Message from the Chief Nursing Officer

As we were preparing to go to print with our 2019 Nursing Annual Report, the COVID-19 global pandemic surged through Connecticut and ultimately reached UConn Health. At that point, many activities ceased, and our priority became serving the citizens of Connecticut that had fallen ill with COVID-19, along with maintaining the safety and well-being of our providers and staff. For our next annual report, we will reflect on the incredible compassion and fearless tenacity exemplified in the extraordinary patient care provided each day by our nursing staff. I know our patients and their families are profoundly grateful for the sacrifices each one of you has made to restore their health and well-being.

Although this 2019 annual report was delayed, we are excited to share our wonderful accomplishments with you in this report. 2019 was a year of transition. Ann Marie Capo retired in November after serving UConn Health for over 40 years in numerous nursing leadership positions but, most importantly, as Chief Nursing Officer, Vice President of Quality and Patient Services over the past four years. I would like to thank Ann Marie for her years of dedication, loyalty, and leadership to UConn Health and our Department of Nursing.

The Department of Nursing’s impressive accomplishments are highlighted throughout this report. Our unit-based Shared Governance Councils accomplished significant advances, making decisions and changes to improve nursing practice and patient care at the unit level. I am grateful for our collaborative partnership with the UConn School of Nursing, and I look forward to working with them on future practice and research initiatives. Our Research Fellowship Program began its third year while our previous fellows were writing for publication or working on data collection for IRB approved projects.

Our nurses continue to be dedicated to quality while evaluating the care they deliver and the associated patient outcomes. I am proud to say that in 2019 we met our performance goals in all of our NDNQI measures.

In my transition to the role of Chief Nursing Officer (Interim), one of my highest priorities has focused on staff and patient engagement. Since November, I have actively met with each unit throughout the hospital to gain insight into your concerns and opportunities related to staff engagement. As we move into our “new normal” phase, I will continue to seek these discussions and staff meetings to increase staff satisfaction while ensuring that our Shared Governance structures continue to thrive. I will continue to co-chair the Connecticut Hospital Association’s Safer Hospital Initiative, which is dedicated to ensuring that all hospital staff in Connecticut can practice in a safe and supportive environment.

There is no limit to what can be achieved by a nursing workforce that is engaged and empowered to transform their practice environment. I am incredibly proud to now lead this remarkably talented, compassionate team of professional nurses. Thank you for the exceptional quality care and kindness you always show our patients.

In appreciation,

Caryl Ryan, MS, BSN, RN
Vice President, Quality and Patient Care Services
Chief Nursing Officer (Interim)
Message of Appreciation from the Chief Executive Officer

There are many qualities that set UConn Health apart from other healthcare organizations, but one that gives me great pride is the commitment and dedication of our skilled nurses. They are on the frontlines of patient care, and the friends, confidants, interpreters, and consoling voices to our patients. Each day, you choose to provide the best quality, compassionate, tender, and personalized care. Your “patients-first” mentality, healing hands and kind hearts are the face of our healthcare system.

I am grateful that by working together, we are able to create the best patient experience possible and guide our patients through their healthcare journey whether big or small.

The success of the shared governance project increased autonomy, enhanced patient safety, and provided important proactive care for our patients. Our bustling patient care and growth in clinical care services over the past year is a testament to your excellent work and what we can accomplish for our patients when we work together.

I want to extend my sincerest appreciation for your continued service and dedication. I am grateful and proud that you have chosen UConn Health for your nursing career.

Andrew Agwunobi, MD, MBA
Chief Executive Officer, UConn Health
Executive Vice President for Health Affairs

Message from the Chief Quality Officer

This edition of the Nursing Annual Report once again highlights the breadth and significance that the nursing profession has at UConn Health. From ambulatory to inpatient settings and from primary care to specialty services, nurses are integral to our goal of providing high-quality, compassionate, and patient-centered care.

In appreciation of your quality care, our patients continue to recommend their friends and families to our hospital. These recommendations reflect, in large part, the wonderful care that they received at the hands of our nurses. In addition to your role in healing and health maintenance, you are instrumental in helping to educate future care providers. You are an important member of the multidisciplinary team that includes nursing, medical and pharmacy students, residents, and fellows. Your role in working with these groups is critical to their education and our goal of achieving optimal outcomes. Many members of the nursing staff are advancing their own education. UConn nurses showcase the academic mission of the University of Connecticut: from moving up the clinical ladder, to obtaining professional certifications and advanced degrees, to pursuing research endeavors.

As Assistant Dean for Education, I thank you for your collaboration and continued teaching. As a general internist, I thank you for your excellent care of our patients. As a member of the UConn Health Executive Team, I thank you for being a nurse at UConn Health.

Scott Allen, MD
Chief Medical Officer (Interim)
Chief Quality Officer (Interim)
Assistant Dean for Education
UConn John Dempsey Hospital
A Message from the Dean of the University of Connecticut School of Nursing

As I begin my third year as Dean, I could not be more pleased with the strong, ongoing partnership between the School of Nursing and UConn Health Nursing! You serve as the primary source for clinical education for our traditional undergraduates and an important site for our CEIN, master’s and doctoral students. Quite simply, we cannot accomplish our educational mission without you.

I hope that in the coming year we can have a greater presence at UConn Health, both in-person and virtually. As we think about how to meet your needs, in addition to conferences, such as Planting the Seeds of Nursing Innovation, I am delighted to announce that we will be starting two online, new master’s tracks – Nursing Leadership and Nursing Education – and two new online certificate programs – Nursing Leadership and Healthcare Innovation.

As many of you are aware, the World Health Organization has designated 2020 as the “Year of the Nurse and Midwife,” in honor of the 200th anniversary of the birth of Florence Nightingale. We are planning a series of special events throughout the spring and hope that you can join us. To show our appreciation for your presence at UConn Health, both in-person and virtually.

Throughout 2019, the focus of nursing professional shared governance at UConn Health has been placed on supporting unit based councils to develop and evolve. Many of the unit-based Shared Governance Councils have shared their success stories for publication in this annual report. The Department of Nursing acknowledges their efforts, celebrates their successes, and congratulates them on their achievements in collaboration, improving patient safety, and influencing professional nursing practice. The Department of Nursing hopes that others are inspired by their stories to sustain our efforts to realize the power of possible.

Professional Shared Governance Boards
A revised shared governance structure was proposed during the latter part of 2018 in order to improve efficiency and more clearly delineate areas of responsibility. As a result of this reorganization, six boards were proposed: Professional Advancement Board, Clinical Practice Board, Nursing Research Board, Nurse Manager Board, APRN Board, and Assistant Nurse Manager Board. These boards will report to the Nursing Executive Board which will be chaired by the chief nursing officer. The membership of the Nursing Executive Board will include the chairs of each of the six boards. Full implementation of the central professional shared governance structure was deferred in 2019 as emphasis was placed upon supporting activities of the unit-based councils.

Assistant Nurse Manager (ANM) Shared Governance Board Report (submitted by Betsy Baker, MSN, RN, Chair). The ANM Shared Governance Board meets on the third Wednesday of every month for one hour. During its first year, meetings have been organized with multiple speakers who have provided education to the ANMs on topics such as human resources, emails, the Employee Engagement Survey, interviewing techniques, disciplinary investigations, and Loudermilk hearings. We have been obtaining surveys before and after each session to track data and obtain feedback. We have completed a project to review and make some changes to our orientation check lists. Some of our meetings have been productive with sharing how we all do things a little differently and are learning from each other.

Exemplary Practice/ Clinical Practice Outcomes Professional Governance Council Progress Report
The Cardiac Catheterization and Electrophysiology Laboratory Shared Governance Council has implemented sharing a positive quote and/or inspirational story to the end of each morning huddle. We did this to put a positive spin to the start of each day because staff felt that huddle was often times ending on a negative note. Discussions focused on debriefing a tough case from the previous day, sharing a safety story, or staffing issues. We felt it was important to start the day on a positive note to unify the team and remind us that although our work can often times be challenging, it is less challenging when facing it with a positive mental attitude and a sense of gratitude.

Shared Governance 2019 Year in Review
Professional Shared Governance: Unit-Based Councils
Our nursing professional practice model emphasizes the four characteristics of exceptional nursing practice – compassion, integrity, collaboration, and innovation. Professional shared governance provides a framework and a means through which nurses can exert control over their practice and modify practice to adapt to changing nursing roles and needs of the healthcare environment.

