illness. It's not so much if, but when, nurses outside of behavioral health units will care for patients with a mental illness, says Skowronsky.

At Cleveland Clinic Marymount Hospital, Chief Nursing Officer Barbara Zinner, DNP, MSN, RN, NE-BC, CENP, says vulnerable populations with behavioral health issues are more often seeking care in the ED.

"They're not necessarily coming in for psychiatric issues, but for other conditions," she says. "When they're not cleared to go to a psychiatric floor, they are transferred to a med-surg unit or ICU. Especially with today's opioid crisis, we've had patients placed on ventilators who exhibit disruptive behavior when coming out of a drug overdose."

The opiate epidemic is just one of the reasons there is a need to increase behavioral health training, says Karen Hogan, DNP, RN, NE-BC, Director of Behavioral Health at Marymount Hospital. Cultural stressors and more stringent criteria for hospitalizing patients on behavioral health units further underscore the need for training.

And caregivers shouldn't assume that behavioral health issues affect only patients already diagnosed with a mental illness, says Janet Schuster, DNP, MBA, RN, NEA-BC, CPHQ, HACP, Chief Nursing Officer at Cleveland Clinic Lutheran Hospital. "Any patient coming in could experience anxiety requiring caregivers to have mental health awareness," she says.

BEYOND CONSULTS

Lutheran and Marymount hospitals offer cross-training between behavioral health and other medical units (often through in-service support) and prepare nurses with de-escalation training. Skowronsky's and Solomon's two-day workshop goes deeper:

- **Day 1** features four hours of didactic learning. Cleveland Clinic experts in social work, psychiatry and psychology give interactive presentations on behavioral health conditions and care practices.
- **Day 2** has nurses interacting with standardized patients in Cleveland Clinic's simulation center. In groups of five to seven, nurses encounter patients with schizophrenia, substance use disorder and manipulative disorder/borderline personality traits. Patients portray behaviors that make essential care activities more challenging (e.g., hiding under a blanket when given medications).

"We use a stop-and-go format, taking breaks during each scenario to discuss the thoughts and feelings of the participants, observers and even the patients," says Skowronsky. "We gather feedback and then start again, maybe with a different participant taking over."

ESTABLISHING TRUST, SETTING LIMITS

Nurses learn that when dealing with patients with behavioral health issues, establishing a relationship is paramount. "Patients need to trust that nurses are working for their good," says Skowronsky. In addition, nurses learn the therapeutic value of setting limits.

"In nursing school, you're taught to comfort patients and be caring at all times," says Skowronsky. "But from a behavioral perspective, the best care is sometimes telling patients when their behavior is inappropriate, like when a patient throws something at you. We don't just pick up the item and go on as if it didn't happen. We say, 'Throwing things is not acceptable. I want to listen to what you have to say and understand how you're feeling.'"

> "We know training is successful when nurses are more comfortable walking into patients' rooms..."
>
> *– Catherine Skowronsky, MSN, RN, ACNS-BC, CMSRN*

Nurses also learn tactics for protecting themselves, such as standing within easy access to an exit when talking with an agitated patient, and proactively calming a patient who shows signs of rising stress.

"Keeping patients and caregivers safe is equally important," says Zinner.

Skowronsky says the right training can help nurses feel better prepared to provide the proper care. "We know training is successful when nurses are more comfortable walking into patients' rooms, and they feel confident that they can meet patients' needs," she says.

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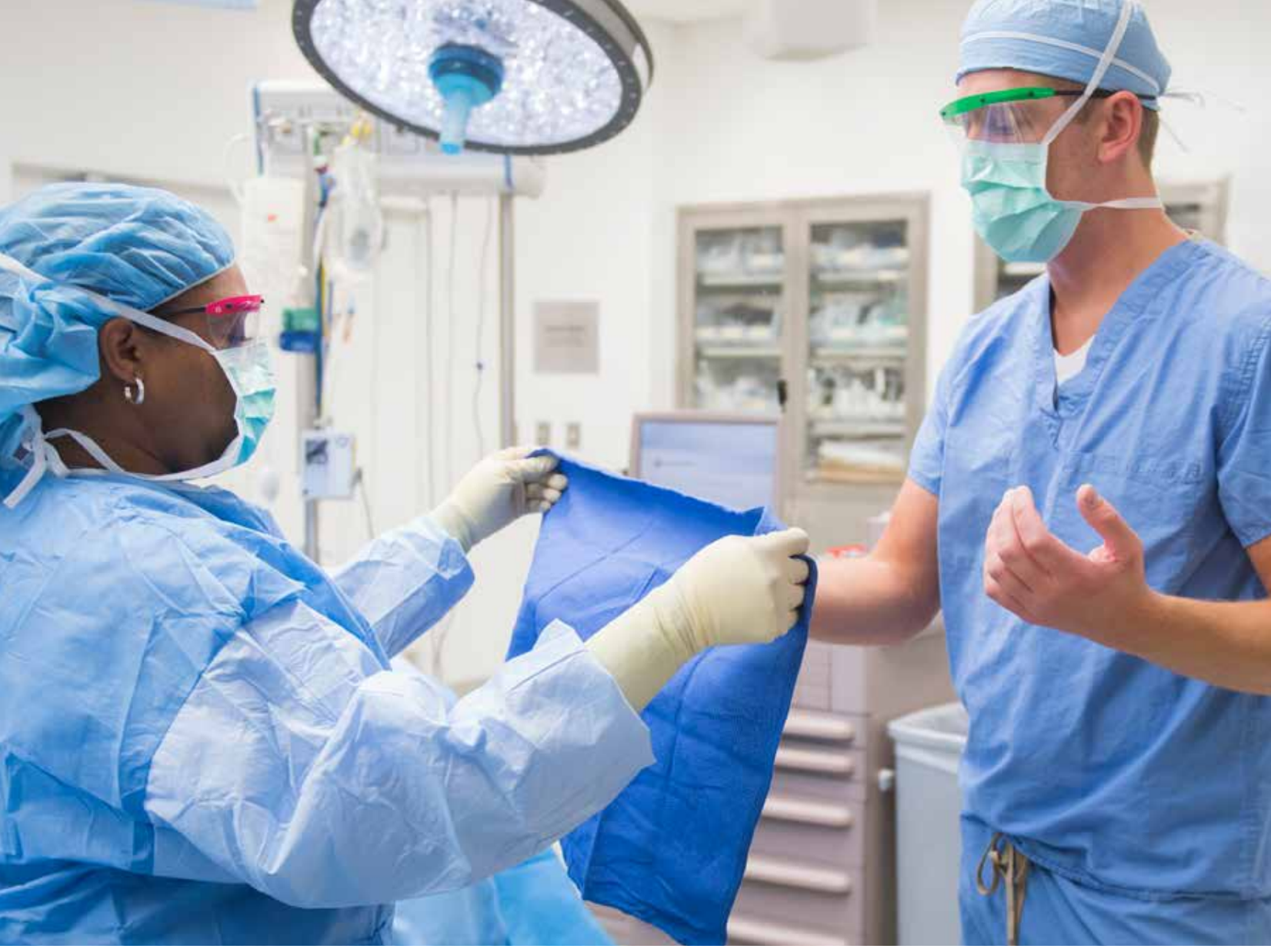


