NK 8: Describe and demonstrate innovations in nursing practice.

**innovation:**

In service delivery and organizations, innovation is defined as a novel set of behaviors, routines, and ways of working that are directed at improving

- health outcomes,
- administrative efficiency,
- cost effectiveness, or
- users’ experience,

and that are implemented by planned and coordinated actions.

Innovation is defined as, “a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users’ experience and that are implemented by planned and coordinated actions.” Throughout this Magnet document, many innovations have been described, a selection of which are presented in Table 1, for review (attachment NK 8.a). Prior to describing additional innovations in nursing practice, it is important to describe the culture from which they arise—our “ways of working.”

The Senior Vice President for Patient Care and Chief Nurse (CNO) expects and encourages nurses to use what Benner1 calls, “clinical imagination,” and what Watson2 calls, “all ways of knowing/being/doing/becoming” in order to meet the needs of our patients and families. In her communication with individuals and groups of nurses, and in the biweekly newsletter, Caring Headlines, the CNO uses every opportunity to reiterate the Patient Care Services (PCS) Vision, Guiding Principles, and Core Values (attachment OOD 3.h). The Core Values statement is, “It is through our professional practice model that we make our vision a demonstrable truth everyday by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure that our practice is caring, innovative, scientific, and empowering, and is based on a foundation of leadership and entrepreneurial teamwork.” (emphasis added).

Likely one of the most effective ways of making Core Values explicit is through the regular feature in Caring Headlines, the “Clinical Narrative” column, written by Staff Nurses and clinicians from other disciplines across PCS.

Clinical narratives are embedded in the fabric of MGH Nursing; it is often said that MGH Nursing is a “narrative culture” (attachment NK 8.b). When the Clinical Recognition Program (CRP) originated in 2002 (TL 7 and EP 20), clinical narratives became an important part of the culture. Benner’s work, From Novice to Expert (1984) is the theoretical foundation for the CRP. Visits to MGH in 2005, 2006 (attachment NK 8.c and attachment NK 8.d) and 2010 (attachment NK EP 7.v) by Dr. Benner were extremely affirming to both leaders and clinicians in PCS, who were thrilled to be able to share our narrative culture, based upon her work. The cornerstone of the applicant’s CRP portfolio, the clinical narrative, provides an

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important glimpse into the applicant’s practice. Clinical narratives are also a requirement for the annual performance appraisals (EP 20).

Whereas the clinical narratives for CRP and annual performance appraisals are relatively private, the clinical narratives published in Caring Headlines, are important strategies for fostering clinical learning, caring practices, and understanding patients’ and families’ needs. In Expertise in Nursing Practice, Benner et al. state that, “practice is based on socially-embedded knowledge.” So, the benefits of sharing clinical narratives are that they maximize the clinical knowledge of a group and promote a shared consciousness. Clinical narratives inspire others to be creative in care delivery. They give permission to innovate caring practices—to meet the needs of our patients and families in ways that are meaningful to them.

Clinical narratives set the bar for excellent practice. After every clinical narrative featured in Caring Headlines, the CNO adds a very brief comment about the salient aspects of the narrative. In this way, she recognizes the nurse’s exquisite practice and emphasizes what could otherwise be, “taken-for-granted,” thereby making excellence explicit. In the first clinical narrative, found in attachment NK 8.e, the CNO made these comments:

**Clinical Narrative**

A glimpse into the delicate dance that is the art of nursing

If the art of nursing is like a delicate dance, then Megan is a very good dancer, indeed. In a very short time, she came to ‘know’ Mr. G’s stoic nature and understand his need to maintain control. She tailored her interventions to support not just his physiological needs, but his emotional needs. Megan’s care of Mr. G respected his dignity and privacy and helped him sustain a sense of hope. That Megan is such a ‘good dancer’ so early in her career is a promising indicator of the kind of nurse she will become. Thank-you, Megan.”

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In her comments, the CNO emphasized the importance of “knowing the patient,” a highly regarded value among MGH nurses. The CNO also stressed tailoring care to meet the patient’s needs for dignity and privacy, as well as promoting hope. The CNO affirmed the excellent practices of Megan Keating, RN, thereby recommending them to the entire nursing community. The second clinical narrative (below) can be found in attachment NK 8.f.

Comments by CNO

“What a poignant story. So often clinicians see first what families and loved ones find too painful to see. End-of-life care is a delicate balance between honesty and compassion, a balance that Colleen struck beautifully in her care of Mr. C. Surgical intervention was not going to cure Mr. C. In fact, there was a greater risk that surgery could end his life or impair his quality of living for the time he had left. Colleen’s conversation with the family was a difficult one, but she didn’t shy away from it. Without imposing her own opinions, she provided information that enabled Mr. C’s family to make an informed decision. Thank-you, Colleen.”

In this example of a clinical narrative, the story told by Colleen Kehoe, RN, depicts how nurses often find themselves in unchartered waters when it comes to end-of-life discussions. The CNO stressed the importance of not imposing one’s own opinions, while giving nurses permission to engage in end-of-life discussions in order to promote informed decision making.

These two examples are what Benner calls, “constituting and sustaining” narratives because they depict situations that constitute the person’s understanding of what it is to be a nurse. They are also “liberation” narratives because, in these clinical situations, nurses found their voice.

In the last example of a clinical narrative (attachment NK 8.g), Robert Ferdinand, RN, describes a situation in practice that was an “omega point,” where clinical expertise, clinical reasoning, evidence, technical skill, and interprofessional skills came together. In his concluding paragraph, the Staff Nurse states, “As a nurse, I sometimes forget how much I affect patients’ lives. When clinical situations like this arise, I’m confident in my knowledge, clinical experience, and individualized approach, certain that I’ll give each patient the very best care based on his or her clinical situation…” In her comments, the
CNO noted Robert’s clinical know-how and emphasized the human connection he established with the patient, who was ultimately put at ease.