Through shared governance, frontline nurses are supported in having the authority and autonomy to control clinical practice and to contribute to a healthy work environment. One author described an autonomous nursing environment as a “collaborative atmosphere where nursing contributions are valued, processes for participation in nursing research are established, nursing practice is refined, patient safety is assured, and caring is perceived. Self-governance influences nursing practice and promotes patient advocacy. Autonomous nurses are accountable and responsible to make discretionary, independent and proactive decisions.” (Jasmine, T. Art, Science or Both? Keeping the Care in Nursing. Nursing Clinics of North America 2009; 44: 415-421)
Shared Governance Council Accomplishments:

1. Implemented nursing aide checklist to assist with shift report and patient safety
   Change:
   • Allowed aide-to-aide handoff to be more efficient and complete
   • Increased communication with nursing staff to ensure patient safety was constantly addressed across different roles
   • Improved consistency to decrease variability in report among individuals

2. Started data log to capture when RNs are off the floor doing patient transports
   Change:
   • It was found that nursing staff is off the floor for a significant portion of time during any given week
   • Will continue to gather data to try and provide evidence to support possible implementation of staffing roles to assist in these transports

3. Developed bedside shift report checklist for RN staff
   Change:
   • Allowed increased attention to detail for RN-to-RN report during shift change and point of care handoffs
   • Increased patient safety due to more consistent evaluation of infection control measures and fall and safety mechanisms

Shared Governance Story:

When Professional Shared Governance (PSG) was implemented throughout the hospital, the ICU struggled with how to initiate the program successfully while encouraging and maintaining staff involvement. A survey was created by PSG co-chairs to give to staff RNs in the ICU, in order to facilitate a more strategic approach that would address the “most important” staff issue(s) and automatically foster a sense of involvement. These surveys allowed us to focus our approach and enhance staff buy-in with the goal of attaining Magnet® status.

Through these surveys, we discovered an almost unanimous area of interest for staff was the use of nursing aides within the unit. Through PSG meetings, the committee was able to establish a checklist that could be used for nursing aides at both change of shift and throughout the day to increase communication and effectiveness of care. Our management facilitator, Patty Hurley, was able to assist in creating a flowsheet checklist within Epic to track certain measures and allow for consistent shift report between different staff members. Nurses were able to have a meeting with aides at the beginning of the shift to reassess measures such as fall risk, dietary status, toileting needs, activity restrictions, and any social issues. These measures were then also communicated to oncoming shift members to ensure consistency in change of shift report and to avoid gaps in care. A flowsheet checklist was implemented in the unit and every aide received electronic access to the sheet via Epic. Aides and RNs started to communicate about patients’ needs and risks and this allowed for more safe and consistent care for the patients. Aides were able to assist patients more quickly and readily, since they knew the limitations and plan for the patient at the beginning of each shift.
also increased their sense of autonomy as they were able to be proactive with patient care instead of just reactive. This also enhanced patient safety by adding a double-check system to ensure that the right orders were in place for the patient at the beginning of each shift. For example, to improve outcomes, patients are encouraged to get “out of bed.” This aide sheet made it possible to address this issue at the beginning of the shift as RNs and aides would verify a corresponding order for activity. This helped to facilitate a patient’s movement earlier in the day, or, if an order was missing, the nurse was able to obtain the correct order in a timely manner. Nursing staff on the unit has felt that this has been a positive change and has allowed the aide staff to work with more autonomy and structure. PSG will continue to evaluate the effectiveness of the checklist flowsheet through frequent communication with staff and will make revisions when necessary. Through the implementation of this project we hope to show the PSG committee to be inclusive and effective and further enhance staff involvement in the goal of building PSG and attaining Magnet® status.

Calhoun Cardiology Center

According to American Heart Association statistics, over 5.7 million adults in the United States have heart failure. Diseases such as coronary artery disease, hypertension, and diabetes can affect blood flow to the heart or damage heart structures and function causing heart failure. Treatment for heart failure, once diagnosed, includes medications, reduced dietary sodium, and consistent physical activity. Our UConn Health practitioners in the Pat and Jim Calhoun Cardiology Center use Guideline Directed Medical Therapy (GDMT) to streamline medication titration of patients with systolic heart failure and follow them at close intervals to evaluate their symptoms and quality of life. The Calhoun Cardiology Center nurses are proud to be part of the care team, and have ramped up their involvement to include assessments and follow-up both in the clinic and via phone calls.

Cardiology’s GDMT clinic is conducting an active research study that involves baseline, two-month, and one year assessments to evaluate the effects of timely research-based medication titration. Through shared governance we identified a need for close observation of these high risk patients, and saw an opportunity to make a positive contribution to these patients by assisting closely with their care. Staff were educated on the specific needs of this patient population in general and more specifically those of the research patients, and became active participants in their care plans. We assist with weights, vital signs, medication reconciliation, six-minute walk test data, bloodwork, and medication administration during patient appointments. We personally meet and greet the patients so they will be able to connect a face to the voice they may hear over the phone when we call. Patients are given written information concerning their personal list of medications, and the diet and activity that will optimize their health. Future visits and required lab work are reviewed both verbally and in writing. Beyond this, the cardiology nurses follow these patients’ lab work and their compliance with appointments, triage phone calls from them, and communicate concerns with their providers with the goal of early identification of heart failure changes that require intervention. With prompt identification of issues, patients can be treated while at home or in clinic, and can avoid unnecessary and expensive hospital admissions.

Patient education and compliance with the treatment plan are key to their positive progress. When a patient is discharged from the hospital, cardiology clinic nurses call them and/or their caregivers, whether that is family, visiting nurses, or even extended care facility nurses. We make sure the medication list is accurate, that the patient’s weight will be recorded daily, and that they are familiar with the “Zones of Heart Failure” that outline how to handle weight changes. We make or review dates of upcoming appointments, discuss dietary salt restrictions, and the need for daily activity, and reinforce that we are just a phone call away should they have a question or a concern. We hope that the personal attention helps to alleviate any fears the patient and family have related to the diagnosis of heart failure. We also hope the relationship we establish also has a positive effect on patient compliance to their plan of care because their lives literally depend on it.

Dermatology

Fall risk screening is the NDNQI indicator that our UConn Dermatology Unit Shared Governance Council chose to address. While we are always conscious of initiating interventions immediately for patients who appear to be at risk for fall, the communication of this assessed risk to other members of the team via Epic was a problem we recently uncovered.

Dermatology is comprised of three ambulatory care clinics in Farmington, Canton, and Storrs. Many of our patients are elderly and have multiple comorbidities. A situation occurred in which an elderly patient, with undiagnosed cardiac issues, slowly collapsed and fell against a wall on the way to the door after checkout. After reviewing this unanticipated event and the patient’s chart, we saw that the fall risk screening flowsheet had not been completed. The involved staff stated the chart indicated “yes” at the top in Epic and was highlighted in red, and they thought this meant the fall risk assessment had been completed and interventions initiated. Other staff (medical assistants and nurses) within the Farmington unit were quickly polled, and they also had a similar impression of this Epic indicator. This was immediately recognized as a potential communication problem, as well as a patient safety issue. Other patient charts were then reviewed for fall risk flow sheet completion, with the finding that this screening tool was being overlooked for at least 20 patients per week. This was an obvious problem that needed to be rapidly solved, not only for patient safety, but as an opportunity for clarifying our nurse quality indicators.

What did we do to rapidly correct this problem? First, we clarified the meaning of the “yes” indicator with the Epic team. We learned that the “yes” indicator doesn’t mean the fall assessment was completed. However, Epic uses this as the default display for the chart for anyone over age 70. It will remain so for the foreseeable future, so it will be up to staff and providers to open this flowsheet every time to see if an update is needed. Next, staff nurses and medical assistants were retrained to be aware of these flowsheet update requirements. At the retraining, they were taught to compare changes between last flowsheet and the current visit within patient parameters, and either update as appropriate or complete a new flowsheet.

Patient charts are being audited daily by the Assistant Nurse Manager, Scott Calderone, BSN, RN. Currently, between all UConn Health Dermatology Units, the audit results show that we are missing no more than one fall risk flowsheet update per day. We also have not had any additional falls since the incident.

We will continue to work hard to align our goal of fall risk management not only within the framework of the UConn Health nursing professional practice model, but to try to also exceed the national standards.

Intermediate Unit

Starting on March 14, 2019 and ending on July 1, 2019, the Intermediate Unit initiated skin rounds to help aid in Hospital-Acquired Pressure Injury (HAPI) prevention. We started with biweekly skin checks on each patient that were performed by two RNs. Our clinical nurse specialist and five identified skin champions assisted each primary RN with skin assessments.