Smooth Operations

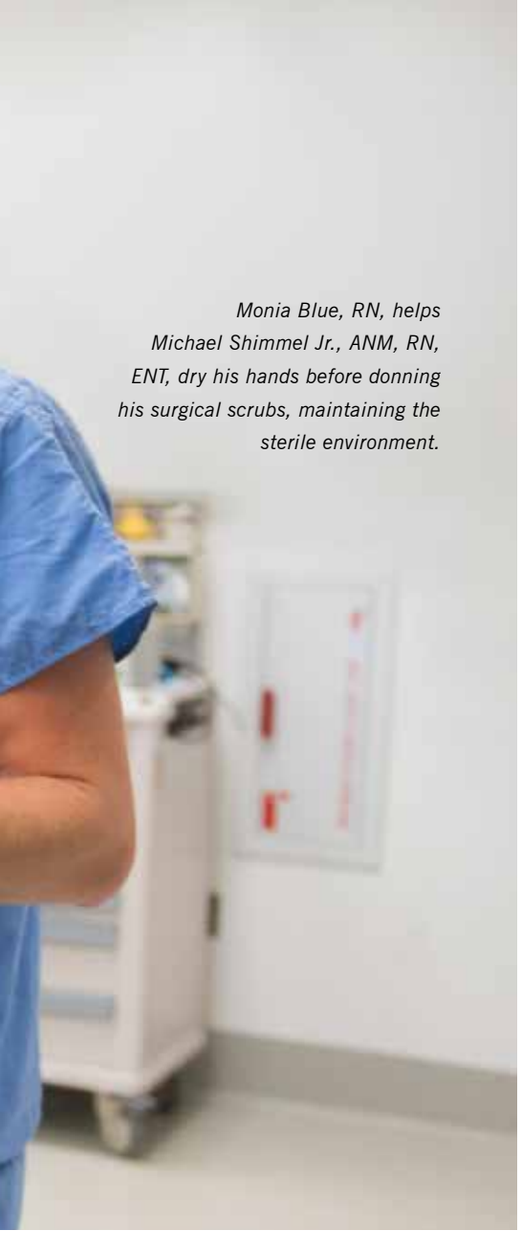
AN INSIDE LOOK AT PERIOPERATIVE NURSING AND TRAINING

In 2018, organ transplant surgeries at Cleveland Clinic reached record-setting levels, with a 24 percent increase in solid organ transplants compared to 2017.

"Every time you do a transplant, it's one of the most amazing things you can be part of," says Meghan Glanc, MSN, RN, CNOR, a nurse manager for cardiac, thoracic and pediatric congenital heart surgery at Cleveland Clinic main campus. "Watching somebody come in gray and struggling to breathe and then giving them the gift of this new organ is so powerful. It's such a beautiful experience."

Transplants are just one of a multitude of surgeries done by surgical teams at Cleveland Clinic, where more than 216,000 surgical procedures were performed in 2018. Surgeries range from appendectomies to aortic valve replacements, from life-saving craniotomies to life-enhancing abdominoplasties. Perioperative nurses are part of the Cleveland Clinic Nursing Institute, and they are integral members of each surgical team within Cleveland Clinic's clinical institutes, where the focus is on safety and optimal outcomes.

"Part of the secret to our success is that perioperative nurses partner closely with all members of our interprofessional team," says Carol Pehotsky, DNP, RN, NEA-BC, ACNS-BC, CPAN, Associate Chief Nursing Officer of Surgical Services for Cleveland Clinic. "Nurses who choose to work in the surgical setting are detail-oriented, energetic, technologically savvy and flexible. They have to be as they react to unanticipated emergencies every day, facing some of the most challenging cases and evolving situations."



Monia Blue, RN, helps Michael Shimmel Jr., ANM, RN, ENT, dry his hands before donning his surgical scrubs, maintaining the sterile environment.

Pehotsky started her nursing career on a medical-surgical unit and moved to perioperative nursing in 2005. "It's action-oriented. A patient has a problem, and we're going to do everything in our power to fix it. It's exciting."

PATIENT ADVOCACY AND SURGICAL INNOVATION

Cleveland Clinic's perioperative nurses work in preoperative, operating room and post-anesthesia care units (PACU) within our hospitals and outpatient centers. They serve as the liaison with patients and families.

"We are truly patient advocates when they don't have a voice to speak for themselves," says Mary Szostakowski, MSN, CNOR, Nurse Manager of Urology and Gynecology operating rooms at Cleveland Clinic's main campus. "As a surgical nurse, it's all about giving people better function or a better life, or fixing a problem."

"What an amazing gift to be part of patients' lives when they are so vulnerable — to protect them and keep them safe. It's such a special gift to be their advocates," says Glanc.

"Sometimes patients are here for those rare and unusual surgeries that nobody else has done," says Pehotsky. "But sometimes patients come to Cleveland Clinic for our reputation, even when they're having a common procedure — for example, a hip replacement — or because they have comorbidities that necessitate a high level of care."

High-profile surgical cases are not uncommon. For example, a surgical team from the Head & Neck Institute performed the first near-total face transplant in the country in 2008. Then in 2017, the Dermatology & Plastic Surgery Institute led Cleveland Clinic's first total face transplant. In 2011, a surgical team from the Sydell and Arnold Miller Family Heart & Vascular Institute performed the nation's first transcatheter valve replacement and repair. In 2016, a Cleveland Clinic surgical team in the Ob/Gyn & Women's Health Institute performed the first uterus transplant. And the innovations continue.

Every day at Cleveland Clinic's Heart & Vascular Institute, up to 36 cases can be scheduled in 21 surgical suites at the No. 1 hospital for heart surgery since 1994 (*U.S. News & World Report)*. "We care for the most complex heart cases in the world, and we have to be ready for anything," says Glanc. "It keeps your adrenaline flowing."