**Clinical Narrative**

Every contribution by every member of the care team makes a difference

**Mr. H** had been admitted to the Phillips House with a cystic fibrosis exacerbation. Having PICCs in cystic fibrosis patients can be challenging because their veins have been accessed so many times, scar tissue develops at the insertion site.

**Comments by CNO**

If you’re one of those people who thinks all IV nurses do is insert IVs, Robert eloquently dispelled that notion. His advocacy, skill, and foresight in caring for Mr. H show the depth of his clinical expertise and spotlight the important role IV nurses play in the care of patients. Not only did Robert’s clinical competence contribute to a positive outcome for Mr. H, his confidence and compassion put Mr. H at ease before he even began. We’re fortunate to have Robert and his IV nurse colleagues making life “a little easier” for our patients. Thank-you, Robert.

In summary, Benner states, “clinical reasoning and caring practices are socially embedded.” At MGH, our guiding principles and values are similarly socially-embedded, as demonstrated by the ethic of care emphasized by the CNO after each clinical narrative. The CNO, through her thoughtful comments, has emphasized responsiveness, promoting comfort and well-being, providing culturally-sensitive care, being aware of individuals’ vulnerabilities, and encouraging human connectedness, among other themes.

Publishing clinical narratives is a **sustaining innovation** that makes explicit the values and guiding principles of MGH Nursing. Just as nurses are encouraged to be clinically creative in meeting the needs of patients and families, nurses are also given permission to, and actually expected to, innovate in order to “improve health outcomes, administrative efficiency, cost effectiveness, and/or users’ experience …through planned and coordinated actions” (Greenhalgh, 2003).

**in*no*va*tion**

Nurses on the Gynecology/Oncology Unit, Phillips House 21, changed standard medication administration times to 0900 and 2100 to facilitate patient-centered care.
In the remainder of NK 8, innovations in nursing practice will be described and demonstrated. Call out boxes, like the one above, will be used to highlight frontline innovations by Staff Nurses who often implement small tests of change on their units in order to achieve any or all of the goals of innovation: health outcomes, administrative efficiency, cost effectiveness, or users' experience. Additional frontline innovations are found in the last section of this narrative.

In TL 7, how the CNO and nursing leadership team strongly value innovation as both a philosophy and strategy to meet the challenges of the future was described. At MGH, innovation is not just something that happens; it is encouraged and resourced. Nurses are trained in the processes of innovations through such programs as the Partners Clinical Process Improvement Leadership Program (NK 7EO), and in programs described in this section.

- Center for Innovations in Care Delivery
  - CMS Innovation Project
  - Transforming Care at the Bedside (TCAB) Project
  - PICC Line Innovation
  - Accent Reduction Program
  - Innovations in Practice Program
  - Equine-Assisted Learning
  - Improving the Detection of Delirium
  - Nursing Education Studio
  - Bedside Hand Offs
- Nurse Practitioner Models of Care
- IHI STARR Initiative
- Retooling for Evidence-Based Practice Project
- AgeWISE™

- The Center for Innovations in Care Delivery

The Center for Innovations in Care Delivery (the Center), the newest of the four centers in the Institute for Patient Care (SE 11), was launched in 2006 when Patient Care Services (PCS) received a $1 million gift from an anonymous donor. The mission of the Center is to match interdisciplinary education and research with opportunities to impact care delivery. The intent is to bring teams together to identify opportunities, evaluate the impact of proposed changes, and construct and implement innovations to improve care delivery. The Center provides opportunities for all disciplines in PCS to come together to promote safe, timely, efficient, effective, and equitable care that is patient- and family-centered. The Center, by design, has a small core, dedicated to convening teams.
The Center’s Innovation Specialist, Barbara Blakeney, RN, MS, FNAP, is the former President of the American Nurses Association, and long-time advocate for Boston’s homeless population. Since coming to MGH in 2007, she has conducted much of the foundational work in the Center. Her thinking has been influenced, in part, by two local experts in innovations theories, both of whom have had small, consultant roles in the development of the Center.

The first is Eric von Hippel, PhD, the T. Wilson (1953) Professor in Management, Professor of Management of Innovation and Engineering Systems at Massachusetts Institute of Technology (MIT). His research explores patterns in the sources of innovation and develops new methods to improve the innovation process. Dr. von Hippel was the co-facilitator of the Center’s Innovations Retreat in 2007 that launched the work of the Center. His teaching continues to influence the work of the center, which utilizes his approach to innovation.

The second is another influential innovation expert, Clayton Christensen, DBA, the Kim B. Clark Professor of Business Administration at Harvard Business School and the author of the theory of disruptive innovations. But, it has been Dr. Christensen’s “job-to-be-done” framework that has really influenced the work of the Center, because it helps staff who are trying to solve problems on the front lines, begin with the very critical question, “What is the job to be done?” This framework helps nurses to pinpoint gaps in service or care delivery. Blakeney, trained by Innosight, uses the methodology frequently with nurses who are grappling with best approaches to systems innovations. A group of nurses at MGH had several opportunities to attend Dr. Christensen’s lectures and meet with him to discuss the work of the Center.

Newly-appointed as Director of the Center, Jeffrey Adams, PhD, RN, is a doctorally-prepared nurse and the author of two theories: 1) The Adams Influence Model (AIM), which defines the factors, attributes and process of influence & power, and 2) The Model of the Interrelationship of Leadership, Environments, and Outcomes for Nurse Executives (MILE ONE), which provides structure of emphasis for nursing administration education and care delivery roles. Both Adams and Blakeney have been using their broad range of expertise to evaluate the implementation of the Innovation Units, fully described in TL 7.

The Innovation Specialist is currently an inaugural Innovation Advisor to the Centers for Medicare and Medicaid Services (CMS) and is developing skills learned from an intensive process that focuses on implementation science, rapid cycle improvement, Clinical Microsystems, and the CMS triple aim of better health for the population, better health care for individuals, and lower costs through improvements, shown here (attachment NK 8.h and attachment NK 8.i). The “triple aim” is a dominant framework in CMS and serves as a foundation for innovations.