Our data found that, while our intervention was in place, we had no HAPIs on our unit. While this audit took place, we increased our stock in heel boots. Our two RN approach improved our compliance with pressure injury prevention techniques.

Medicine 3

In October 2018, the Medicine 3 professional shared governance unit council met for the first time. This council has had the unique experience of working in partnership with the Connecticut Hospital Association Innovation Council. The Medicine 3 council has successfully completed one project that has been rolled out hospital-wide and has completed a second project in conjunction with the Innovation Unit that is preparing to be implemented hospital-wide.
The first project that the unit council addressed was an idea that was brought to the council by two staff nurses on Medicine 3 who voiced concerns over the difficulty of finding lab draw supplies and intravenous line start supplies during emergency situations.

**Medicine Surgery 5 (DOC)**
As in the other nursing units, the chair for shared governance reached out to the staff to determine what was working for them, what was not working, or what process would they like to see improved. There was a consensus that one of the biggest dissatisfiers was how the meals were ordered for DOC inpatients and the time the nursing staff spent on managing their requests.

The original process was that the inpatients had a modified menu from which they ordered. The nurse would fax the menu to the diet office; meals were prepared and sent the unit. Although this process sounds simple and straightforward, it became, as the nurses felt, labor intensive at times. The inpatients would change their minds about their choice, or have complaints such as missing items, and the responsibility to get things corrected belonged to the nursing staff.

The Shared Governance Council distributed a survey to all the staff; would they prefer to see a modified menu choice for the inpatients or a choiced option in which the diet office would send up the “meal of the day” for breakfast, lunch and dinner? The majority of the staff chose the choiced option. This option kept the nursing staff out of the loop when it came to ordering meals.

The shared governance group worked closely with the diet office to change the meal ordering process. The inpatients adjusted well to the change. The process closely mirrors the process in their facilities, achieving consistency with procedures to which the inpatients are accustomed.

The implementation of this process by which the inpatients on Medicine Surgery 5 receive their meals, envisioned by the nursing staff, has been a success and has been sustained for several months now.

**Medicine/Surgery/Oncology**
An email was sent to all staff to determine, what do we, as a unit, want to work on for a shared governance project. There were several thoughts and ideas, but one consistent theme kept coming up. It seemed the staff was becoming increasingly frustrated with the often difficult behaviors of certain patients and family members. Nurses were verbalizing feelings of defeat. They sensed there was no support for them, and felt ill equipped to care for these patients effectively.

Our first shared governance meeting began as a debriefing session and we elicited the guidance of Heather Spear, APRN, and Chaplain Katy Wilcox, M.Div., ACPE. Katy and Heather ultimately became the facilitators for our group. They listened to our concerns as we, the nurses, expressed frustration with having to take care of patients and not feeling equipped to manage the behaviors we were seeing. It was clear that we needed to meet again as the level of frustration and the issues confronting the nurses seemed larger than anything one single meeting could solve. We agreed to meet again in two weeks. The meeting ended with a facilitator offering some pointers on managing difficult behaviors and encouragement for self-care to cope.
By the time of the next meeting a facilitator suggested three areas to consider and explore that may help:

- what is already in place within the hospital administrative structure for caring for patients and families with violent or abusive behaviors,
- what education could be offered to teach nurses how to better manage the behaviors they have been seeing, and
- self-care to cope as professionals within the context of caring for difficult patients and families.

Facilitators continued to listen to the feelings of the nurses on the unit for several sessions, knowing that they needed to be heard. They took notes on what they were hearing such as “Can we say no to certain behaviors?” “Will we get in trouble for setting boundaries?” “What are appropriate boundaries?” “Should we be reporting these behaviors?” “How much am I supposed to be able to take?” “Who will back us up?” “What can be done?” “What about abusive families?” “Can they stay overnight?”

Nurses expressed that the Code Strong team is not communicating with the bedside nurse. The team comes and medicates a patient and then leaves before the behavior has been settled. “Can the code strong team communicate a behavior plan for the patient before they leave?” “Can they tell the bedside nurse they are leaving?” This is important because the RN is often with another patient when the team leaves. “Can there be a behavior plan for these patients?”

As nurses shared frustrations, concerns, and questions, ideas started to surface among the group regarding what could be done. They started to answer their own questions with ideas. The meetings then morphed into genuine shared governance as nurses themselves began to take charge of creating solutions to problems. Their first conquest was, could there be a sign that is

Neag Comprehensive Cancer Center

The Neag Comprehensive Cancer Center infusion room nurses noted a high incidence of phlebitis in patients receiving a peripherally-administered IV antiemetic premedication. This phlebitis often necessitated an IV restart prior to the patients’ receiving their chemotherapy. The nurses investigated by performing a literature review which confirmed that the IV antiemetic premedication can cause an increase in episodes of phlebitis and extravasations when given peripherally. Nursing staff worked with their peers, the management team and the pharmacy to identify an alternative formulation of this medication. The alternative medication identified had the potential to decrease incidences of phlebitis. This medication was added to the formulary and replaced the previous medication in all Epic treatment plans. Since this change was implemented, zero incidents of phlebitis related to the new antiemetic have been reported. In addition, the medication can be administered over two minutes via IV push versus the standard formulation which took 30 minutes to infuse, thus reducing chair time for patients.

Nephrology Clinic

As the only registered nurse in the Nephrology Clinic, I collaborate with eight doctors, one APRN, and two medical assistants in caring for patients with chronic kidney diseases (CKD). My responsibilities as a nurse include anemia management, giving hepatitis B vaccinations to patients before they start their dialysis, providing blood pressure checks after medication changes and helping in the development of the treatment plans.

Outcomes achieved over the past year include:

- Increased number of blood pressure checks for patients.
- Initiation of more hepatitis B vaccinations to patients with CKD stage 4 so they are prepared earlier for dialysis.
- Expanded patient education regarding chronic kidney disease. We obtained educational materials from the National Kidney Foundation and give these to patients so they can learn more about their diseases and treatment plans.
- Adding the educational materials into our Epic computer system, making this information easier to print out and hand to patients upon leaving the clinic.
- Creation of a new clinical response grid to help separate our clinic task roles. In the grid there are separate task boxes for nurse and medical assistants. This was created with assistance from the APRN and unit manager.

I have also assumed increased responsibilities in anemia management, including providing more Retacrit injections. This involves checking the patients’ blood work to see if there are any improvements in their hemoglobin/hematocrit and iron/TIBC levels. Any changes in the lab results discovered are communicated to our providers so that they can make the necessary adjustments to the Retacrit injection dose or treatment plan, which may include iron infusions.

Operating Room (JDH)

In the JDH Operating Room Unit, we successfully completed our goal of reorganizing the way we stock sutures. As a first step, our shared governance group sought suggestions from our coworkers regarding how we can improve our workplace. We chose to address our suture trees, mobile stocking shelves designed to hold sutures for each particular service (e.g., general surgery, neurosurgery, plastics, etc.). As a group we thought this was a manageable task that would both improve efficiency in our workplace and fulfill the staff.

In coordination with our OR manager and the materials management team, we researched options and selected our favorite. We trialed one cart, which was very well received by the shared governance group and the rest of the OR staff. We then purchased suture...
trees for every service and had each service lead organize and stock them. The suture trees are a huge improvement from the older, messier trees that were falling apart. Nurses and techs on the unit now have the resources they need in an orderly, easily-accessible fashion. In turn, workflow is improved and patients receive better care. We were happy to remedy this problem and satisfy the rest of our unit by doing so. We are excited to extend this project in the future by reorganizing the entire stock room of sutures.

Preoperative Services Unit

In March of this year, we began a new journey. In our desire to provide truly patient-centered care, delivered according to the highest quality and safety standards, we established shared governance committees on each unit. On the Preoperative Unit, one of our initial areas of focus was the Pillar of Excellence, Growth.

Our goal is to transform our unit practice culture to one that involves decision making that is truly shared and gives the bedside clinicians a strong voice in advocating for our patients and determining unit practice. Toward that end, in order for staff to feel competent to provide excellent patient care, we felt that our unit needed additional and ongoing education.

Due to the unusual hours of operation in the preoperative area, Monday, Tuesday, Thursday, and Friday 6 a.m. to 2:30 p.m. and Wednesday 7 a.m. to 3:30 p.m., the staff communicated an inability to attend many of the educational offerings provided within the hospital. The later start time on Wednesdays at 7 a.m. occurred because the OR had an hour set aside each week for in-service time. The preop staff felt strongly that we also should be allowed to start at 6 a.m. on Wednesdays, and be permitted to utilize that hour for educational offerings, inservices, and journal club presentations. In that way, the staff could stay current on standards of care, evidence-based practices, and performance improvements applicable to our area.