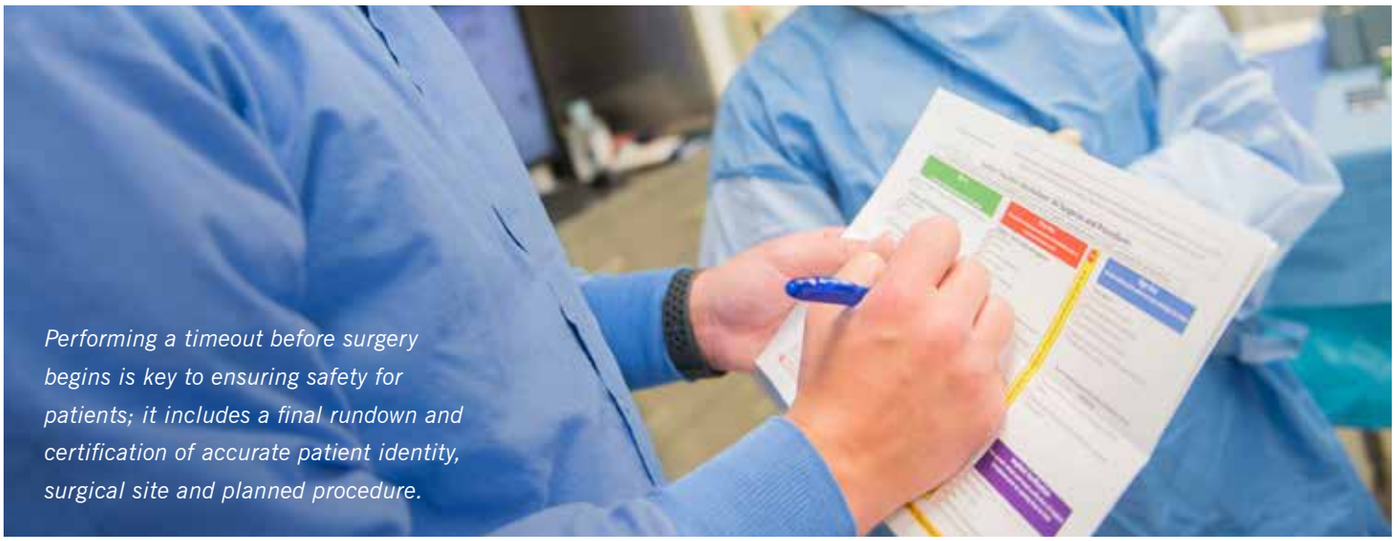
ROBOTIC SURGERY

Last fall, OR nurses on Szostakowski's Urology team were among the first in the country to use the da Vinci SP® single port robotic surgical system (Intuitive Surgical Inc.). Many surgical robots utilize three or four arms, but this system uses only one 2.5-centimeter cannula. The benefits to patients are tremendous. For example, a patient can have a prostatectomy with just one incision around the belly button and can often be discharged the same day.

Szostakowski sent her assistant nurse manager and robotics coordinator to specialized training on the da Vinci SP. Then, they worked alongside representatives from the company to train other Cleveland Clinic nurses at main campus to assist in procedures using the equipment.

> "We are truly patient advocates when they don't have a voice to speak for themselves."
>
> – *Mary Szostakowski, MSN, CNOR*

Pehotsky says with advances in robotic surgery expected to continue, Nursing added the unique role of a perioperative robotics coordinator. This new role involves arranging schedules, coordinating equipment usage, and ensuring that nurses and surgical technicians are trained and competent to



Performing a timeout before surgery begins is key to ensuring safety for patients; it includes a final rundown and certification of accurate patient identity, surgical site and planned procedure.

interact with the highly complex machines and surgical instruments. Looking to the future, the coordinator will ensure nurses at all Cleveland Clinic locations, along with their surgeon colleagues, have access to needed education on emerging robotic technology.

TRAINING FOR THE FAST PACE

With perioperative nursing removed in large part from most nursing school curriculums, Pehotsky says Cleveland Clinic has implemented a number of programs to enhance understanding and to provide the breadth of training necessary.

Cleveland Clinic requires both experienced nurses and new graduates to participate in its six-month Perioperative Nurse Residency. The program is tailored to new hires' needs based on experience level and includes time in the classroom, simulation lab and live surgical suites.

Nurses learn how to circulate and scrub for a variety of procedures. "Our nurses and surgical technicians learn the types of procedures they assist in at a particular hospital, but they also learn a little bit of everything with the understanding that they may need to assist in any procedure," Pehotsky explains. "Teaching our nurses multiprocedural skills helps our staffing to be more flexible, and provides them the hands-on experience with surgical instruments to aid in their critical thinking when they are circulating."

Perioperative nurse associate externship — This is a subset of the successful nurse associate externship. Nursing students entering their senior year of nursing school can participate in perioperative clinical experiences to provide them with an in-depth "insider's view" of the technical skills required, as well as the unique aspects of advocacy and safety that are core to perioperative nursing.

Robust observational experiences — Perioperative leaders partner with nursing schools to open their doors to student observers. The program includes matching students with circulating nurses who can show them the unique roles of perioperative nurses in the OR.

Perioperative residency — The perioperative nurse residency is centralized at Cleveland Clinic to provide all perioperative RNs the opportunity to learn, and be supported, as a cohort. Offered several times a year, the nursing cohorts spend one to two days each week with the Perioperative Education Department to learn "bite-sized" amounts of information in didactic and lab settings. Residents spend the remainder of each week with a preceptor in their own hospital setting, applying what they have learned.

WHAT MAKES THE PROGRAM UNIQUE

Beginning in 2012, Cleveland Clinic changed the format of its residency program. Rather than front-loading classroom content followed by OR application, the program is now a blend of classroom and lab-based learning. Each week, students return to the OR to apply what they've learned under the watchful eye of their preceptor. Nurses build on skills. "It has accelerated their learning," says Pehotsky. "We are able to accomplish in six months what used to take 12, and we have found that the program increases their confidence in their skills."

COLLABORATION WORKS

Surgery at Cleveland Clinic is "a well-oiled machine," says Pehotsky. "We participate in really cool high-tech care, but we're also pushing the envelope in terms of teamwork."

Nurses are valued members of the surgical team, given the same respect as surgeons and anesthesiologists.