Three-part Aim

- Better Health for the Population
- Lower Costs Through Improvement
- Better Healthcare for Individuals
CMS Innovation Advisor’s Project: Reducing Time from “Admission to Chemo”

This project is being conducted as part of the Innovation Specialist’s new role as CMS Innovation Advisor. The Hematology/Oncology Unit located on Lunder 9, is a 32-bed unit with a focus on solid tumors. The CMS Innovation Advisor (Advisor) has partnered with staff on this unit to plan and implement several innovations that will produce measurable outcomes. The Advisor serves as coach and mentor to the project.

On a weekly basis, the unit averages ten planned admissions for chemotherapy. The Advisor assisted the Nursing Director and Attending Nurses (the team) in utilizing the Institute for Healthcare Improvement’s (IHI) Waste Assessment Tool, to identify specific gaps in the planned hospital stay where care might be delayed. Using the tool, along with a Failure Mode and Effects Analysis (FMEA), rapid cycle improvement methods, and run charts, the team established a goal of safely decreasing the length-of-stay for this patient population by 10%.

The team first focused on the admission process where they identified a delay between time of admission to the beginning the induction of the chemotherapeutic agent(s) (“admission to chemo”). After 3 weeks of monitoring patients and tracking their progress to “chemo in” it was clear that, within this sample, those patients who 1) arrived on the unit by 2:30 pm, 2) had been seen by their oncology team the morning of admission, 3) had bloods drawn with results back, 4) had chemotherapy orders written prior to admission, 5) successfully followed the pre-admission plan for hydration and other requirements, were able to begin their chemo in a much shorter time period (on average, 3 hours v. 7+ hours). The team set a goal of reducing admission to chemo by 20%.

Because admission to chemo relies on many other individuals, the team and the Advisor began to engage the ambulatory practices in discussions. In essence, the team suggested a standardized, pre-admission process to ensure all patients have undergone laboratory tests, assessments, and received written orders, prior to admission.

The graph below shows the mean wait time of 8.78 hours at baseline which improved after the interventions to 3.89 hours and rose to 5.96 hours while the intervention nurse was on vacation.
Other potential factors influencing admission to chemo in will be addressed in sequence in the future. They are: patient education in preparation for chemo, adequate hydration, venous access, either by port or peripherally-inserted central catheter (PICC line), and arrival no later than 2:30 pm. Additional factors for study that influence length of stay may include periodic interruptions in chemotherapy due to factors such as radiation treatment and symptom clusters such as nausea, constipation, and pain.

The Advisor is leading, teaching, and coaching the Lunder 9 team through this process. It is expected that this team—Nursing Director and Attending Nurses—will be well positioned to continue this work on the unit, as well as teach the process to others. This project is described in greater detail in attachment NK 8.j. The CNO, Executive Director of the Institute for Patient Care, and Director of the Center support the Advisor and this project (TL 7).

- **Transforming Care at the Bedside**  
  (*Innovation: administrative efficiency, cost effectiveness, users’ experience*)

Transforming Care at the Bedside (TCAB) is a national program designed by IHI and disseminated by the Robert Wood Johnson Foundation and the American Organization of Nurse Executives (AONE) to provide nurses at the bedside with tools to improve efficiency. The program teaches a specific methodology for process improvement. MGH joined the third round of TCAB hospitals. During the two-year study (2007 - 2009), RNs on a General Medicine Unit conducted thirty-three tests of change and adopted eleven of those. A series of seven articles, published in the *American Journal of Nursing* in 2009, is listed under the Nursing Director/co-principal investigator’s name, Amanda Stefancyk, RN, in attachment NK 4.a. The Innovations Specialist was also a co-principal investigator for that project.

The CNO, highly enthusiastic about TCAB, stated,

> “TCAB embraces a new way of thinking about care delivery. The goal is to empower nurses and other frontline staff to have a voice in unit-based systems — to tap into the knowledge and experience of direct caregivers and use that knowledge to re-design care-delivery models. In that respect, according to the Institute for Healthcare Improvement, TCAB ‘does not simply fine-tune the status quo, but rather transforms the elements that affect care, including: care-delivery processes, nursing care models, the physical environment, organizational culture and norms, collaboration, and performance.’ In short, TCAB encourages nurses and other team members to quickly identify, test, and then implement new ideas based on their perceptions and observations at the bedside. And who better to make those important decisions than direct-care providers?”

The TCAB project created sustainable practices on the General Medicine Unit. One pertains to the MGH tradition, called “green books,” three-ring binders where much of the relevant clinical information is kept. Nurses reported a “morning rush” to access the green books (vital signs from the previous shift, etc.) by several groups of clinicians—interns, nurses, student nurses, and patient care associates (PCAs), all needing the same information at the same time and from the same source.

In order to create a win-win, the TCAB RNs had to devise a new plan that decreased the competition for the information. After some consideration, the nurses proposed that they, not the interns, would present the patient’s case information at morning rounds. This would free up the interns from needing to access the green books. This simple change created a culture change in
several ways. First, the RNs accessed what they needed and then gave the green books to the PCAs who could then begin their early morning activities, specifically, vital signs. It also placed the RNs into morning rounds where they would not only provide patients’ information, but could hear first hand and often influence the plan of care for the day. Rounds developed into a venue of greater knowledge sharing, RNs had a much better understanding of the plan of care, and PCAs got the information they needed (TL 10E0).