In April, we changed our Wednesday schedule and we now work 6 a.m. to 2:30 p.m. five days per week. From 6 to 7 a.m. on Wednesday, staff members take turns to provide an educational session on a topic of their choosing that is pertinent to preoperative care. We have had sessions on moderate sedation, hidranitis, meditation for healing, hypothermia, and surgical site preps just to name a few.

All the staff participates, and we all feel empowered with this additional knowledge to provide superior patient care. This initiative to improve staff growth has been extremely successful. Though this schedule change started out on a temporary basis, it has become our normal schedule, and we all look forward to our Wednesday morning education. We are eager to continue this journey toward improved levels of satisfaction for both staff and patients alike.
Pulmonary Clinic

Nurses in the Pulmonary Clinic have set a number of goals that are directed both at workflow and patient outcomes. These include:

- Improving efficiency of care and patient satisfaction as evidenced by decreasing clinic wait times for patient care.
- Improving discharge care for patients hospitalized with pneumonia and/or COPD by promoting optimal self-care as they transition from the inpatient setting to home or a skilled nursing facility.
- Improving wait times for patients needing injections.
- Outperforming national benchmarks for COPD and pneumonia all-cause readmission rates.

Activities that have been implemented for achieving these goals include:

- Separating the workflow of the Clinic/Procedure RNs from that of the Telephone Triage RN.
- Monitoring hospital readmission rates and ED visits of patients following hospitalization for COPD or pneumonia.
- Tracking adherence to discharge follow-up appointments after hospitalization for COPD or pneumonia.
- Implementing post-discharge calls to patients who have been hospitalized with a primary diagnosis of COPD or pneumonia. Nurses will identify patients through daily review of the inpatient census and:
  1. Make calls within two days of discharge; if the patient was discharged to another facility, communication will be with the patient’s nurse.
  2. Ask patients discharged with home care services for permission to speak with the nurse from the home care agency in order to review the discharge plan.
  3. During follow-up calls review the discharge plan of care with the patient or the patient’s caregiver, including the patient’s pulmonary status, medication regimen, prednisone tapers, oxygen requirements, verification of delivery of oxygen and nebulizers by DME vendors, and dates and importance of follow-up appointments with the patient’s PCP and the pulmonary provider. Nurses will review COPD Action Plans and Pneumonia Zones as applicable and attempt to reconcile any discrepancies in medications or the plan of care.

Surgery/Orthopedics 5

On Surgery/Orthopedics 5, the shared governance model facilitates decision making involvement at all staff levels. The frontline nursing staff has been empowered to recognize barriers to clinical practice on our unit and collaborate with management to resolve identified issues. Our unit practice council is the proletariat governance structure by which staff nurses and other team members partake in decision-making regarding how to improve nursing practice and provide quality care to the patients on our unit. Our unit practice council identified two key issues that needed to be addressed, our call bell response time and the need to implement an admit/discharge nurse role.

Our call bell response time was a top priority that needed immediate attention. Based upon our patient satisfaction survey we were at an all time low of 33.3% in July of 2019. Preceding that time frame, our call bell response time hovered between 36% and 56.3% (from November 2018 to June 2019). Being cognizant of our poor call bell response time and the negative impact it had on our patient population the unit practice council worked on implementing strategies that would improve our unit’s response time. The call bell data were reviewed for each shift on a daily basis and were discussed with staff members at every safety huddle.

We created a little competition by comparing day shift to night shift results and compared our unit as a whole to other units throughout the hospital. Staff members were encouraged to use a team approach with everyone responding to all call bells even if not assigned to that room and we utilized volunteers on our unit to aid us with this venture. Over time we have seen significant improvement with average call bell response time of less than 2 minutes throughout each 12 hour shift. Our Press Ganey scores skyrocketed from the 30th percentile to the 70th percentile as of October 2019. Based upon the improvement with our call bell response time there was an upward trend in our Press Ganey scores with patients reporting improved staff responsiveness from 43.9% in July 2019 to 75.7% in October 2019. Help with toileting as soon as it was needed also improved from 54.5% in July 2019 to 80% as of October 2019. Overall since November 2018 to October 2019, our unit has hit its highest rank in the abovementioned areas based upon our Press Ganey surveys.

Secondly, we identified that our unit had a very high patient turnover rate of postoperative patients. Throughout a 12 hour day shift we averaged 10 to 15 discharges and 10 to 12 admissions. This new role was made official and two 75% positions were implemented for two admit/discharge nurses on our unit.

As we continue our journey in taking on new challenges; our aim is to continue to work on improving our practice on our unit and maintaining favorable patient outcomes. Nursing staff from Surgery/Orthopedics 5 constantly strives for excellence. It is our hope to have shared governance transition from invitation to expectation in which all staff on our unit, managers and administration will equally assume responsibility, ownership, and accountability for their respective roles.

The members of the Surgery/Orthopedics 5 Shared Governance Council are Toni Ann Ryan, unit chair; Monika Mukollari, co-chair; Gina Barlow, secretary; Amanda Darcey, facilitator; Ligia Luangpraseuth, advisor; Kristel Rivera, advisor; Durand Tessier, nursing assistant liaison, and Angela Beausoleil, nursing assistant liaison.
OB/GYN

SITUATION:
The merging of OB/NBN with Labor & Delivery into one unit created stress and animosity among staff nurses. Nurses were often expected to float between each unit depending on staffing needs without always considering unit-specific skill sets. Because not all of the nurses had the same skill level, some nurses had to float more than others did, and, sometimes more than one time during a shift. Some nurses even had to be scheduled for emergency staffing out of turn because they had the specific skill set required. At a shared governance meeting we discussed ways to alleviate the stress and worked together to come up with a process for floating between OB and L&D that is fair for all involved.

BACKGROUND:
Over the past several years, the three separate units of Newborn Nursery, Postpartum, and Maternal-Fetal ICU were merged into one unit consisting of OB and Labor & Delivery. Although we are now one unit, we are still physically separated by a door between the units. This provides added challenges with staffing. The nursing staff from the three original units have very specific unit-based skill sets. The transition from three to one has not been without “growing pains.” Newborn nurses became part of the postpartum unit with training provided to all. Cross training was offered for “volunteer” nurses from OB to the L&D unit, but not everyone accepted the challenge. Any new staff that are hired are hired specifically as LDRP (labor delivery recovery postpartum) nurses and they are expected to travel between all areas. Although we are officially one unit, the term “float” is still used when staffing. The expectation is that we are competent in two of the three areas. Nurses have been vocal regarding their preferred work area and their comfort level taking specific assignments and because of this, we decided to bring it to the shared governance group to come up with an improved process.

ASSESSMENT:
A questionnaire was posted on each unit asking nurses if they had a preference or no preference regarding the unit on which they worked. We did this in an attempt to perhaps have enough nurses to make up a core group that would be willing to float between units. The responses were almost unanimously split in favor of working on the unit to which the nurse was originally hired. A second questionnaire was then posted asking nurses to identify their specific unit-based skill set. This aimed to identify those areas in which each nurse felt her skill sets were the strongest.

RECOMMENDATION:
1. The six newly-hired LDRP nurses, and all new hires, will “float” first.
2. Nurses who float will self-advocate and communicate their competencies and speak up if they feel their assignment is unfair.
3. Nurses will seek out experiences that will strengthen their skill levels.
4. The float nurse will be treated as a “guest.” Assignments will be made fairly with consideration given to the nurse who is leaving an assignment on her home unit to help during an emergency so that she does not fall behind on her original assignment.

We will continuously look at this process and solicit feedback from staff as to ways to continue to streamline the floating process between the two units.
Generating New Nursing Knowledge: The Nursing Research Fellows Program

The Research Fellowship Program was created in 2017 for UConn Health nurses to professionally advance in their nursing research skills and to improve quality patient care through innovation and evidence-based practice. The Research Fellowship Program is a didactic and experiential course that is nine months in duration. The fellows attend 20 days of classes (two days every other month). At the completion of the program, the fellows are expected to have developed a performance improvement or research project for implementation in a clinical setting to meet challenges and needs of UConn Health nursing.

The program faculty are Robin D. Froman, Ph.D., RN, Executive Research Consultant for UConn Health and Research Professor UConn School of Nursing, Regina M. Cusson (2017-2019), Ph.D., NNP-BC; APRN, FAAN, Professor and former Dean UConn School of Nursing and Betty Moll, Ph.D., RN, Assistant Professor in Residence at UConn School of Nursing and Nurse Scientist at Middlesex Hospital. All course materials are provided and the fellows are provided with release time for their attendance.

