



Seattle Nursing Research and EBP Conference 1-26-2010

0800-0900 AM POSTER SESSION – R & T 117/121

First Responders: Two-Tiered Approach to In-Hospital Emergency Response

Pickett, J., Thomas, R., Swedish Medical Center, Seattle, WA

Purpose: Improve time to defibrillation as well as overall first response to a patient in cardiopulmonary arrest.

Background/Significance: According to the AHA 30% of patients in cardiac arrest receive defibrillation more than 2 minutes after identification. Patients with delayed defibrillation are less likely to survive to hospital discharge.

Description: Post-code analysis indicated the first minutes of a cardiopulmonary arrest response lacked leadership and organization. The concept of “First Responder”, members of the health care team that initially identify a patient in arrest, was created. This team provides basic life support (BLS), including early defibrillation, before the advanced cardiac life support (ACLS) team, the Code Blue team, arrives. Next, we identified the roles of the First Responder team applying a specific function. A chief role is the nurse that delivers defibrillation via the automated external defibrillator (AED). Implementation began with Phase I consisting of AED education and First Responder procedures, using a hands-on case based approach. Phase II consisted of selection and education of First Responder Champions to conduct drills at the unit level. Phase III consists of the champions conducting unit based drills in each nursing unit.

Evaluation and Outcomes: The Code Blue Evaluation team reviews post-code data to identify gaps in safety, performance, and leadership. Areas for improvement within each layer of response, either First Responder (BLS) or Code Blue (ACLS) are identified. Code Blue Drills are performed monthly identifying areas for improvement in this two-tiered resuscitation model. Phase I training evaluation (classroom/drill analysis) demonstrated improved safety and performance as a result of decreased anxiety, increased confidence, and repetitive training. At the end of Phase III, a retrospective chart review comparing time to first shock prior to implementation to the end of first year will be conducted.

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A Collaborative Project To Improve Code Blue Skills Outside The Intensive Care

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Purpose: Outside the Intensive Care Unit, staff nurses receive exposure to the emergency code cart and their Code Blue responsibilities while in initial orientation. For many, equipment and charting has changed since orientation. Staff nurses expressed feeling ill prepared for their role in Code Blue situations. Recognizing these emergency events are low volume, high stakes events, opportunities for improvement were sought.

Description / Methods: An educational curriculum was developed and piloted collaboratively by STAT nurses and the Critical Care CNS. Program goals were: introduce staff nurses to the hospital code documentation form and key elements of documenting; reacquaint nurses with contents of the code cart; ensure nurse understanding of members of Code Blue team and staff nurses' roles on the team; provide opportunity for hands-on practice with equipment (resuscitation bag, pocket mask, code cart contents, defibrillator), practicing a cardiopulmonary arrest scenario which the nurse may encounter; and lastly, build relationships between staff nurses, STAT nurses, and the Critical Care CNS. The program was offered to nurse managers of acute care units for incorporation in staff meetings, initially lasting 60 minutes, and later lengthened to 90 minutes. During sessions, staff rotated through four stations: 1. Self-directed poster review of hospital Code Blue team composition and roles, followed by matching exercise; 2. Crash cart hunt-and-find, including assembling medications; 3. Documentation practice on poster-sized Code Blue forms with post review to ensure understanding of key elements; 4. Hands-on participation with simulated cardiac arrest scenario.

Evaluation/Outcomes: 7 ed sessions covering two units were conducted. On Unit 1, success was measured by response to two questions: Did you find this exercise helpful, and what would you change? All participants indicated value in the education, but many requested more time. Session time was increased from 60 to 90 minutes. Unit 2 staff were asked to complete an expanded survey utilizing a Lickert scale to evaluate relevance and effectiveness of education. Results are pending. The ultimate measure of success will be increased staff comfort and efficacy during future Code Blue events. The medical center has just begun a mock code program, with higher level simulation equipment involving the entire Code Blue team, which will allow further evaluation on these units.

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House Wide Delirium Education

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Purpose: To disseminate the new Providence Service Area Delirium Guideline and educate nurses about delirium.