Last May, surgical teams at main campus implemented interprofessional huddles as part of enterprise development of the huddle process. Everyone who supports the patient — from surgical ops leadership to representatives from surgical supply — meets each morning to review the day's cases and ensure they are ready to proceed. Huddle content helps the team head off problems, even small ones. For instance, at a recent huddle, a nurse mentioned that her team needed a specialized surgical table for an afternoon case. A nurse manager chimed in that she knew where one was and called the OR to deliver it. "Instead of making several phone calls, the problem was solved in 30 seconds," says Pehotsky.

It's all about providing quality care to patients for a short time and often while they are under anesthesia. "It's different than being a clinical unit nurse," says Pehotsky. "Nurses choose perioperative nursing knowing that they're not going to get a chance to interact very much with patients, but at the end of the day you are doing something really special."

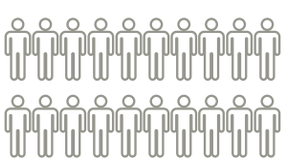
Interestingly, Pehotsky notes that perioperative nurses are the fastest-aging demographic across the country, with up to 65 percent of all perioperative nurses retiring by 2022, based on the Association of Perioperative Registered Nurses statistics. "At Cleveland Clinic, we are working hard to make sure our perioperative nurses have a solid base of training, and we hope that the dynamic and varied environment keeps them engaged for many years to come."

Email comments to **notablenursing@ccf.org**

SURGICAL SERVICES AT A GLANCE

244
Total Number of ORs throughout Cleveland Clinic (in the U.S.)

216,301 = **153,963** + **62,338**
Surgical Cases in 2018 — Outpatient — Inpatient



2,000+
Number of Perioperative Nurses

Visit clevelandclinic.org/notable and click on the "Notable Nursing" tab to add yourself or someone else to the mailing list, change your address or subscribe to the electronic form of this newsletter.

Nursing Plays Critical Role in Addressing Opioid Crisis

EDUCATION, ADVOCACY HELP NURSES IN GRASSROOTS EFFORTS

In the face of the opioid crisis gripping the nation, nurses are taking on initiatives to educate themselves, advocate for their patients, and change perceptions surrounding addiction.

Nurses are often the first point of contact for patients seeking support for substance use disorders, which are often the result of prescription medications for pain or surgery. Their skill in navigating the healthcare system, combined with their ability to serve as compassionate patient advocates, makes nurses critical in addressing the opioid crisis.

According to the National Institutes of Health (NIH), more than 47,000 Americans died of opioid overdose in 2017. More than 50 million people suffer from chronic pain — half of those with daily chronic pain — and more than 2 million have an opioid disorder.

JOINING THE FIGHT

In 2015, Cleveland Clinic launched a leadership opioid task force. Cleveland Clinic Nursing Institute's Legislative and Health Policy Council did the following:

- Helped develop alternatives to pain medication.
- Advocated for a new law to make naloxone more widely available.
- Formed a speakers bureau to provide community education about the dangers of opioids.
- Created the Caring for Caregivers program to educate employees on addiction, strategies for handling addicted patients, and how to combat "compassion fatigue."

At the advanced practice level, Cleveland Clinic is part of the Northeast Ohio Hospital Opioid Consortium, a hospital system-based and physician-led consortium working to significantly reduce the epidemic's impact.

Cleveland Clinic's Catherine Skowronsky, MSN, RN, ACNS-BC, CMSRN, serves on the consortium's Education Subcommittee. It just released for review a nursing education module draft on substance use disorder for nurses and front-line staff to use across the continuum of care. Once approved, it will be released for use in Northeast Ohio hospitals.

ADDICTION AT EVERY DOOR

Nurses see patients with substance use disorders in every area of medicine. Serious infections are more common among people with substance use disorders.

Mary McLaughlin Davis, DNP, ACNS-BC, CCM, Senior Nursing Director of Inpatient Care Management for Cleveland Clinic Akron General, says acute care interdisciplinary teams meet to discuss individual care plans for difficult patients — including those who repeatedly present at the emergency department (ED) for drug-related issues.

"So many of these patients end up in the hospital, and they do not need to be," McLaughlin-Davis says. "It's a cycle — if we're not helping them when they come into our EDs and setting them up with the right support, it can become a costly endeavor."

Skowronsky says treating the acute issue a patient presents with in the ED is just the tip of the iceberg. "In so many cases, there are unmet behavioral health needs that often involve substance use disorders," she says. "We're making sure people are connected with services, whether those are outpatient

Speaking at an opioid panel discussion at Cleveland Clinic Hillcrest Hospital are Rose Hosler, RN, BSN, HNB-BC, HWNC-BC, Healing Services Coordinator (left), and Michael Scipione, MBA, a local police detective, and Teresa Dews, MD, Chief Medical Officer for the hospital.

services or treatment options, or ensuring they have a case manager in the community."

SUPPORTING CAREGIVERS

Karen Guzi, MSN, APRN, CNS, BCEN, a clinical nurse specialist in Emergency Services, was a panelist who discussed the power of empathy in the ED during the 2018 Cleveland Clinic Patient Experience Summit. It addressed caring for caregivers who suffer compassion fatigue. Frustration mounts when patients' needs exceed available resources.

"A patient is discharged with instructions to follow up with a resource the next day, but they are back in the ED that night after overdosing," Guzi says. "Staff have strong emotions when that occurs. We've asked our team to be empathetic to patients' immediate needs and issues, but we lack the resources to give to team members immediately."

In response, the Healing Services program in the Cleveland Clinic Office of Patient Experience is called to meet with staff members to process their emotions.

"Although the patient's needs are paramount, it's not only about the patient. Equally important is helping the caregiver team deal with the stresses placed on them," Guzi says.

Ruthann Gavrilescu, MSN, MEd, RN, Senior Nursing Director for Cleveland Clinic Community Care, is a member of Cleveland Clinic's Regional Response & Resuscitation Committee (CCRC), which monitors emergency care provided in express care, urgent care and regional outpatient facilities. It worked on initiatives to support caregivers:

- Creating a guideline allowing caregivers to decide whether to respond to events that happen outside a building, such as an overdose patient driven to Express Care.
- Adding nasal naloxone (NARCAN®) HCl nasal spray to its formulary for emergencies. The regional CRRC is working on a nursing protocol in conjunction with the Ohio's pharmacy, medical and nursing boards to allow RNs and licensed practical nurses in outpatient settings to administer naloxone. Now, only advanced practice providers and physicians can administer the antidote to an opioid overdose.
- A new pharmacy policy that guides ambulatory care patients to bring unused controlled medication for proper disposal.