Projects developed to date by the research fellows include:

1. Quality Improvement Initiative: A Comprehensive Care Management Approach to Reducing COPD Readmissions was designed to test a care management intervention to determine if we can reduce our COPD readmission rate. Data collection is progressing with Priscilla Cabán, PhD, RN, CCM, as the principal investigator.

2. “Dress for Success: A Randomized Control Study Looking at How Dressing Patients after Elective Surgery can Influence Recovery” has been approved by the Institutional Review Board (IRB) although data collection has not yet commenced. The investigators are Christine Campbell, RN, Nurse Manager and Laura Glynn, RN, from Surgery/Orthopedics.

3. Safety Perceptions of Drug Handling (SPED) by Devon Bandoukeres, MSN, RN, OCN, Beth Brookshire, MSN, RN, and Sam Busam, RN, OCN, was originally conceptualized as a project to identify barriers to nurses’ following recommendations for handling hazardous drugs. Under the guidance of the research faculty, the investigation was modified to devise and test the reliability and validity of a new instrument that measures RNs’ adherence to National Institute for Occupational Safety and Health (NIOSH) safe handling practices. The study authors presented their preliminary findings at the poster session of the Eastern Nursing Research Society’s conference in April 2019. The investigators have completed two rounds of data collection and are finalizing the interpretation and factor analysis of their instrument.

4. Effectiveness of Quiet Time Protocol Compared to Usual Standard of Care on Perception of Sleep is a project initiated by three investigators from the 2018 class of research fellows, Rachel Meehan, MSN, APRN, ACNS-BC, Kate Falotico, BSN, RN, and Pamela Nolan, BSN, RN. The project has been approved by the IRB and data collection is beginning. These investigators will be joined by two members of the 2019 class of research fellows, Carolyn Guarino and Marisa Fernandez, and the goals of the project expanded to measure patients’ perceptions of barriers to sleep and their sleep efficiency.

5. The “Cardiac Arrest Debriefing Study” is a project designed to improve the performance of nurses both in and after cardiac arrest situations through post-cardiac arrest debriefing. This project is being conducted by Lauren LeBlanc, BSN, RN, Ryan Massicotte, BSN, RN, and Amanda Murphy, BSN, RN. The investigators are aiming to improve the mindset of nurses in cardiac arrest situations. They are proposing to use a standardized debriefing model post-cardiac arrests to help improve teamwork between different disciplines. Their project is predicated on the belief that debriefing will lead to professional and personal improvement, which will further improve patient outcomes. Domenic Roy, BSN, RN, has joined the study team as a 2019 research fellow. Data collection for this performance improvement project is expected to begin in mid-December.

The nursing research fellows continue to receive expert advice and mentorship from the faculty throughout project implementation. The members of the September 2019 class of research fellows are Marissa Fernandez, BSN, RN, Surgery Orthopedics Unit; Carolyn Guarino, MSN, RN, Quality Assurance Specialist in Clinical Effectiveness Administration; Domenic Roy, BSN, RN, Intensive Care Unit; Sara Mavredakis, BSN, RN, Postoperative Services; and Claire Suits, BSN, RN, Medical/Surgical/Oncology Unit.

Supporting “Second Victims” with Peer-to-Peer Support Training

An unanticipated adverse patient event, such as an unexpected patient death, a medical error, or a patient injury can cause intense emotional suffering to healthcare providers. An estimated 10 to 40% of healthcare professionals have the experience of being “second victims”, because they were victimized and traumatized by an adverse event. This phenomenon can exert a huge personal toll with feelings such as guilt, anxiety, depression, self-doubt, anger and frustration. There may be psychological consequences such as fatigue, difficulty concentrating, or sleep disturbance or deprivation. Less commonly, clinicians may experience suicidal ideation or symptoms of PTSD. Experienced professionals may leave their work setting or their profession, especially if they are working in a non-supportive environment or if they are suffering in silence.

A peer-to-peer support infrastructure, through which staff have immediate access to support and guidance following a traumatic event, can be instrumental in assisting staff to cope and to recover. Peers are considered to be ideally suited to perform the initial support function because they are able to offer the unique gift of working side-by-side within the organization and having similar professional experiences.

Five rights have been proposed for second victims in accordance with the acronym TRUST. (Coughlan, B; Powell, D; and Higgins, MF. The Second Victim: A Review. (2017) European Journal of Obstetrics and Gynecology and Reproductive Biology. 213: 11-16.)

TREATMENT
Immediate emotional peer support and debriefing
RESPECT
Understanding and Compassion
Supportive Care
May include consultation with experienced professionals internally (e.g., Employee Assistance Program) or psychotherapy
TRANSPARENCY
And the opportunity to contribute to enhancing systems of care
NICHE: Nurses Improving Care for Healthsystem Elders

UConn Health has been a NICHE Member Hospital for three years. NICHE promotes a culture of geriatric excellence by incorporating evidence-based clinical practice, education, research, and patients’ preferences and values. The program continues to develop and thrive under the leadership of Rachel Meehan, MSN, APRN, ACNS-BC.

An important current NICHE program activity is improving the care for patients with delirium. This activity was identified as a quality improvement activity in 2018 and progress towards care delivery enhancements include:

- Ace Tracker report was built in Epic. This report contains a list of current patients aged 65 and older with specific elements for identifying geriatric syndromes and patients with delirium. Rachel Meehan has educated the geriatricians regarding how to access this report and will be collaborating with the geriatrics fellow regarding using the Ace Tracker to help identify patients at risk for development of delirium.
- A patient and family educational brochure on delirium is being developed to provide important information about delirium to older adult patients and their families.
- Education of nurses toward screening older adult patients for delirium using the Confusion Assessment Method (CAM) tool continues. If a patient screens positive, the nurse contacts the patient’s attending physician and immediately begins implementing the delirium order set. This order set contains a variety of interventions to keep patients safe and oriented and also requests consultations from Geriatrics and Pharmacy staff to evaluate the patients and their medication lists.

Another NICHE initiative is the creation of the “Get to Know Me Board” which is one means to personalize patient care and facilitate meaningful communication with all patients. Newly-admitted patients and their families are asked to provide information such as their preferred name, names of other family members, friends, pets, previous career, and favorite things to do. Staff can utilize this information to engage in meaningful conversation with the patient especially during episodes of challenging behaviors. This component of the NICHE program is currently being evaluated in Medicine 3 by the NICHE committee in order to make the board useful and accessible to all staff with the goal of spreading to other units soon.

The NICHE nursing group is also exploring the possibility of offering music therapy to patients on a more regular basis, following a well-received medical student volunteer holiday “concert.” Many patients, including the elderly, have demonstrated numerous physiological and behavioral benefits from music therapy.

NICHE continues to maintain therapeutic activity carts on the inpatient units of Medicine, Surgery/Orthopedics, and Medicine/Surgery/Oncology as well as in the Emergency Department. These carts contain stuffed animals, playing cards, large print books, and puzzles that can be utilized for any patient to provide a source of socialization and cognitive stimulation, especially for older adults with dementia or delirium. A donation drive for supplies was held in November in order to maintain the supply of frequently-used items. One donated item that we received was a very large stuffed dog. This was so large that it pushed the limits of the NICHE activity cart supply storage, so we hoped
to find it a home sooner as opposed to later. It was timely then, that the next time we went to restock the NICHE carts, a nurse on the 6th floor saw the large dog and thought that one of her older adult patients who was feeling lonely and agitated that day might find it comforting. The nurse’s hunch was correct. Once she brought the dog into the patient’s room, from the hall, one could hear the collective sigh as the patient’s arm reached out to embrace the dog that was half the size of her small frame. After the NICHE cart was restocked, we passed by the patient’s room to see her calmly holding and petting the dog and the nurse expressed to us that the large dog was exactly what the patient needed that day!

NICHE continues its collaboration with UConn Allied Health Science undergraduate students by training and supervising students in the Purposeful Visitor Program. This program was designed for students who want to experience working in a healthcare environment. They volunteer their time to earn 1 credit for volunteering time and 3 credits for volunteering time and doing an independent study project. The students visit patients and engage them in therapeutic activities such as conversing, reminiscing, listening to music, reading, completing puzzles, etc. The program has been recently expanded to include them in performing safety rounds such as making sure patients have their call lights and personal items within reach and that their rooms are free of clutter. Students also answer call lights, and act as meal mates by providing assistance to patients during mealtime by identifying food items on their trays, opening containers, cutting food as needed, coaching/encouraging patients to eat or drink, and visiting patients who need company during mealtime. Currently there are eight students participating in this very successful program. During the fall semester, students performed 142 patient visits and 111 patient safety rounds as part of the Purposeful Visitor Program. Plans are being made to expand the program to include additional students and hospital volunteers.