Background/Significance: Delirium is a medical emergency. A patient admitted to the hospital with a diagnosis of delirium has a mortality rate of 10-26% (McCusker, Cole, Ambrahamowics, Primeau, & Belzile, 2002). If a patient develops delirium during their hospital stay, this mortality rate drastically increases to 22-76% (American Psychiatric Association, 1999). The acute care setting must provide prevention and early intervention strategies for these individuals in order to decrease the incidence and severity of delirium.

Description: January of 2009, the Portland Service Area Providence Hospitals completed a Delirium Protocol for patients admitting to the hospital with a diagnosis of delirium and also for patients who become delirious during their hospital stay. In anticipation of this order set, our NICHE group (Nurses Improving Care of Health System Elderly) from Portland Providence Medical Center created a DVD on delirium. The house wide teaching plan included showing the DVD (about 20 minutes in length), using a patient scenario to work through the Confusion Assessment Method (CAM) as a group, and lastly, we discussed the new order set. Over a two week period, we hosted educational offerings throughout the day and night.

Evaluation and Outcomes: We were able to reach about 75% of the nurses from our hospital. The responses from the nurses included, "This was well worth the thirty minutes" and "When can we use this protocol?"

Conclusions: As educators and support staff, we enjoyed pooling our time and energy to create this educational offering meant to benefit the entire hospital. This educational blitz provided nurses the opportunity to come together as a group and learn how to prevent, identify and treat something that can be fatal.

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Increasing Recognition of Delirium in the ICU Setting with the Institution of a Delirium Model

Hodson, P., Madigan Army Medical Center, Tacoma, WA

Purpose: To demonstrate that implementation of a delirium model will increase the recognition of delirium in the ICU patient population.

Background/Significance: Delirium is characterized by an acutely changing or fluctuating mental status, inattention, disorganized thinking, and altered level of consciousness. The occurrence of delirium in the ICU ranges from 11% to 87%. Delirium has been associated with poor outcomes in hospitalized patients, including increased length of stay, and higher mortality rates. Prompt recognition of delirium in the ICU allows caregivers to differentiate patients' symptoms from other conditions and facilitate the initiation of the proper therapy.

Method: Our Critical Care Service selected the CAM-ICU and the Intensive Care Delirium Screening Checklist (ICDSC) to compare for use within the hospital intensive care units. A survey was developed to determine which delirium scale the nurses felt was more effective with the patient population served by our facility. Education on delirium was provided to the ICU staff upon initiation of the selected scale.

Results: Based on survey results, nurses felt their knowledge of delirium was lacking. Results for the ICU scale selected will be presented along with results related to nurses' knowledge about delirium prior to and following a structured educational activity.

Conclusions: Performing delirium assessment using an evidence-based scale along with focused education of staff results in better patient outcomes. Prompt recognition of delirium assists caregivers in instituting appropriate interventions to achieve better outcomes for patients.

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OHSU Interdisciplinary ICU Delirium Quality Improvement Project

Henkle, J., Goodell, T., Oregon Health and Science University, Portland, OR

Purpose: Delirium in hospitalized patients is associated with lasting cognitive decrements and longer length of stay. The OHSU Interdisciplinary ICU Delirium Workgroup was formed to improve assessment, prevention and treatment of ICU delirium. The workgroup also aimed to reduce sitter use and address a sentinel event related to inappropriate monitoring of intravenous haloperidol given to a delirious patient.

Background: There was no delirium protocol at OHSU, and each of the four adult ICUs initiated different treatment modalities. Despite high incidences of delirium, there were no standardized prevention strategies utilized. Registered nurses were not using the CAM-ICU delirium assessment tool correctly and literature indicates that hypoactive delirium is often missed.

Description: The workgroup standardized treatment, assessment and prevention methods within the ICU-cluster. To increase delirium awareness and CAM-ICU assessment accuracy, senior nursing students completing a leadership practicum provided 1:1 instruction to bedside ICU nurses. Delirium assessment flip cards were created and placed at the bedside to encourage accurate CAM-ICU assessments. The workgroup updated the ICU sedation policy, created an evidence-based pharmacological treatment reference card and initiated day/night focused nursing prevention strategies.