Gynecology/Oncology Unit. (Phillips 21)
TCAB Group—now called CIT Team
L to R Standing are CIT RNs
Seated: Innovations Specialist, Nursing Director, Clinical Nurse Specialist

The next iteration of TCAB, now called Center for Innovation and Technology Program, or the CIT Program (AONE) began in 2011 with the RNs participating from the Gynecology/Oncology Unit, Phillips 21, a 21-bed, women’s health unit. Staff members decided to procure pill cutters for each patient’s bedside, which has saved time “hunting and gathering,” a known time-waster for nurses. The Staff Nurses changed the time for morning medications administration to 9:00 am, which allows RNs the opportunity to round and meet patients at the beginning of the shift, instead of getting involved in medication administration first. An email from one Staff Nurse to the team leader for the project suggests:

“As an initial test maybe we should suggest that RNs introduce themselves to all their patients first and ask if they need anything immediately (time: 7:30-8), and then make an effort to get meds out between 8 and 9. That way if a nurse is delayed in a room and meds are not administered until after 9, the patient knows who their nurse is and that their meds are coming. This may also reduce call lights with patients asking for pain meds, bathroom, and RN questions around change of shift. If we feel like this system is working well and we want to assess each patient at the initial meeting and change standard med times, then we could work with Pharmacy/MD’s (innovation #3?).
Thoughts???
Jane
PS - loving the pill cutter idea Katie!! It has saved me a bunch of times. And we're going through less pill cutters, cutting costs!” CIT RN

The CIT Team has worked on other tests of change, noted here:

- A SharePoint site has been developed to allow all staff to participate in the efforts, offer feedback, and suggest new tests of change;
- Daily huddles have been tested, adapted, and adopted, and are ongoing;
- A call bell has been placed in the treatment room for patients receiving infusions;
- A chemo orientation day for new graduate RNs has been established;
- Hourly lunches for all staff off-the-unit have been established;
- Clinical updates from the CNS on commonly seen clinical topics occur Fridays;
Monthly meetings with newly-hired RNs, Nursing Director, and CNS established. As the e-mail above demonstrates, Staff Nurses are engaged in the process and are working to improve care for the patient, while at the same time lowering costs by creating efficiencies. While this project is a CIT initiative, it is also clearly following two of the three components of the CMS three-part aim—that of better health care for individuals and lower costs through improvements.

Because Staff Nurses on the unit are developing skills in rapid cycle improvement and are already doing tests of change, the unit can ideally partner with the Hematology/Oncology Unit (Lunder 9), currently involved in the CMS Innovation Advisors Program (IAP). Both units share a similar population and could benefit from the use of run charts and control charts to measure progress toward goals. One of the primary goals of the IAP is the development of process improvement skills at the clinical level, described in Quality by Design: A Clinical Microsystems Approach, authored by Nelson, Batalden and Godfrey at Dartmouth.

As on the Hematology/Oncology Unit (Lunder 9), the Innovations Specialist is leading, teaching and coaching the Gynecology/Oncology Unit’s (Phillips House 21) staff as they conduct a process improvement project addressing the issues of at-risk elders. The goal of this process improvement project is to reduce length of stay (LOS) by 15% secondary to hospital-acquired complications for at-risk elders. The Phillips 21 project is described by the diagram below. Run charts are being developed for the metrics noted in the middle box. This project is underway.

**Phillips 21**

- **Targeted sub populations**
  - “At risk elders”
  - Falls
  - Poly-pharmacy/ co-morbidities
  - Lack of social support
  - Hx. Of delirium on previous admits

- **Interventions to decrease/prevent delirium**
  - Early engagement of/development of social supports

- **Decrease LOS**
  - secondary to hospital-acquired complications by 15%

- **Decrease Foley days**
  - Hourly rounds
  - Med reconciliation
  - Beers List review

- **Decrease LOS**
  - Secondary to hospital-acquired complications by 15%

**PICC Line Database Management**

*(Innovation: health outcomes, administrative efficiency, cost effectiveness, users’ experience)*

Nationally, as well as at MGH, the increased demand for peripherally inserted central catheter (PICC line) placement has challenged IV teams who are pressed to find effective ways to track requests and prioritize patients waiting for PICC lines insertions. Delays in PICC line placement are costly to patients and health care organizations—delays in therapy, increased length-of-stay, increased risk of thrombophlebitis, increased risk of infection, decreased IV team productivity, and increased costs to hospitals. Fifteen IV nurses at MGH place over 4,000 PICC lines annually and the number is increasing. Paper systems for tracking and documenting were cumbersome to use and to audit. The IV team leader and a staff member decided to develop a computerized data management system.
First, the PICC Team identified components of an ideal solution:

- data entry and retrieval that is seamless;
- maintain quality assurance and be able to target areas for quality improvement;
- recognize patterns;
- get real-time reporting;
- facilitate EBP;
- support practice changes; and,
- optimize patient outcomes.

The team then created a rationally designed PICC Database that has both clinical and managerial applications, including data on consults, insertions, tip location/interventions, care and maintenance, complications, and removal, not only for in-patients but for out-patients, as well. Generating reports on volume, complications, procedures, products, lot number recalls, and employee reports, the PICC Database is a first-of-its-kind-in-the-nation innovation. The PICC Database was constructed by PICC Team Staff Nurse, who has expertise in database management. This resource has allowed the PICC Team to move from a paper—pencil operation to one that is linked to Provider Order Entry (POE). It has allowed the PICC Team to prioritize insertions, thus creating efficiencies that impact length of stay, resulting in substantial cost savings for the hospital. The PICC Team changed its model from one requiring two PICC-RNs per insertion to a model of requiring one PICC RN and one IV Technician per insertion (EP 7EO). This change resulted in increased productivity and decrease turn around time (from medical order to insertion) from an average of 31 hours and 25 minutes to 11 hours and 3 minutes. This is even more impressive when one considers that the PICC Team does not work from 7 pm to 7 am.

In addition, instituting new technology which allows for bedside tracking of the insertion of PICC lines, has lead to a decrease in directionally malpositioned PICC tips from 9.66% to 2.03%, or an 80% reduction. This has been described in EP 7EO. Analysis of the data showed a 4-month cost savings of $17,856. The Innovations Specialist has provided support and coaching for this project including seeking additional hospital sites for testing and engaging in discussions regarding possible marketing of the program. This innovation provides the IV Department with data-driven practice.