UConn Health's Primary Stroke Center

UConn John Dempsey Hospital has been recognized with The Joint Commission’s Gold Seal of Approval® and the American Heart Association/American Stroke Association’s Heart-Check mark for Advanced Certification for Primary Stroke Centers. These awards recognized sustained compliance with stroke related standards and requirements and are illustrative of a commitment to excellence in care of patients with stroke. In 2019, the Stroke Center won the Gold Plus, Target Stroke Honor Roll Elite Plus. This is the highest award a stroke center can win. It is not an easy award to obtain and shows the Elite status of our Stroke Center for Excellence.

UConn Stroke Center has grown considerably since its inception in 2014. In 2019, we saw almost 500 stroke alerts for the year! This annual growth is illustrated in the graph.

In addition, our thrombectomy program has flourished. Only a small percentage of stroke patients qualify for and obtain benefit from thrombectomy. We have almost doubled our procedures since last year, completing 25 of these procedures in 2019. Most importantly, we have had many of our patients come back and share their success stories.

A major educational initiative was undertaken in May 2019, in conjunction with National Stroke Month, to introduce the BE FAST mnemonic for stroke recognition. BE FAST expands upon the traditional FAST designation (Face drooping, Arm weakness, Speech difficulty, and Time to call 911) as a means of improving early recognition of atypical stroke symptoms. Failure to recognize these atypical signs may delay initiation of the stroke clinical pathway with subsequent adverse effects on patient outcomes. BE FAST includes Balance (sudden loss of balance) and Eyes (vision loss). The SABA learning platform and unit-based inserviceing with case reviews have been used for staff education. In the fall, BE FAST competency was validated for staff in multiple clinical settings and with both clinical and non-clinical roles to ensure early recognition and prompt and correct action. Revised posters, badge buddies, flyers, and elevator signs were created as communication tools. Stroke champions play an integral role in sustaining communication and acting as liaisons between the Stroke Center administration and unit staff.

Jennifer Sposito, MSN, RN; Diane Swol, MSN, RN; and Sanjay Mittal, MD, presented a poster entitled “Need for Speed: Saving Critical Brain Function with System-Wide BE FAST Stroke Education” at the International Healthcare Institute National Forum and at the Northeast Cerebrovascular Consortium. Successful implementation of BE FAST at UConn Health is reflected in data which demonstrate:

• 51% increase in overall stroke alerts
• 27% increase in stroke alerts with atypical symptoms
• 17% increase in combined TPA/thrombectomy acute stroke interventions
• Reduction in missed opportunities to perform dysphagia screens in patients with BE FAST atypical symptoms from 43% to 8%

Professional education remains a priority of the Primary Stroke Center, with regularly scheduled continuing education offerings. The annual stroke conference was attended by more than 250 care providers and continues to be a popular and informative educational program. Over 100 members of the community attended our Stroke Survivor Symposium. One hundred eighty eight (188) Stroke Unit RNs completed the 8 hours of stroke education required annually by The Joint Commission. This equates to more than 1,500 hours of continuing education.

On a more personal note, patient stories of stroke survivors have been shared in news releases and at the Stroke Survivor Symposium and EMS Symposium which attest to the dedication of the stroke team in providing exemplary care to individuals experiencing stroke.

Closing the Loop by Taking ACA (Apparent Cause Analysis) on the Road

Sustaining a culture of safety requires ongoing communication, transparency and involvement of unit staff at all levels in problem solving. The quality and safety nurses responsible for reviewing Safety Intelligence™ (SI) reports discovered that there were missed opportunities to obtain perspectives from frontline staff when apparent cause analysis investigations were performed.

Apparent Cause Analysis (ACA) is a formal investigative method but is limited in scope as compared to root cause analysis (RCA). An ACA is warranted when the level of harm to a patient is minor or temporary, or even if the patient was not harmed, the risk to another patient is high. The goal is to identify and mitigate any factors that are at the system level.

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At UConn Health, all Safety Intelligence™ reports undergo committee review and the necessity for performing an ACA or an RCA to investigate further is determined. The SI review committee has acknowledged that event reporting and review have been perceived by some staff as punitive. Closing the loop and providing follow-up communication to staff involved with safety events has been done inconsistently, potentially hindering staff investment in the processes of safety event reporting and evaluation.

In order to demystify the ACA process and to increase staff participation and engagement in discussions about patient safety, the Department of Quality and Patient Safety has initiated “ACA on the Road”. These safety ACA rounds have been conducted within the involved department and at change of shift. The discussion focuses on the actual events from the SI™ report. Neither staff nor patient names are used, only the roles of involved individuals. Discussion items include the event leading to the SI™ report and pertinent information from the review. Staff are asked to talk about what they think might be barriers within our system that contributed to the event and what corrective actions they feel would mitigate the event from occurring in the future. The ACA rounds leaders stress that the goal is to bring the information to the sharp edge, as they don’t live in their world, and want to hear from the bedside clinicians or department experts because they often have great ideas as to how to fix the system.

To date, the ACA rounds have been conducted on all inpatient units and within other departments including Transportation, Pharmacy, Food and Nutrition, Respiratory Therapy, and Central Sterile. The team is now well into its second cycle of inpatient unit rounding. One potential future initiative to enhance staff understanding is publishing de-identified ACA information in the Friday Flyers; this requires clearance from legal to ensure that there are no confidentiality concerns. Another future goal includes developing on the road interprofessional rounds that will include medical and ancillary staff as well.

In addition to involving staff in risk prevention, patient safety and problem solving, team goals are to reinforce that safety event reporting and review is not punitive. Staff are strongly encouraged to report near misses - what we at UConn Health call Good Catches. Near misses are those events that do not reach the patient but are caught by vigilant attention to detail or by a barrier such as a double check that is designed for error prevention. Reporting near misses allows us to identify potential weaknesses in our care processes that might benefit from greater attention and resources.

Ann Sakitis, BSN, RN, and Amy Zipf, MSN, RN, are coordinators of the Safety Coaches meetings and are striving to reinvigorate and reenergize the program. From the reported Good Catches the Safety Coach group is now selecting the Best Catch each month. Best Catch winners are acknowledged in the Friday Flyer and receive a recognition certificate. In addition, the Best Catch awardees are highlighted at the hospital’s daily safety huddle and rewarded with a $25 gift card. Each Best Catch winner will be eligible to be awarded the Greatest Catch, a determination that will be made annually. All staff are encouraged to communicate with their Safety Coaches regarding safety issues of concern or to express interest in participating in unit-based safety initiatives. Review of our 2018 data indicates that we have met our performance goal in all measures.
Medicine 3 Innovation Unit Activities
In 2018, UConn Health joined the Connecticut Hospital Association’s initiative to develop a Patient and Family Engagement Innovation Unit. Medicine 3 was designated as our Innovation Unit. In order to accomplish its goals, an Innovation Unit Design Team, comprised of members from nursing leadership, the Medicine 3 Shared Governance Council, other unit staff, and the Patient and Family Advisory Council was created. The Innovation Unit Design Team will devise and examine strategies for increasing patient and family-centered care.

The introduction of the Innovation Unit Project to the Patient and Family Advisory Council (PFAC) and to the Medicine 3 staff occurred in the fall of 2018. Under the auspices of the CHA and the Innovation Unit Design Team, thoughtful and methodical performance improvement processes were followed. The initial steps were exploratory and included brainstorming, open discussions at shared governance meetings and huddles, and surveys of nurses and PFAC members to explore topics such as exceptional patient experience, important issues for patients, and barriers and facilitators of communication. Feedback was also obtained from interviews with discharged patients at the time that follow-up calls were made.

The Medicine 3 Innovation Unit Design Team selected bedside shift report, an evidence-based practice, to implement in order to enhance the experience of hospitalized patients by improving communication and increasing patient and family engagement. In order to be successful, the Innovation Unit Design Team recognized that it was critical for staff to champion this endeavor and to understand the “why.” The need to answer call bells during change of shift was identified as a barrier that had to be overcome in order for bedside shift report to be successful. Involving staff from the outset and implementing the change in a systematic way with all staff were priorities.