Outcomes: The pre-education chart audit showed that nearly fifty-three percent of nurses (n=145) were documenting the CAM-ICU inappropriately. Some nurses reported anecdotally that they knew if their patients were delirious without completing the CAM-ICU assessment. The workgroup was unable to complete all goals due to loss of nurse project champions.

Conclusion: Delirium is likely to be missed without correct administration of the validated CAM-ICU assessment tool. At OHSU, additional hospital resources are required to follow up on the effectiveness of bedside 1:1 nurse education and achieve all goals of the quality improvement plan.

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Critical Care Track: An Innovative Transition Program for New Graduate Nurses

Bunke J., Weinberg S., Brinegar M., Waterson S., Richardson J., Meyer L., VA Medical Center, Portland, OR

Purpose: To create an alternative “grow your own” recruitment stream for increasing preceptor capacity and RN staff; to compare newly developed strategies with the traditional PVAMC approach to RN orientation.

Background/Significance: The combined medical-surgical Critical Care Unit (CCU) at Portland Veterans Administration Medical Center (PVAMC) is experiencing a work environment of continually increasing bed capacity with a subsequent expanding patient census. As the CCU expands, it must respond by recruiting, training and retaining an adequate number of nursing staff. The Portland area faces a competitive local market for experienced critical care nurses. In light of an abundance of new graduate and critical care naive RNs interested in working in the CCU, yet limited capacity to train them, this newly developed Critical Care Track (CCT) program functions as an innovative recruitment stream. The CCT RNs work on a medical-surgical ward for 15 months with concomitant, gradually increasing exposure and specialized education in critical care nursing. At the end of 15 months, the CCT nurses transition completely to CCU, completing an abbreviated orientation period.

Results: The program has now been in effect for 15 months. As of October, 2009 the first cohort transferred into the CCU and has started the orientation process there. Bed capacity is unchanged over the last year awaiting planned infrastructure improvements. Data will be collected and contrasted between the CCT program and nurses who are oriented to PVAMC CCU using the traditional orientation method when the orientation period is complete. Data to be collected includes the number of nurses and those who are preceptors, (Basic Knowledge Assessment Tool) BKAT and satisfaction scores, nurse retention over 3 years, and (Critical Care Registered Nurse) CCRN certification.

Conclusion: Pending.

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Conclusion: Pending.

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Developing the RN Leader

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In an attempt to implement hospital initiatives and bedside quality improvements, Inpatient Psychiatric Leadership looked to their bedside RNs and Charge RNs to do this. It became clear when investigating this that the charge RN and bedside RN did not have the appropriate tools to carry these demands out, therefore leaving leadership not able to implement goals or quality improvement programs. The barriers that RNs often encountered were giving difficult feedback to peers in the moment, implementing needed changes and balancing all this with the patients and families. The Leadership investigation provided the insight that their RN staff possessed the specific tools to do these tasks but rather lacked the ability to lead the implementation in the moment. A comprehensive training was found, John C. Maxwell, Developing the Leader within You. This training focuses on the self development of the RN to take all the tools they have and be able to access and utilize them in the moment while modeling and instructing staff around them. The leadership training is an on-going training this occurs monthly in 90 minute blocks of smaller groups. RNs come having completed each chapter exercises and prepared to discuss in this group. Quarterly the entire group comes together to complete and review important work from the training as a team. Being 6 months into the work the outcomes are illustrating our RN staff are now better prepared and are currently giving the feedback in the moment to their peers and moving treatment plans along with confidence. They are experiencing increased engagement which has illustrated an impact on the implementation of evidenced based guidelines of care, assisting in decrease length of stay and increased participation in unit shared governance. As a group they are now embracing the standardization of work processes and leading the development of this work.