### Accent Reduction Program

*(Innovation: health outcomes, users’ experience)*

As a nationally recognized academic medical center with a four-prong mission in health care, education, research, and community, MGH attracts high quality clinicians from around the world. For many, English is a second language. Strong accents, however, can be a barrier to successful integration into the clinical practice environment. Highly competent clinicians, as well as other team members and patients, become frustrated by misunderstood communication. This could lead to potentially dangerous circumstances, as well as decreased patient and staff satisfaction. At its simplest level, this may present as patients requesting that a different nurse be assigned to him/her because, “I can’t understand her/him.” This can be embarrassing and uncomfortable for both the nurse.

**in*no*va*tion**

In 2011, when Neuroscience Nurses moved to the Lunder Building, they set up a buddy system for lunches and breaks, changing the culture to one that promotes time off the unit.
and the patient. Lack of intelligibility can be perceived not only as a language issue, but a competence issue as well.

One of the National Patient Safety Goals (#2) is to improve the effectiveness of communication between caregivers. The rationale for this goal is stated as follows:

*Ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous and understood by the recipient, reduces error and results in improved patient/client/resident safety.*

Multiple factors impact effective communication. Ineffective communication is the most frequently identified root cause of the most serious errors leading to severe harm/death of a patient.

The Center, in partnership with the Department of Speech, Language, and Swallowing Disorders, developed the Accent Reduction Program (ARP) (attachment NK 8.k). The ARP was supported, in part, by the Hausman Family Trust (attachment NK 8.l). The purpose was to determine whether an 8-week program, structured ARP, led by a Speech and Language Pathologist, would measurably improve the intelligibility of Nurses for whom English is a second language. The initial sessions were designed for RNs for whom intelligibility problems had been identified.

The ARP was designed to address one aspect of effective communication, that of intelligibility, by assisting nurses and eventually others, in decreasing their accents and increasing their ability to be clearly understood by colleagues and patients. The RNs were taught strategies and best choices for increased speech intelligibility for the listener.

The aim was to achieve a 40 to 60% improvement in vowels, consonants and intonation as measured by pre- and post-program assessments, a portion of which were videotaped. Additionally, a decrease was expected from pre-program baseline in patients requesting a change in nurse assignments because of intelligibility issues. A major factor for a Nurse’s success was the ability to practice outside of classroom time. Assignments were given at the end of each session. Nurses were more successful when they practiced between sessions.

At the final session of the pilot program, nurses expressed disappointment that the formal teaching was ending. They recognized the need to continue to practice until the changes became second nature. Despite the perceived brevity of the program, each participant reported noticeable change in the quality of their intelligibility and ease of understanding by patients in their care. One RN, by Nursing Director report, has had no further requests from patients for changes in nursing assignment. Additionally, by report, the RN became intelligible over the phone, and during face-to-face interactions. Another RN stated that the most helpful aspect was the one-on-one time she had with the Speech Pathologist. She stated, "Although my jaw was sore for two days, my consonants were clear."

This pilot program was undertaken to determine whether an 8-session structured program lead by a Speech and Language Pathologist could measurably improve the intelligibility of nurses for whom English is a second language. Based on self-reports of the participants, feedback from colleagues and supervisors, and the video taped pre- and post-readings by participants, the ARP was highly rewarding and successful.

At this time, the ARP is ongoing. There have been three additional classes and ways to expand the class are being explored. Next steps include adding another Speech Therapist as well as inviting the Speech and Language Graduate Program at the MGH Institute for Health Professions.
to consider student placement in the program. The program has expanded to 14 weeks in length. This change is to accommodate the need for continued direct practice and effective improvement based on feedback from initial participants and anecdotal and outcome data. The ARP is now open to the entire MGH hospital professional and support staff.

The ARP helps to unleash the potential of a diverse workforce through enhanced communication. The program has impacted the participants through:

- Additional advancement opportunities;
- Increased productivity through clearer communication;
- Enhanced cross-cultural relationships through more comfortable conversation skills;
- Being perceived more positively and recognized for one’s special talents and skills; and,
- More effective and organized spoken presentation.

**Innovations in Practice Program**  
(*Innovation: administrative efficiency, cost effectiveness, users’ experience*)

During the winter of 2010-2011, the Center sponsored a five-session education program on Innovations in Practice (attachment NK 8.m). The creation of the program highlighted the strong value of innovation in MGH care delivery and was supported by the CNO and the Executive Director of the Institute for Patient Care. The program was designed to provide clinical leaders, Nursing Directors, Clinical Nurse Specialists, as well as leaders from other disciplines, with basic tools with which to lead, encourage, support, and implement innovation within clinical settings. This program has been fully described in TL 7.

The goal for the program was to develop a cadre of clinical leaders with basic knowledge in innovation theory and tools who could support innovation in the clinical environment and support staff in innovative endeavors. One outcome of the program is the development of a first-of-its-kind, evidence-based simulated Left Ventricular Assist Device (LVAD) education program for staff (attachment NK 8.n). The idea for the program crystallized for the Clinical Nurse Specialist for the Cardiac Surgery Unit when she participated in the Innovation in Practice Program and saw a different way of thinking through the need for greater competency in an emerging technology (LVAD). She enlisted the ongoing support of the Center as well as the Evidence-Based Practice Mentors, the Knight Center Simulation Staff, and the vendor to develop and implement a state-of-the-art education program which is likely the first-of-its-kind in the country.

**Equine-Assisted Learning**  
(*Innovation: Users’ experience*)

Can horses help nurses be better nurses? That was the question the Innovations Specialist and an Emergency Department Case Manager sought to answer with a...
phenomenological study which partnered nurses with horses for a day-long program of structured exercises.

Equine-assisted learning has been used with medical students to provide them with feedback about their stance, body language, and approach, from the vantage point of an animal that is extremely sensitive to human body language and behaviors. It was hypothesized that this unique style of innovative and often transformational learning has implications for strengthening the skills of nurses, for improving the nurse-patient relationship.