Preparatory work included:
• Creation of a Nurse Bedside Shift Report patient education brochure to be given to patients on admission. This was modified with permission from the AHRQ resources.
• Clarification of expectations and education of certified nurse aide regarding rounds done prior to change of shift to accomplish patient care needs such as toileting, water pitchers, and obtaining supplies. This was determined to be a key element in nurses’ ability to perform bedside shift report efficiently and for patients to be engaged in the process.
• Modification of the certified nurses’ aide worksheet, in collaboration with the Epic team, to address important elements related to rounding and communication.
• Devising a strategy for small scale change implementation, for testing, review, and modification prior to full implementation.
• Development of a standardized structure/process for bedside shift report using the HELLO2U format.

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HELLO2U
Hello (introductions of staff/patient/family)
Exam by exception (focused assessment)
Labs and tests (what tasks need to be done)
Outcome and plan (what to expect for the day)
2 RN safety check (bed alarm and call bell)

Unanswered questions and update whiteboard

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The full roll out for RNs and nurse aides on Medicine 3 occurred in early June 2019. Results of the implementation of bedside shift report are being measured through documentation of the number of call lights (using the Rauland Report) during change of shift, patient experience metrics, and falls. Preliminary findings have been positive and will continue to be monitored.

These results have not been achieved without some challenges, including ensuring consistency of implementation during weekends and with float staff as well as compiling and organizing data from multiple sources. The Innovation Unit Design Team has proposed the creation of door hang tags as a means of identifying those patients who want to participate in bedside shift report. This permits autonomous patient decision making; however, RNs must still enter the patient rooms for change of shift bedside safety checks. The door hang tags are being finalized in collaboration with the Medicine 3 Shared Governance Council.

Plans are also being developed for broader implementation to other inpatient units so that bedside shift report using the HELLO2U structure will become more widespread. The Medicine 3 Innovation Unit Design Team is currently collaborating with the medical director and the Shared Governance Council to identify its next project. Stay tuned!
Congratulations to the Following Nurses Who Were Promoted in 2019 After Meeting All Clinical Advancement Requirements

Promotions to Clinical Nurse III:
- Kristen Bryant, Intermediate Unit
- Dawn Carroll, Emergency Department
- Randy Henry, Neag Comprehensive Cancer Center
- Monika Mukolari, Surgery/Orthopedics
- Kara Parker, Intermediate Unit
- Michelle Sandore-Shea, Cardiology
- Julie VanNieuwenhuyze, Postoperative Services
- Meagan Zolla, Postoperative Services

NDNQI Nursing Database of Nurse Sensitive Quality Indicators

Our nurses continually evaluate the care they deliver and the associated patient outcomes. Our nurses review nurse sensitive patient outcomes including falls, falls with injury, hospital-acquired pressure injuries (HAPI) Stage 2 and above, central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).

We compare ourselves to like academic medical centers participating with the National Database of Quality Nurse Indicators (NDNQI). Our goal is to outperform the mean of our comparison group in greater than half of our units for more than 4 of 8 quarters over a two-year period. Review of our 2019 data indicates that we have met our performance goal in all measures.

Stay for Safety: Reducing Patient Harm from Falls

The Falls Committee has been working diligently to continue its efforts of reducing falls with injury by reviewing each fall that occurs. By doing so, we are better able to understand why patients fall and what we can do to prevent similar falls from occurring in the future. Falls are classified as either anticipated, unanticipated, or accidental, and if injury occurs, the extent of injury is also identified. Quarterly, we review NDNQI data to determine how we are doing in relation to our comparison peer group, academic medical centers.

Our data show that we are outperforming the mean of our comparison peer group for 7 out of the past 8 quarters for total falls per 1,000 patient days and 4 out of 8 quarters for falls with injury per 1,000 patient days.

The online learning (SABA) course specific to preventing patient falls is currently under revision and will be assigned to staff. Floor mats are available in each patient room and continue to be utilized on a regular basis on the inpatient units. Hip protectors are available on the units for use with patients who have a history of fall-related fracture within 12 months of admission and for those who have documented osteoporosis or metastatic bone disease. Gait belts are also available on the units for use with patients who have an “Ambulate with Assist” or “OOB with Assist” activity order and newer wedge cushions are available for patient use.

The Fall Prevention Education Handout is available on the Department of Nursing website and is also included in the binder that patients receive when they are admitted. Since falls and fall-related injuries are common problems experienced by older adults, it is important for patients to be aware of the various interventions that may be put into place to keep them safe while here, as well as what they can do to prevent falls at home.

Several fall screening tools have successfully rolled out in Epic (Morse, OFRAS, Ambulatory, and ED). Some revisions have been made to optimize the documentation of patient fall risk in various clinical settings, specifically in ambulatory areas.

In response to a few patient falls over the past year which resulted in patient harm, some changes are being made in Epic. A few questions have been developed that will be incorporated into the registration/appointment scheduling process, including “Have you fallen in the past 30 days?” and “Do you require assistance, such as a cane, walker, wheelchair, or holding onto someone when you walk?” For “in-touch” reminders in which someone may not verbally talk to the patient, a message will be left instructing the patient to call prior to the appointment to discuss services that may be needed. By adding these few questions, we hope to identify patients who need assistance with ambulation so that we can have a wheelchair available for them upon arrival.
Currently, the falls committee is investigating the use of TIPS (Tailoring Interventions for Patient Safety). Fall TIPS is a fall prevention tool kit that consists of a formal risk assessment and tailored plan of care for each patient. It was created as a direct response to reduce fall risk factors in hospitals, and really promotes the involvement of the patient and family in fall reduction strategies. Committee members participated in a webinar and will be discussing how to best roll out the Fall TIPS initiative.

The Division of Epidemiology is collaborating with physicians, nurses, APRNs, PAs, and the Division of Interventional Radiology with the aim of decreasing the number of peripherally inserted central venous catheters (PICCs) that are placed because not all patients receiving PICCs have been found to meet established criteria. Alternatives to PICCs include midline catheters as well as using ultrasound guidance for peripheral IV insertion. Training of staff in these insertion techniques is underway with the goal of increasing the use of midline catheters and reducing PICC use. The epidemiology RNs now receive “PICC alerts” which allow them to consult with the care team to determine if a PICC is warranted or if another infusion device is preferable. Routine use of PICC lines for laboratory sampling is an additional avenue for infection and is a practice that is discouraged.

A major change in caring for patients with indwelling urinary catheters implemented in 2018 was the introduction of a nurse-driven protocol for urinary catheter removal. When the protocol for “Indwelling Catheter Removal” is ordered, nursing staff are empowered to remove the catheters for patients who meet all criteria for removal. The purpose of the protocol is timely catheter removal and elimination of unnecessary catheter days which dramatically increase infection risk. Education about this protocol was reinforced for RNs during annual mandatory inservice sessions and education is continuing with guidance given to nurses at the bedside. The Division of Epidemiology is also working with the Epic team to facilitate correct order implementation by practitioners. External urinary drainage devices for both men and women are being used more frequently as an alternative to indwelling catheters.

Work is currently being done to examine the procedure for obtaining urine specimens for patients with urinary catheters – both routine urinalysis and cultures and opportunities for improvement have been identified. The importance of obtaining site-specific cultures, as opposed to “pan cultures” when infections are suspected, is an additional topic for review. Stay tuned for more information.

Prevention of healthcare-associated infections is interdisciplinary and multifaceted. Future efforts will be directed towards examining best practice related to midline catheters and prevention of infections associated with ventilator use. UConn Health is fortunate to have bedside resources and professionals aimed at “Getting to Zero.”

Wound Care and Hospital Acquired Pressure Injuries

Our statistics continue to show expansion for the wound/ostomy service. The wound/ostomy service has demonstrated a steady increase in the number of patients/consult visits per month since moving into our new hospital tower three years ago. In May 2019, seven staff nurses were selected by the management team to become wound care certified (WCC). The nurses attended a week long course followed by a certification exam. The WCC nurses
shadow with the certified wound ostomy nurses (CWONs) quarterly to practice and improve their assessment in wound management skills. The hospital has acquired a new per diem Certified Wound Ostomy Continence Nurse (CWOCN), Angela Paradis. She will assist in providing wound/ostomy coverage to help with service coverage when one of the scheduled WOCNs is not here. This is especially important due to the increase in both inpatient and outpatient referrals. Amanda Darcey, MSN, RN, CWCN, has also been instrumental in providing coverage for the wound and ostomy service during the past year in order to ensure timely responsiveness to patient needs.

The wound/ostomy nurses continue to develop and improve our integumentary screens in the hospital’s Epic documentation system. The WOCNs have worked closely with our IT developers and continued support of the Epic specialists. During this past year pressure injury prevention intervention measures were added to the RN staff assessment flowsheet.