EDUCATING CAREGIVERS

Jennifer P. Colwill, DNP, APRN, CCNS, PCCN, a clinical nurse specialist in the Heart & Vascular Institute, leads a group of bedside nurse pain mentors who provide education to nurses. The team looked at substance use disorder and alternative pain control methods.

"Interest is growing," Colwill says, adding that in 2018, 307 nursing caregivers were impacted by her program. "Nurses who participated are very passionate about pain management for their patients."

Barbara Morgan, MSN, RN, NE-BC, Associate Chief Nursing Officer of Emergency Services for Cleveland Clinic health system, and Director of Nursing for the main campus ED, says the path that leading to addiction can be complicated. "We educate our nursing staff on factors in peoples' lives that may lead them to addiction, how we can identify it and how to be aware of our own feelings toward addiction," Morgan says. "We need to be in touch with our feelings and unconscious biases to help in an empathetic and meaningful way."

Guzi says, "This is not going to be a quick fix. We are going to have to maintain and sustain."

The nursing profession, Skowronsky says, is acutely aware of the problem and its psychological and physiological impact.

"Nurses are consistently voted as the most trusted profession — we are seen as less of an authority figure, less judgmental," she says. "Patients' view of nurses and our profession makes it even more important that we know how to receive substance abuse information and how to act on it. And we need to be able to have the right resources in place to act appropriately when we encounter patients who need help."

Email comments to **notablenursing@ccf.org**

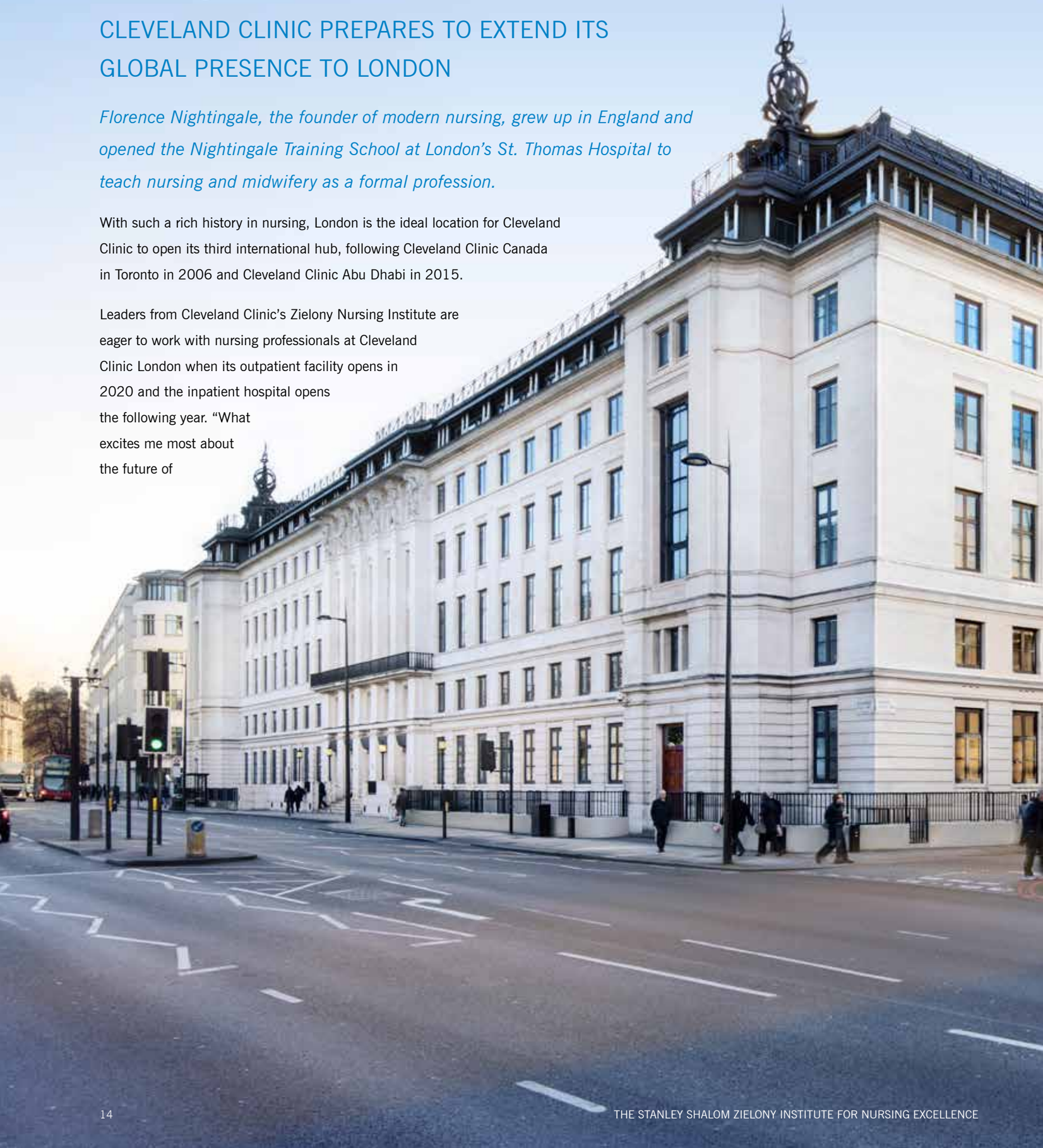
Nursing Across the Pond

CLEVELAND CLINIC PREPARES TO EXTEND ITS GLOBAL PRESENCE TO LONDON

Florence Nightingale, the founder of modern nursing, grew up in England and opened the Nightingale Training School at London's St. Thomas Hospital to teach nursing and midwifery as a formal profession.

With such a rich history in nursing, London is the ideal location for Cleveland Clinic to open its third international hub, following Cleveland Clinic Canada in Toronto in 2006 and Cleveland Clinic Abu Dhabi in 2015.

Leaders from Cleveland Clinic's Zielony Nursing Institute are eager to work with nursing professionals at Cleveland Clinic London when its outpatient facility opens in 2020 and the inpatient hospital opens the following year. "What excites me most about the future of



nursing at Cleveland Clinic London is the idea of marrying the best practices of nursing care Cleveland Clinic is known for with the best practices of the United Kingdom to deliver exceptional care," says Deborah C. Small, DNP, RN, NE-BC, Chief Nursing Officer for Cleveland Clinic London.

Small, who served most recently as CNO and Vice President of Patient Care Services at Cleveland Clinic Fairview Hospital, relocated to London last summer to help shape the direction of the new state-of-the-art outpatient facility and 185-bed hospital. She is collaborating with a team of healthcare professionals — some in the United States and others in the U.K. — to ensure nurses are ready to hit the ground running when the first patients arrive at Cleveland Clinic London.