“Being present” with patients is integral to nursing praxis. The study described the experience of 16 RNs who participated in a one-day structured Equine-Assisted Learning (EAL) Program. As nurses led horses through grooming and walking exercises, they gleaned insights about themselves that carried over to the care of their patients. Descriptive phenomenology was used to explore this lived experience. Five themes emerged:

- **Talk to the horse? What would I say?** *(The Experienced Novice)*
- **Groom the horse? A great start to the day** *(Present in the Moment)*
- **I figured it out. Hooray!** *(Discovery of Self)*
- **Horse won’t comply? Try my way, eh?** *(Team Building)*
- **Walk the horse? Who’ll lead the way?** *(Leadership)*

The study suggests that EAL can be a meaningful venue for nurses through which they may hone their ability to be present and centered. A quintessential concept within the nurse-patient relationship and a catalyst in helping patients achieve and maintain optimum health is the phenomenon of nurse presence. The ability to draw conclusions about the connection between what nurses do or say or think in the presence of patients and the resultant changes in their patient's health is an essential requirement of research into the effectiveness of nursing.

Further research using EAL to explore the nature and impact within the nurse-patient relationship is recommended. The authors believe that this until now, uncharted area, has the potential of opening a rich environment for the further development and study of the nurse-patient relationship especially in the area of “being with” the patient. The authors wish to continue this research and, more broadly, the use of EAL as a teaching modality for nurses regarding presence, mindfulness, and the use and meaning of body language. The manuscript for this pilot study is in submission.

- **Improving the Detection of Delirium**

  *(Innovation: health outcomes, cost effectiveness, users’ experience)*

Delirium is a common neuropsychiatric condition experience by hospitalized patients. It is characterized by changes in mental status with an acute onset and a fluctuating course represented by inattentiveness, disordered thinking, and altered levels of consciousness, and disturbances in the
The onset of delirium is a clinical challenge and affects the course of the hospitalization and potentially the long-term outcome for the patient. Thus prevention and early detection of delirium is a significant clinical concern. The Psychiatric/Mental Health Clinical Nurse Specialist (PMH-CNS) Consult Team partnered with the Innovation Specialist to:

- Improve the knowledge and ability of Staff Nurses to assess and care for patients at risk of delirium, as well as patients with delirium;
- Improve recognition of delirium by teaching Staff Nurses how to assess using the Confusion Assessment Method (CAM); and
- Reduce safety risks by use of targeted delirium prevention nursing interventions.

The outcomes variables of interest were unit-level data on patient falls, the use of observers, the number and nature of assaults on staff, and length of stay, pre- and post-delirium education. The study was conducted in four phases. First, the co-investigators conducted focus groups with nurses to establish baseline knowledge and practice. Second, the co-investigators provided delirium education, including use of the CAM. Third, the Staff Nurses conducted daily CAM screening of all patients for two months. Fourth, the co-investigators conducted focus groups to assess knowledge regarding delirium. The process variables of interest were the numbers of Staff Nurses who received training and the number of CAMs performed daily. Using aggregate data and focus group content, the pre and post training periods were compared.

Study participants included 81% (n=39) of the unit’s RNs. Seven of those received an additional 4-hour intensive training to be Delirium Champions. Twenty-three RNs participated in the focus groups (Pre, n=11; Post, n=12). Focus group content for the pre- and post-training periods was compared.

- Participant RNs demonstrated a good understanding of the features of delirium in both pre- and post-groups; an increase in the use of clinical terms as descriptors was noted in the post group.
- Participant RNs were well-versed in orienting and communication activities as well as safety measures, but rarely mentioned treatment interventions such as mobilization, maintenance of hydration and nutrition, maximizing sensory experience, and pain management to target delirium.
- Participant RNs’ concerns when caring for the patient with delirium included the safety of the patient, the unpredictable nature of the patient’s presentation, and the burden of responsibility. These themes were noted in both groups. However, following training, additional themes emerged, including searching for the cause of delirium, and sensitivity to the patient’s/family’s fear and distress about the experience of delirium.
- Anecdotal observations by investigators included staff enthusiasm for the educational program given the reported challenges they face in ensuring safe and effective care for this vulnerable patient group.

Adherence to daily CAM administration was 90% during month one and 83% during month two. The most common reasons for not completing the CAM were language barriers and patient communication problems. Overall, 8% of patients screened positive for delirium, as measured by the CAM. Compliance with use of the CAM was high, particularly given competing demands and limited...
reminders to the Staff Nurses. The prevalence of delirium was lower than would be expected for this patient group. While this may reflect a low incidence of delirium during the study period, communication barriers, addressing the differences between dementia and delirium, and accuracy with tool administration may have contributed.

Focus group content identified clinicians’ knowledge of delirium, as well as the gaps. Based upon these results, recommendations for future investigations include bedside coaching to help integrate new knowledge, special consideration for non-English speaking patients, patients with baseline cognitive dysfunction, and communication problems, and interdisciplinary treatment components to ensure complete attention to patients’ needs.

Incident data (falls, assaults) were low during the study period preventing any meaningful comparisons. There was no change in observer utilization in the post training period.

This study resulted in a heightened awareness of delirium and improving RN competency in using the CAM, which has been a difficult screening to implement, even nationally, because of the nuances associated with it. The Innovation Specialist guided the co-investigators through the process.

- **Nursing Education Studio**
  
  *(Innovation: Administrative efficiency, cost effectiveness, users’ experience)*

  In 2011, the Innovation Specialist and a Nurse Scientist in The Yvonne L. Munn Center for Nursing Research formed a small team which successfully applied for funds in the amount of $297,925⁴ to enhance nursing education at MGH and beyond by developing a Nursing Education Network. The funds were used to procure videoconferencing equipment which were piloted in a variety of forums. The Nursing Education Studio, pictured right, is a state-of-the-art studio that is equipped to handle videoconferencing and videostreaming to nurses at MGH, and beyond. The equipment has been used to teach nurses in other states and in other countries. The equipment is HIPAA-compliant, located behind a Partners firewall, which means that it can be used to safely transmit patient-related information. The mobile equipment, not pictured here, is being considered for clinical use by one of the Innovation Units as a way to conduct hand-offs between the hospital setting and the primary care practices. Nurses are imagining ways to conduct real-time, video hand-offs, including having the camera zoom in on IVs, dressings, and other devices, in order to facilitate knowledge preservation during transitions of care.