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Designing and Implementing a Clinical Nurse Leader Scorecard: Successes, Challenges, and Lessons Learned

Rounds, K., Kim, E., Hanson, J., Virginia Mason Medical Center, Seattle, WA

Purpose: To describe the process used to design and implement a Clinical Nurse Leader Scorecard in the acute care setting.

Background/Significance: In 2004, Virginia Mason Medical Center (VMMC) implemented the Clinical Nurse Leader (CNL) role. Scorecards are used by healthcare organizations as tools that enable a leadership team to briefly visualize strategic metrics to guide decision making grounded in actionable information. So far there has been little or no mention of developing a CNL-specific scorecard. This presentation describes the VMMC project undertaken to develop a CNL-specific scorecard to evaluate the impact of the CNL role on patient care in the acute care setting.

Methods: Key outcome measures relevant to the CNL role were initially identified through a review of the literature and the CNL White Paper by the AACN. Key stakeholders were consulted to identify the indicators for inclusion on the scorecard. A new tracking form was created for CNLs to record data about the common nursing interventions they provide and ongoing barriers to patient discharge. Data was compiled using a Microsoft Excel spreadsheet and is updated on a monthly basis for each hospital unit with a CNL presence. Retrospective review of data 3 months prior to CNL role implementation will be conducted to examine the impact of CNL interventions on these outcomes.

Results: A CNL Scorecard has been implemented with data updated on a monthly basis. The greatest challenges were in identifying CNL-specific measures that truly capture their impact. Lessons learned include the importance of having buy-in, input from key stakeholders from the beginning, and realizing the process of design and implementation takes time.

Conclusions: A CNL scorecard can be successfully applied in the acute care setting to track patient care outcomes, maintain alignment with organizational goals, and validate the presence of the CNL in the hospital setting.

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Development of Nurse Quality Leaders (NQL's) for Fall Prevention

Heaton, S., Swedish Medical Center, Seattle, WA

Purpose: To increase staff awareness of falls prevention and to decrease falls and fall related injuries.

Background/Significance: Patient falls are a multi-factorial problem that is not resolved with a single intervention. Reducing injury from falls is a national patient safety goal and injury from a fall is also a CMS never-event.

Description: In September 2008 unit based a Nursing Quality Leader committee for fall prevention was established. Nurses and NACs were selected by the unit manager to participate. NQLS received education on falls and fall prevention strategies. The goal of the Falls NQL is to increase fall awareness on their units and serve as experts on fall prevention strategies. The NQLS work together as a committee on projects and share ideas on fall prevention. The committee meets monthly. In addition, the members work individually on fall prevention activities on their patient care units.

Evaluation and Outcomes: NQLS perform audits to assess compliance with fall prevention program and disseminate information to staff. Information is disseminated at change of shift huddles, staff meetings, email, and staff in-services. The NQLs utilize a form for the documentation of their NQL fall prevention activities. Work completed to date includes a falls specific QVR which elicits more detail on patient falls. This information is then shared with staff. NQLs have also reviewed falls documentation on electronic medical record, and worked with CIS to make changes to documentation in order to more efficiently document all activities related to falls prevention. The NQL's are currently working on revising the fall prevention protocol, developing a post-fall communication tool to Physician and a post-fall algorithm.

Conclusions: The fall NQLs have been successful in raising awareness on their units regarding fall prevention. The goal is to show impact on the fall rate and fall rate with injury.

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Impact of Removing Assigned Patients from the Medical Surgical Charge Nurse Role

Hodge, N., McCarthy, M., Gaudreau, L., Madigan Army Medical Center, Tacoma, WA

Purpose: Evaluate the impact of charge nurses not taking patient care assignments.

Background/Significance: One of the biggest obstacles to effective charge nurse (CN) functioning is the requirement to carry a patient care assignment while also assuming management and leadership responsibilities for the entire unit. When patient care workload is heavy, it may be impossible for the CN to fulfill the other duties inherent in the CN role.