A big part of that preparation is identifying similarities in nursing between the U.S. and the U.K., as well as sorting out the differences. "It's about sitting down, taking what's best from both places and amalgamating that in a way that will benefit us all," says Frances Campion-Smith, RN, BSc, an experienced registered nurse and healthcare executive from the U.K., with a degree in management, who joined Cleveland Clinic London as Director for Acute and Ambulatory Care. "Fundamentally, I believe all nurses want to provide the best care possible."

COMPARING SCOPE OF PRACTICE

Both the U.S. and the U.K. have organizations that oversee regulation of nursing practice — boards of nursing in the U.S. and the Nurse & Midwifery Council in the U.K. "Both exist to keep the public safe and ensure the workforce is competent to provide care," says Small. "But how they interpret that responsibility and establish standards varies."

The scope of practice in the U.K. is defined not only by training and competence, but also by "the Code" — professional standards of practice and behavior set by the Nurse & Midwifery Council. Nurses can perform nearly every task related to their specialties, from starting an IV to prescribing medication and providing respiratory therapy, as long as they are deemed competent in that task. "if a nurse has been trained to do a skill, has the ability to do it and can prove they have done it safely — then they may do that skill," says Small.

Nurses prove competency, in part, through an observation that's part of the registered nurse examination. "In the U.S., to become a registered nurse and prepare for entry-level nursing, candidates must graduate from an accredited nursing program and take a standardized exam called the National Council Licensure Examination (NCLEX)," says Patty Sypek, BSN, RN, Director of Nursing Operations for Cleveland Clinic, who is helping develop Cleveland Clinic London's nursing operations model. In the U.K., nurses must graduate from accredited nursing programs and pass two exams — one comparable to the NCLEX, the second a videotaped observation called the Objective Structure Clinical Examination (OSCE).

"Licensing in London is based on nursing training, competence and practices that nurses have been safely signed off on to practice independently," reiterates Small. For example, nurses can pass a nonmedical prescribers course and get prescriptive authority, but only within the specialty in which they practice, such as cardiology or oncology. Advanced nurse practitioners require a master's degree and a separate license to practice in the U.S. In the U.K. these roles are known by various titles defined by different competencies and qualifications. In 2017, to avoid role confusion, a framework for advanced clinical practice was defined by Health Care England. Nurses can receive the title if they have a master's or the equivalent degree qualification and are trained in clinical practice, leadership and management, education, and research, and demonstrate the core capabilities and competence within a clinical specialty.

"In the U.S., we have acute care nurse practitioners with broadly developed skill sets to care for people with acute and critical conditions across the spectrum," says Nicolas Houghton, DNP, MBA, RN, ACNP-BC, CFRN, the APN and PA Manager in hospital medicine at Cleveland Clinic. "In some ways, the U.K. is more advanced, having nurses with a depth of knowledge in a very specific area, such as nephrology, and prescribing privileges in just that area."

DIFFERING TITLES AND UNIFORMS

Many of the titles and responsibilities are the same on both sides of the Atlantic Ocean. For instance, both the U.S. and U.K. have chief nursing officers and clinical nurse specialists.

Renderings of the new hospital in Cleveland Clinic London.

Some titles are different, although the roles remain similar: A nurse manager in a private hospital in the U.K. is called a matron, and an assistant nurse manager is a senior sister.

One of the biggest differences is the banding system. "In the U.K., depending on your years of experience, education, and additional classes and certifications you take, you fall into a band," says Sypek. "We don't have these structured distinctions in the U.S." The National Health Service (NHS) has delineated nine bands, with accompanying pay scales, for all healthcare workers. Within nursing, for instance, a clinical support worker is band 3, a new registered nurse is band 5 and a matron nurse is band 8.

A walk down the halls of a hospital in the U.K. points to another distinction — uniforms. "At Cleveland Clinic, we've chosen to put our nurses in white in most settings," says Small. "In the U.K., the various nursing roles — staff nurse, charge nurse, clinical nurse specialist, matron — can be distinguished by the color of their uniform." In addition, all healthcare workers in the U.K. are required to wear short sleeves as an infection prevention tactic, often described as "bare below the elbows."

"The policies in the NHS, such as those related to infection control, are backed by research or evidence-based data that defines why nurses should practice a specific way," says Small. This is one of many ideologies shared by nursing in the U.K. and the U.S.

SHARED CARE PLANNING AND VALUES

"The U.K. places a huge focus on patient safety," says Kathryn Stuck Boyd, MSN, RN-BC, a Cleveland Clinic education manager. "As we think about onboarding our nurses in the U.K., it will be a little different because all nurses come with a variety of experiences, strengths and opportunities. But the focus on competency and patient safety is the same."

Care planning for patients is also similar. "Nurses in the U.K. use assessment, problem identification, individualized care planning, implementation and evaluation — the nursing process, as we call it," says Small. Just as Cleveland Clinic nurses rely on care path guides to treat patients for various conditions and diseases, U.K. nurses use guidelines from the National Institute for Health and Care Excellence (NICE). For example, Cleveland Clinic has a care path for preventing, assessing and treating pressure injuries, and NICE has guidelines for risk assessment, prevention and treatment of pressure ulcers.

In 2016, the NHS adopted the "6Cs", stressing the importance of care, compassion, competence, communication, courage and commitment. These are ideals echoed by Cleveland Clinic's emphasis on relationship-based care and putting patients first.

As Cleveland Clinic London ramps up its staffing, with the ultimate goal of employing 1,200 total caregivers, it will recruit nurses from the U.K., the U.S. and around the world who embody the 6Cs. The team will be among the most diverse workforces in the profession — about 52 percent of bedside nurses in London are international. "It's a very culturally diverse city and has a very culturally diverse workforce," says Small, adding that nurses from Cleveland will also have the opportunity to relocate to London.

There may be a few challenges as Cleveland Clinic London strives to recruit a cohesive group of nurses who are respected leaders in healthcare. But the organization is up to the challenge. "As nurses, we will continue to keep the patient at the center of everything we do," says Campion-Smith. "If we're all advocating for the patient, it is irrelevant which part of the globe we come from. We will be an integrated team and part of the global family of nursing."