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⁴ This project was supported by funds from the Division of Nursing (DN), Bureau of Health Professions (BHP) Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under 1D76HP20530, ARRA Equipment to Enhance the Training for Health Professionals, for $297,925. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any official endorsement be inferred by, the DN, BHP, HRSA, DHHS, or the US Government.
Bedside Hand-offs on the Cardiac Surgical Unit Using SBART
(Innovation: health outcomes, administrative efficiency, cost effectiveness, users’ experiences)

Nurse-to-nurse handoffs are critical points in care when essential information loss can lead to omissions of care, errors, near misses, unreported use of or inaccurate settings pertaining to adjunctive equipment, resulting in threats to patient safety and well-being. The goal of the handoff is to transfer the needed information within a context of identifying the priorities of care for the incoming nurse. A 2012 National Patient Safety Goal is to improve the effectiveness of communication among caregivers.

The Clinical Nurse Specialist (CNS) on the Cardiac Surgical Unit was trained as an Evidence-Based Practice Mentor in the Clinical Inquiry Institute. Using the Iowa Model of Evidence-Based Practice to Promote Quality Care, she noted several safety reports that identified discrepancies between the medical orders and what intravenous (IV) fluids were actually infusing. Her expertise led her to believe that bedside hand-off between two RNs would prevent this type of error. She asked the question, “Does a customized bedside handoff improve communication and safety for cardiac surgery patients, improve patient satisfaction, and improve nurse satisfaction more than usual report practices?” She was trained to ask this question, using what is commonly called, the PICO method:

P – Population/Problem: Cardiac surgery patients; incomplete information;
I – Intervention: Customized bedside handoff;
C – Comparison: Usual report based on nurse report and reading the chart;
O – Outcome Fewer safety-event reports; greater patient satisfaction; improved nurse satisfaction with customized, bedside handoff

Although the importance of quality hand offs are ubiquitous in the literature, there was little high quality evidence to guide the project. After a thorough literature search, including national guidelines, the CNS created and piloted a standardized bedside report form that included the specific technology used for the patient population on her unit. The CNS had the standardized bedside report printed and laminated and placed in every patient room (attachment NK 8.o) and then instituted the practice of bedside hand-offs. The CNS also placed new communication boards at the bedside, another strategy to standardize communication flow:
Several outcomes occurred. No further safety reports for IV discrepancies occurred. Overall, there were fewer communication errors in all areas. Staff Nurses were satisfied with the procedure; it has become the standard of care. Feedback from patients suggests that they prefer this method of handoff because they are included in the communication and have enhanced understanding of their care. As it turns out, bedside handoff may be the only time that patients and families hear a cohesive snapshot of the patient’s progress and the plan of care. And, they can participate, as well. Patients and families also expressed that the communication boards were very helpful.

One challenge has been that bedside handoffs take more time than usual practice, usually due to patient/family participation. Staff Nurses are finding ways to make report more efficient, while preserving the patient/family involvement. They are also enlisting the help of Patient Care Assistants (PCAs) to assist with requests for physical care, that arise during handoffs. Although there are several groups in the hospital working on standardizing hand offs, the Cardiac Surgical Unit has taken a lead and demonstrated success. The outcomes of this project were disseminated in a poster presentation during Nursing Research Expo in May 2012 (attachment NK 8.p).

- **Nurse Practitioner Models of Care**
  
  (Innovation: health outcomes, administrative efficiency, cost effectiveness, users’ experience)

  New models of care delivery are providing expanding opportunities for Acute Care Nurse Practitioners (ACNP s) in academic medical centers. This is largely due to the need to shift some of the work of Medical Residents who are restricted to an average of 80 hours a week by the Accreditation Council for Graduate Medical Education (ACGME).

  At Massachusetts General Hospital (MGH), Nursing Directors took leading roles in the collaborative design and creation of two ACNP collaborative care models. The development and implementation of these ACNP models are aligned with two key recommendations put forth by the Institute of Medicine’s *The Future of Nursing: Leading Change, Advancing Health*. The first recommendation is that advanced practice registered nurses (APRNs) should be able to practice to the full extent of their education and training. A second recommendation is to expand opportunities for nurses to lead and manage collaborative efforts with physicians and others to redesign and improve practice environments and health systems.

  The first model, the Academic Hospitalist Service, was designed to care for 13 patients on a general medical unit. The second model, the Oncology Inpatient Nurse Practitioner Service, was designed to care for 14 medical oncology patients. The Norman Knight Nursing Center for Clinical & Professional Development assisted by customizing the NP Orientation program and by including the new element of simulation. A complete description of this project is found in the publication in attachment NK 8.q.

- **Institute for Healthcare Improvement STAAR Initiative**
  
  (Innovation: health outcomes, administrative efficiency, cost effectiveness, users’ experience)

  Staff Nurses on the Orthopaedic Units collaborated with faculty from the Institute for Healthcare Improvement (IHI) by piloting the State Action on Avoidable Rehospitalizations (STARR) Initiative, a four-year, multi-state effort to reduce avoidable hospitalizations. The STAAR focuses on creating ideal transitions for patients from the hospital to home. The aim is to reduce 30-day readmission rates by 30% and increase patient and family satisfaction with optimal transitions and coordination of care. During the collaborative, the Staff Nurses and the entire interprofessional team are developing skills to design safe and reliable transition processes, more effectively engage
patients and families to be better self-managers, and effectively coordinate care at discharge across disciplines and care settings.

Staff Nurses play a major role in one of the key changes required by participation—that of patient and family education. Their role was to identify the learner(s) on admission, redesign the patient education process to improve patient and family caregiver understanding of self-care, and to use “Teach Back” daily in the hospital setting and during follow-up calls. The Team Leader for the project is the Clinical Nurse Specialist, also trained as an EBP Mentor. She integrated and extended her knowledge of Teach Back from her EBP course work, into the work of this project.