Our WOCNs have been busy with education this year and continue to make adjustments to our skin products to remain updated with research-proven treatment strategies. In collaboration with the infectious disease team and the CAUTI (catheter associated urinary tract infection) committee, we have successfully trialed and implemented a female external device for urinary incontinence. The use of this device has decreased the number of CAUTIs and prevented skin complications that are more commonly seen as a result of female urinary incontinence.

Wound Care continues to provide formal education in monthly nursing orientation and an educational in-service for our registered dieticians on pressure injury staging and documentation. This education was provided by Tanya Carter, RN, CWOCN, in response to a knowledge gap that the registered dieticians identified within their department. Wound Care is currently developing content for nursing grand rounds presentations in the spring of 2020 in which the wound care nurses (WCCs) will present educational material in conjunction with the CWOCNs. Arlene Morin, MSN, RN, WOCN, will be providing an educational in-service on biofilm for the Division of Epidemiology in January 2020.

National Database Nursing Quality Indicators (NDNQI) data show that we continue to perform well below the national monthly hospital acquired pressure injury (HAPI) benchmark of 2.9% and national total pressure injury (combination of hospital and community acquired) of 8.8%. Our NDNQI data are shown in the chart. These data encompass all of our inpatient hospital units reported to NDNQI, with the exception of our Psychiatry Unit. Of note, we had the busiest months for wound consults ever recorded in February and October 2019. The service continues to see a steady increase in the number of ostomy consults per month. We continue to provide quarterly data to the CT AHA for Health Research and Education Trust (HRET)/Health Improvement Innovation Network (HIIN) for all our adult patients with stage 2 pressure injuries or greater.
Infection Prevention: Winning the Battle Against Clostridioides Difficile Infection (CDI)

Preventing hospital-onset CDIs is critical because these infections are frequent causes of morbidity and mortality among older hospitalized patients. UConn Health’s Division of Epidemiology has implemented a number of strategies over the past several years aimed at reducing our CDI infection rate. Using clinical decision support tools is one critical component of infection prevention efforts because they are derived from best practice recommendations and remove clinicians’ personal preference and influences of their training and experience upon patient management.

In 2016, UConn Health experienced an upsurge in hospital-onset CDI cases. Cases were examined for meaningful associated factors and no consistent relationships were identified. A C. difficile action team was created to address ways of reducing cases of this potentially devastating infection. Some of the initial prevention strategies implemented in 2017 included optimization of C. difficile testing as a preventive measure. Ongoing engagement with housekeeping staff will function as a liaison between the laboratory and practitioners about the appropriate use and frequency of diagnostic testing.

Clinical nursing staff are instrumental to the success of these infection prevention initiatives. With their knowledge, experience and patient advocacy, they can ensure that proper handwashing and infection prevention precautions have been implemented and are followed. By adopting a questioning attitude and through collaboration with the medical team, they can educate others and support the use of evidence-based practices related to diagnostic testing, antibiotic use and clinical decision support. Together we can make a difference!

Infection prevention efforts have paid off and since 2016 there has been a steady decline in the number of annual cases. This has been attributed to ongoing aggressive attention to best practice strategies which have included:

- Inclusion of a C. difficile diarrhea decision tree into Epic
- Daily auditing of enteric isolation practices among patients who have tested positive for C. difficile
- Apparent cause analysis (ACA) review of every case of hospital-onset C. difficile occurrence with attention directed at antibiotic use and infection control
- Daily auditing of laboratory testing practices to ensure that the diarrhea decision tree algorithm and clinical decision support guidelines are being followed and that PCR testing is conducted only when necessary

Ongoing engagement with housekeeping staff while pleased with our initial success, it is imperative that we, as an organization that values patient safety, not let our guard down but continue to be vigilant and adaptable to new recommended approaches. Ongoing and future developments are:

- ATP testing on all cleaned rooms of patients with CDI who have been transferred or discharged
- Evaluating the effectiveness of adjunctive high-level terminal disinfection using hydrogen peroxide and ultraviolet light – to be done by the Division of Epidemiology
- Enhancing antibiotic stewardship monitoring and intervention with patients who have a history of infection with C. difficile through collaboration with the Department of Pharmacy. Administration of prophylactic oral Vancomycin is being explored as a preventive measure.
- Collaborating with the Department of Laboratory Medicine, so that the infection prevention specialist will review appropriateness of orders for C. difficile testing. The Infection Prevention team members will function as a liaison between the laboratory and practitioners about the appropriate use and frequency of diagnostic testing.

Strategic Goals for 2020-2021

**BSN - Prepared Nurse**

Initiative: Previous goal was to increase the percentage of RNs with a BSN or higher academic degree to 80% by 2020.

Current: We have exceeded our goal as currently 85% of RNs have a BSN or higher degree in nursing. Partnership with UConn School of Nursing allows tuition benefits to staff matriculated in a nursing program of study.

Target: Sustain or exceed the number of RNs with BSN or higher academic degrees in nursing at 85%.

**Professional Governance**

Initiative: 2018 goal was to establish unit-based professional governance councils on all of the hospital nursing units as to means of RN empowerment.

Current: Unit-based councils have been implemented and are now active.

Target: Inaugurate the Nursing Executive Board. Establish regular meeting schedule and attendance for the Clinical Practice, Nursing Research, Professional Advancement, Nurse Manager, APRN, and Assistant Nurse Manager Boards.
Nursing Research Initiative: Previous goal was to have one completed nursing research project in 2019. Data collection has been completed for one study designed by research fellows and the study is being finalized.

Current: Data collection is in progress for two studies that are IRB-approved and for one quality improvement project. An additional study has been approved by the IRB but data collection has not yet commenced.

Target: One additional completed nursing research project in 2020.

RN Specialty Certification Initiative: 2019 goal was to increase the percentage of RNs with professional specialty certification to 30%. Resources and support are available to RNs who are interested in attending certification review courses in preparation for taking certification exams.

Current: We have been unable to meet our goal; 23% of RNs currently have specialty certification. RNs with professional certification were honored on Certified Nurses’ Day.

Target: Increase the percent of RNs with professional specialty certification to 30%

RN Satisfaction and Engagement Initiative: 2019 goal was to implement the Advisory Board’s Nurse Engagement Survey and outperform the mean on four of seven identified measures.

Current: Survey results using the Advisory Board’s Nurse Engagement Survey showed that we achieved modest gains compared to our prior survey but did not outperform the mean on any of the categories measured. Opportunities for improvement were identified. Our survey completion rate was 87%, which was our highest ever nursing staff response rate!

Target: Advisory Board’s Nurse Engagement Survey will be made available to RN staff once again in 2020 with the continued goal of outperforming the mean on four of seven identified measures.

Patient Engagement Initiative: Establish an Innovation Unit in collaboration with Connecticut Hospital Association initiative, to identify new and different ways to increase patient and family-centered care.

Current: Medicine 3 is the designated Innovation Unit. An Innovation Unit Design Team has been created with membership from nursing leadership, the Medicine 3 Shared Governance Council, unit staff and the Patient and Family Advisory Council. The team’s initial project, Bedside Shift Report Using HELLO2U was implemented in June 2019. This will serve as a model for implementation on other inpatient units.

Target: Test at least one new process in 2020 using a rapid cycle methodology.
CONGRATULATIONS AND SPECIAL THANKS TO OUR 2019 NIGHTINGALE AWARD RECIPIENTS

Janice Brandtling, RN-CNII
Department of Surgery

Karen Cutter, MSN, RN, CHOB, NLN-AC Nursing Director of Procedural Services

Lisa Gentile, RN, BSN, CNIII
Outpatient Infectious Disease and Travel Clinic

Dawn Smith, RN, MSN, CNIII
Cardiology

Arlene Morin, RN, MS, MSN, WCC, CWON, CNS
Organization & Staff Development

Jennifer Sposito, RN, BSN
Clinical Patient Navigator, Cardiac Unit

Anne Niziolek, RN, MSN
Nurse Manager, Medicine 4

Janice Beardsley, RN-CNII
Department of Surgery

Karen Curley, MSN, RN, CNOR, NEA-BC Nursing Director of Procedural Services

Sarah E. Loscheven, APRN, FNP-C, ACHPN
Neag Comprehensive Cancer Center

Patricia Pearce, RN-CNII
Neag Comprehensive Cancer Center

Julie Valentine, BSN, RN
Nursing Supervisor

Michael Wilhelm, DNP, APRN, CRNA
Nurse Anesthetist

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