Email comments to **notablenursing@ccf.org**

A Supportive Culture Encourages All Nurses to Investigate Best Practices

RESEARCH OFTEN STARTS ON THE FRONT LINES OF PATIENT CARE

Clinical nurses at Hillcrest Hospital discussing best practices. (L to R): Kristen Collier, RN; Jocelyn Heckelmoser, BSN, RN; Brianna Greer, BSN, RN; Kaitlyn Rossman, BSN, RN; Victoria Bestvina, RN; Bethany Casto, BSN, RN, CMSRN; Mary Noonen, MSN, RN-BC.

Through direct daily interaction with patients, clinical nurses regularly deal with challenges that sometimes raise questions about best practices. From the simplest to the most complex, clinical questions ignite research that ultimately can help determine the best evidence-based practices to ensure optimal patient care.

"By investigating clinically based questions and discussing ideas with peers, clinical nurses provide the direction for productive nursing research," says Sandy Dankelson, BSN, RN, CNOR, an Ambulatory Surgery Center nurse at Cleveland Clinic Marymount Hospital.

She adds that support from nurse leaders and peers in an environment that values nursing research inspires clinical nurses with "a desire to learn, to investigate and to further nursing knowledge in the interest of providing the best care to each of our patients."

CURIOSITY IS PART OF THE CULTURE

Dankelson is a member of the Marymount Hospital Nursing Practice Council and a subcouncil focusing on nursing research and innovation. She is developing a proposal to investigate what patients in the ambulatory surgery setting believe "comfort" means.

Her proposed research is part of a lengthy list of research projects in various stages of completion by Cleveland Clinic nurses. In 2018, with nearly all of the health system's hospitals participating, Cleveland Clinic nurses worked on 163 nurse-led research projects. Of those, 48 were in the beginning stages and 30 were completed in 2018.

"It is part of our culture to ask questions and search for answers. Sometimes the answers

Clinical Research Fellowship Helps Nurses Develop Skills

The Zielony Nursing Institute recently began offering a distance-mediated clinical research fellowship for registered nurses with a PhD who wish to advance their knowledge and skills in clinical research. Although many academic sites offer postdoctoral research fellowships, the Cleveland Clinic program is believed to be the first offered by a healthcare center that is not associated with an academic institution. The program helps researchers learn about the underpinnings of clinical research in clinical settings.

"Our goals are to help new post-doctoral nurses interested in a clinical or academic research career to increase their methodological expertise and research competencies," says Nancy Albert, PhD, CCNS, CHFN, CCRN, NE-BC, FAAN, Associate Chief Nursing Officer of Research and Innovation. "Fellows are exposed to hospital-based research resources and our vibrant research environment. During on-site immersions, they also receive multiple opportunities to expand interdisciplinary linkages."

Fellows have a full-time role in an academic, industry or clinical setting and receive active mentorship to advance or build a clinical research program focused on chronic or acute illness or population health. The program is learner-centric with a role-specific curriculum tailored to each fellow's unique skill set and research development needs. Fellows are partnered with expert nurse scientists to enrich the immersive experience and support continued learning and development throughout the two-year program.

are found in a review of the literature. All too often, we learn that research evidence on a topic of interest is scarce. The quantity of research projects in motion at any one time reflects our desire to strive for high-level evidence," says Nancy Albert, PhD, CCNS, CHFN, CCRN, NE-BC, FAAN, Associate Chief Nursing Officer of Research and Innovation. "Clinical nurses are curious and passionate about the research they initiate, and they are proud to disseminate findings and translate them into practice."

SUPPORT AND GUIDANCE SMOOTH THE WAY

Tony DiStefano, BHS, RN, CCRN, works on the Adult Medical Emergency Team at Cleveland Clinic main campus and is the principal investigator on a study. He says that when he expressed an interest in pursuing research for his team, he was "given every opportunity to attend conferences and participate in research labs and was assigned to a nurse scientist mentor."

Research support is available to all Cleveland Clinic nurses. Besides mentoring nurses in research, nurse scientists educate, support and encourage staff during the process. Kathryn James, BSN, RN, a staff nurse who is working on an interpreter study, says that the idea of doing research used to seem daunting.

"With the help of the amazing staff here I have felt encouraged and supported every step of the way to be able to conduct the research I want to do," James says.

In addition to a two-day research symposium, hospital-based journal clubs and individualized education to research teams, the Office of Nursing Research and Innovation hosts at least four and up to eight 4.5-hour research workshops throughout the health system each year. Topics include developing a research proposal, understanding the best way to review the literature, finding publishing opportunities for completed research, and understanding the ethics and expectations during peer reviews.

"For us to improve and dictate the future of nursing, it is vitally important to pursue research and evidence-based practice while caring for our patients," DiStefano says. "My most important goal, beyond compassion and empathy, is to deliver safe, efficient and well-founded nursing practice."

Study Looks at Insulin Self-Management in Type 1 Diabetes Patients in Acute Settings

SOME PATIENTS WITH TYPE 1 DIABETES CAN SELF-MANAGE THEIR INSULIN.

Pamela Combs, DNP, MSN, BC-NP

Patient blood glucose levels, food intake and insulin dosages historically are managed by physicians and nurses in acute care settings. Study author Pamela Combs, DNP, MSN, BC-NP, in the Cleveland Clinic Department of Endocrinology, Diabetes and Metabolism, suggests rethinking that approach in certain patients with Type 1 diabetes.

"Patients with Type 1 diabetes have a unique understanding of their own disease and often are more capable of managing their own blood glucose than professionals on their healthcare team," Combs says. "We should give them that latitude."

Study approach

The study, "Self-Management of Type One Diabetes in the Acute Care Setting,"

continued on page 19

Can Attending a Group Class Help Heart Failure Patients Stay Out of the Hospital?

DATA ISN'T YET CLEAR, BUT THE TEAM CONTINUES TO PROVIDE TOP-NOTCH EDUCATION FOR PATIENTS AND FAMILIES.

Josalyn Meyer, MSN, RN, NE-BC

Measuring outcomes and the value of a particular intervention isn't always a straight line from A to B. This is what Kelly Haight, MSN, APRN, ACNS-BC, PCCN, is finding.

Haight, a clinical nurse specialist at Medina Hospital, and her co-investigator Josalyn Meyer, MSN, RN, NE-BC, are examining clinical outcomes data on 3,700 patients attending a group education class during hospitalization for heart failure. They are trying to determine whether there is a link between the group education class setting — versus individual in-room education — and reduced rates of hospital readmissions at the 30-day and 90-day mark.

continued on page 19

collected data on 60 patients with Type 1 diabetes in acute care settings at Cleveland Clinic main campus over a four-year period. Patients made decisions regarding their own insulin dosing based on blood glucose monitoring and meal intake. Patients self-managed either via multiple daily injections or a continuous subcutaneous insulin infusion pump.