Description: This pilot project was conducted over a nine-week period during which CNs on three medical-surgical units did not take patient assignments. CNs used a standardized checklist delineating outcome focused responsibilities and duties to accomplish during the shift. Evaluation data collected 1 month before and after initiation of the CN role change included staff and CN questionnaires (measuring perception of the CN role), unit nurse staffing and patient outcome data from the Military Nursing Outcomes Database (e.g. RN:pt ratio, nursing care hours, fall and medication administration error rates), and nursing documentation audits (adherence to documentation requirements).

Evaluation and Outcomes: Several questionnaire items were significantly improved, for both staff nurses and CNs. Both groups expressed increased satisfaction with their ability to provide care within this model ($p < 0.05$), and felt resources (time and personnel) were better utilized ($p < 0.05$). Nine of 25 documentation items showed significant improvement. Falls, falls with injury, and medication administration errors also showed trends toward improvement.

Conclusions: This pilot project was a short-term intervention that resulted in significant improvements in the nursing work environment and patient outcomes. Findings were used to support a larger trial and evaluation of this new CN role.

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Hospital Acquired Central Line Bloodstream Infections (BSIs) in Pediatric Stem Cell Transplants -a Nine Year Experience

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Purpose: To demonstrate that implementation of evidence based bundles for care of central lines would decrease the rate of hospital acquired BSIs.

Significance: Treatment regimens in pediatric hematopoietic stem cell transplant populations result in profound immunocompromise. Infections such as Central Line Associated Bloodstream Infections (CLA-BSIs) account for significant morbidity and mortality in this population. Care providers at a pediatric facility were concerned about the high rate of CLA-BSIs in a stem cell transplant population. In June 1999, pediatric stem cell transplant patients began receiving inpatient care at Seattle Children's Hospital, a 250-bed pediatric tertiary care center. On average, 50 transplants are performed annually for both oncologic and non-oncologic disorders. Surveillance for hospital associated CLA-BSIs using National Nosocomial Surveillance System (now National Healthcare Safety Network) definitions began immediately upon the patients' arrival. Rates peaked at over 20 infections per 1000 catheter days.

Methods: Using a Plan, Do, Check, Act model, practice changes and quality improvement strategies were implemented over time. Interventions were planned and implemented by multidisciplinary teams, including nurses, infection control practitioners, physicians, microbiology staff, and families.

Results: Hospital acquired CLA-BSI rates decreased immediately and have continued to decrease over a 9 year period. The rate for 2008 is 2.6 BSIs per 1000 central line days (8 BSIs / 3061 central line days). The 2009 rate is in process of being calculated.

Conclusions: Sustained reduction in hospital acquired CLA-BSI rates in this population was achieved incrementally utilizing approaches involving practice revisions, product and equipment changes, and focus and support from the hospital administration and board. The benefit was felt to derive from the cumulative effect of the various interventions rather than from any one practice change.

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Neutropenic Fever in the Emergency Department: An Evidence Based Practice Study

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Purpose: Fever in a neutropenic patient is considered to be a medical emergency and has been documented to be associated with a 70% mortality rate if antibiotic initiation is delayed.

Background: Traditional thinking regarding neutropenic fever is that chemotherapy induced mucositis occurs throughout the alimentary system, and seeding of the bloodstream from endogenous flora in the GI tract is believed to explain the majority of febrile neutropenic episodes. Single organism bacteremia has changed over the years in that the majority of the organisms were gram negative from the 1970's to the mid 1980's at which time the gram positive bacteria became more prevalent. During the late 1990's, the distribution of gram positive and gram negative bacteremia is equal.

Methods: An exhaustive literature search was completed in order to better define neutropenic fever as well as ascertain efficacious guidelines for diagnosis and treatment of neutropenic fever.