In other research literature, rates of hypoglycemia (< 70 mg/dL) and hyperglycemia (> 180 mg/dL) in noncritical care environments were as high as 28.1 percent [1] and > 40 percent, [2] respectively. In this study, more than 700 blood glucose readings were analyzed for both stable and unstable hypoglycemia and hyperglycemia. The frequency of unstable hypoglycemic and hyperglycemic events was < 5 percent each. Overall, hyperglycemic events occurred at slightly higher rates in men, as well as in patients using injections instead of the insulin infusion pump. "Our low percentage of unstable adverse events suggested that self-management was safe and effective," says Combs.

Making it work

Hospitals seeking to undertake a self-management approach to diabetes care need to draft clear institutional policies supporting this practice, name strong team leaders to champion the process and seek buy-in from multiple disciplines, says Combs.

Combs noted that self-management is not the right approach for all patients, and that patients need to be rigorously assessed to determine their motivation and diabetes knowledge.

"Once I determine that the patient is proficient in self-care and that we are speaking a common language, I allow them to self-manage. These patients are usually very ecstatic to find that they will be allowed to make their own insulin-dosing decisions while hospitalized," she says. "Many have experienced serious poor sequelae in previous hospitalizations, where they were not permitted to self-manage."

There is little research exploring the impact of self-management of blood glucose for hospitalized patients. Combs designed her study to address that gap, building on her 21 years of experience working with diabetic patients.

"Allowing hospitalized patients with Type 1 diabetes to manage their own blood glucose through calculation and timing of insulin and meals may minimize the incidence of severe hypoglycemia and hyperglycemia, which are often seen in this population," Combs concludes. "Self-management of insulin allows patients to continue enjoying autonomy. Healthcare providers should leverage their patients' knowledge in order to gain insights into their decision-making process, and offer advice that can improve overall outcomes."

1. *Stuart, et al. Diabetes Med. 2017:34(10): 1385-1391.*
2. *Cook, et al. Journal of Diabetes Science and Technology. 2012: 6(5):995-1002.*

The data was collected when the two were on the medical cardiology and step-down floors at the Sydell and Arnold Miller Family Heart & Vascular Institute.

The heart failure education class began in 2012 based on curriculum developed by Theresa Cary, former clinical nurse specialist for the medical cardiology and step-down floors. The concept was to bring patients — and their family members — together as a group to educate them on how to best manage their disease. Including family members in the class is key since heart failure patients often rely on family as caregivers.

The class, now standard care for heart failure inpatients, educates attendees about heart failure basics. A nutritionist discusses how diet plays a role in managing the condition, and a pharmacist educates attendees about how medications work, potential side effects and warning signs that indicate when to call the doctor.

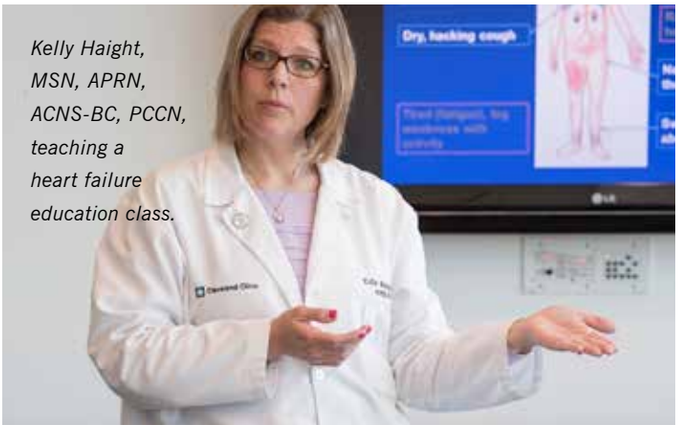
"The class generates a lot of information for patients and has a consistent message, so we can ensure they are receiving education in a valuable way while learning from each other," Haight says. "Attendees can interact, ask questions and see how others are working the various strategies into their lives at home."

Patients who elect not to attend the class receive the same information in their rooms from a nurse.

While it's too early to report outcomes, the data do show lower readmission rates at the 90-day mark for patients who attended a group class with a family member. Haight says the heart failure care team remains dedicated to helping heart failure patients live their best life and avoid hospital readmissions.

"We are trying to determine the relevant information," Haight says. "We know there is value to the class, but we still need to consider confounding factors that may have influenced the clinical outcomes."

Haight and Meyer plan to present their findings later this year.



Kelly Haight, MSN, APRN, ACNS-BC, PCCN, teaching a heart failure education class.

Email comments to **notablenursing@ccf.org**

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Awards and Honors

The long-standing collaboration on initiatives to improve nursing education and practice has earned Cleveland Clinic Nursing and Ursuline College's Breen School of Nursing the **2019 Outstanding Partnership Award from the Midwest Nursing Research Society (MNRS)**. For nearly two decades the two institutions have worked together to develop innovative approaches to clinical education in the academic and clinical settings. The award was presented in March at the MNRS Conference in Missouri.

Clinical nurse specialists **Mary Beth Modic, DNP, APRN-CNS, CDE**, and **Deborah Klein, MSN, APRN, ACNS-BC, CCRN, FAHA**, of Cleveland Clinic main campus, were inducted as fellows into the American Academy of Nursing. Invitation to the academy represents a nurse's substantive impact on disseminating nursing knowledge and influencing nursing practice and is one of the highest individual honors in the nursing profession.

Christian Burchill, PhD, MSN, RN, CEN, was named the *Journal of Emergency Nursing (JEN)* Reviewer of the Year for consistently providing in-depth, constructive feedback to authors to maintain the quality of *JEN*'s content. Burchill is a nurse scientist in the Office of Nursing Research and Innovation.

Nursing School Part of New Health Ed Campus

In summer 2019, Cleveland Clinic and Case Western Reserve University are opening a new Health Education Campus on Cleveland Clinic's main campus. In addition to the Francis Payne Bolton School of Nursing, from which many Cleveland Clinic nurses have graduated, the new campus includes students from:

- Cleveland Clinic Lerner College of Medicine at Case Western Reserve University MD program
- School of Medicine MD and MD/PhD programs
- School of Dental Medicine

"This high-tech integrated health education campus will encourage students to learn from each other," says Joan Kavanagh, MSN, RN, NEA-BC, Associate Chief Nursing Officer of Nursing Education and Professional Development at Cleveland Clinic. "It's a beautiful facility, and the interprofessional environment is an amazing opportunity for innovative pedagogy in healthcare education."

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