Results and Recommendations: Neutropenia has been defined as an absolute neutrophil count (ANC) less than 500 cells/mm³ or an ANC less than 1000 cells/mm³ with a predicted decline of 500 cells/mm³. Fever is defined with transient temperature greater or equal to 38.3 or 38.0 for one hour. Mortality is typically 25% per episode which can be reduced to 14% with proper antibiotic administration. Laboratory evaluation includes CBC with differential, complete metabolic panel, urinalysis, chest radiograph, and one blood culture from an indwelling IV line and one peripheral blood culture. Imipenem 500 mg IVPB and Vancomycin 15 mg/Kg IVPB to be given as soon as possible (within 30 minutes of arrival to the ED).

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0800-0900 AM POSTER SESSION – R & T 117/121

Application of Continuous Process Improvement to the Standardization of Shift to Shift Handoff

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Purpose: Refinement of standardized process for shift to shift handoff communication to improve patient safety, increase patient/family involvement, and decrease end of shift overtime.

Background: Standardized Shift to Shift Handoff Process was initially created through a Rapid Process Improvement Workshop (RPIW) in 2006. In spring 2009, a repeat RPIW was held to refine and improve the process to accomplish the goals identified in the purpose statement.

Discussion: Direct Care staff from each practice area were involved in creating a more efficient process utilizing a standard sequence of content obtained from reliable sources. The sequence was designed to follow the flow of nursing documentation and online resources. Staff complete safety checks at the patient's bedside and discuss the plan of care for the upcoming shift with the parent or caregiver. Implementation of this process change was carefully planned involving direct care nurses and also included formal classroom instruction for each RN prior to unit specific implementation dates. Staff reported feeling well prepared for the change and confident in their ability to achieve the expected outcomes. Staff were encouraged to discuss concerns with their unit leadership and have felt empowered to do so.

Evaluation/Results: Goals were a) to create a standard sequence for all essential information to be followed by every RN at end of shift handoff and b) to reduce lead time for every RN end-of-shift handoff to 30 minutes. By the end of week one, 87% of staff were following the standard sequence and 70% were able to complete handoff within the 30 minutes. By week 5, 93% of RNs were following the sequence and 77% were able to complete handoff in 30 minutes or less.

Conclusions and potential implications for research: The use of RPIW methodology facilitated changes by allowing time to focus on the process with the right staff participating. Preliminary data show marked improvements in use of standard process and a significant increase in the number of nurses able to complete handoffs within 30 minutes. Further study is needed to determine the impact on patient safety and cost. Additional study is planned to measure impact of the process on nursing sensitive outcome indicators.

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Hardwiring Purposeful Hourly Rounding

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Purpose: To hardwire hourly rounding into nursing practice at PPMC.

Background/Significance: Hourly rounding has been shown to increase patient satisfaction and decrease falls and pressure ulcers. Rounding was implemented at PPMC in 2007, but there were variances in adherence to the practice, and new hires were not being oriented to rounding. The Rounding Committee, comprised of representatives from med-surg units, family maternity and inpatient rehabilitation, developed a plan to hardwire purposeful hourly rounding into the practice of nursing at PPMC. To overcome perceived barriers, the Rounding Reps scripted and filmed a video that demonstrated rounding and bedside report (the first round) to give the nurses a “mental model.” A Rounding Competency checklist was completed after viewing the video. A “DVD Release Packet” was developed by the committee that included flyers,, roll-out suggestions, key messages, answers to frequently asked questions and benefits of hourly rounding to ensure a consistent message . After all direct care nurses completed the DVD and Rounding Competency, they were incorporated into nursing orientation. The Rounding Committee continued to look for ways to embed Rounding into the culture of Nursing at PPMC including: a monthly press ganey score contest, an audit tool to be used by unit leadership/Rounding Reps, flyers and reminder signs. Rounding language was incorporated into yearly competencies, yearly RN performance appraisals and the Regional Fall Prevention Protocol. The reps continue to look for ways to embed/reinforce this practice.

Results: Falls and pressure ulcers have decreased. Press Ganey “Likelihood to Recommend has risen from the 60th percentile in 2007 to the 80th percentile in 2009. Nurses have increased understanding of patient satisfaction data. Nurses are becoming more comfortable holding each other accountable.

Conclusion: Many different avenues and continuous reminders need to be utilized to begin a culture change.

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