Another aspect of this project that was very interesting to the Staff Nurses was the fact that all patients received photographs of their surgical site wound so that others—Visiting Nurses, Primary Care Physicians, Surgeons, Nursing Home Staff—could see the state of the wound on discharge. Patients and families retained a copy of the photograph so that they could also call the Surgeon if the wound showed any of the red flags that nurses taught them prior to discharge. They received teaching about how to assess the surgical wound. A copy of this is provided in attachment NK 8.r, which also provides further background of the project.

This project is another example of how Staff Nurses have opportunities for high quality teaching in innovations—in this case, from faculty from the IHI. These skills, when used by the entire team over the course of a project, become a new way of working together, transferable to other projects, as well.

- **Retooling for Evidence-based Nursing Practice Project**
  *(Innovation: health outcomes, cost effectiveness, administrative efficiency)*

In 2008, **Retooling for Evidence-Based Nursing Practice** (REBNP) Project was funded in the amount of $899,129\(^5\) (Attachment NK 7.r). The overall aim was to build evidence-based nursing capacity by developing, implementing and evaluating a staged professional development program based upon the Iowa Model of Evidence-Based Practice to Promote Quality Care (Iowa Model). The goals were to:

1) strengthen all levels of the nursing workforce by teaching knowledge, skills, competencies, and outcomes of EBP through multimodal continuing education programs;
2) provide opportunities for nurses to participate in mentored evidence-based practice projects that would improve the quality of care and patient outcomes (year 3); and
3) build infrastructure necessary to support and sustain EBP in our complex academic medical center.

The REBNP Project was implemented by a doctorally-prepared nurse and several masters’-prepared nurses. The REBNP Project consisted of sequential, multimodal education, which is available to nurses in all roles at MGH. The initial courses were live, one-hour sessions. After attending the “live” courses, nurses could take more in-depth online courses or more intensive “live” training sessions. A list of courses can be found in NK 7.

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\(^5\) This project was supported by funds from the Division of Nursing (DN), Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under D11HP14632, Retooling for Evidence-Based Nursing Practice for $899,129. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any official endorsement be inferred by, the DN, BHP, HRSA, DHHS, or the US Government.
The most intensive training was provided in the Clinical Inquiry Institute (attachment NK 8.s), a three-day training targeted to Clinical Nurse Specialists who are not only recognized as experts of clinical nursing practice, but will take the leading role in mentoring EBP projects upon completion of the funded period. Graduates of the Clinical Inquiry Institute are designated “EBP Mentors” at MGH (attachment NK 8.t). Having nurses with an advanced EBP skill set is critical to the success of EBP, which is extremely time-consuming and difficult, especially critiquing and leveling evidence. Some level of EBP training has been provided to 1634 nurses locally, nationally, and internationally.

The grant staff reviewed the five major EBP models, selecting the Iowa Model of Evidence-Based Practice to Promote Quality Outcomes (Iowa Model), attachment NK 6.n, because it aligns EBP projects with organizational goals and priorities. Recognizing that the process of EBP is the same regardless of the EBP model chosen, the Iowa Model offers distinct advantages including an algorithm format that guides the process across various decision points. A description of this grant is found in NK 7. The exemplar below is the result of an EBP project that was conducted as part of the training. EBP Mentors found it helpful to conduct their first review and synthesis of the literature, as a group, with the assistance of a librarian. This clinical question arose at the same time the EBP Mentors were deciding on a topic, so they decided to conduct this project to test their new skills.

**Exemplar: Temporal Artery Thermometer (TAT) Project**

**Background:** Frontline oncology nurses asked if the temporal artery thermometer (TAT) readings were consistently accurate. A nursing journal article raised some suspicion that the TAT was not accurate. A clinical nurse specialist/EBP mentor brought this issue to an EBP Seminar. The group of EBP mentors decided to tackle this project, not only as a way of answering the clinical question, but as a way to learn the process of writing a “Best Evidence Statement.”

**PICO:** The PICO question was: In the adult inpatient population, does the Exergen Temporal Artery Thermometer provide a precise and accurate measure of core body temperature?

**Process:** Fifteen nurses, assisted by a medical librarian and a nurse scientist, conducted a search of the literature, weighed and leveled the evidence, concluding with the following recommendations.

**Recommendations:**
1. The evidence supports the accuracy and precision of the temporal artery thermometer compared to the pulmonary artery thermistor for detection of normal range temperatures in the adult inpatient population.
2. There is insufficient evidence and lack of consensus to support a recommendation regarding the precision and accuracy of the TAT for identification of hypothermia and hyperthermia in the adult inpatient population.

**Conduct of Research:** Following the Iowa Model, when there is insufficient evidence for practice change, conduct of research is recommended. Upon reviewing an existing data set here at MGH, the TAT was found to be accurate and precise in hypothermic patients. Therefore, staff nurses in the Cardiac Surgical Intensive Care Unit, will be starting a study in early 2012 that compares the TAT with the pulmonary artery thermistor, considered the gold standard, to determine if the TAT is precise and accurate in the febrile population. The findings of the study will guide the future use of the TAT.
The ability to find, distill, and grade evidence for practice is important for clinical decision-making. By conducting mentored EBP projects, RNs are learning the process of finding and applying best evidence in clinical practice. The use of the Iowa Model provides a common framework upon which to base the work. Therefore, this recent, concentrated focus on EBP is an innovation by its planned and coordinated actions.

**Nurse Residency Programs**

New nurse residency programs help novice nurses transition to practice. MGH offers a New Graduate Nurse Residency Program in Critical Care, which has been extremely successful (SE 5). In 2006, another type of nurse residency program was envisioned—one for practicing nurses so that they could develop advanced knowledge in geriatrics and palliative care, two relatively new specialties. That program was called the “RN Residency: Transitioning to Geriatrics and Palliative Care,” and has since been disseminated nationally under the name of AgeWISE™, described below. In 2009, a third nurse residency program was designed for practicing nurses who were interested in developing expertise in clinical ethics—the Clinical Ethics Residency for Nurses (CERN) Project (described fully in EP 23). What was learned was that nurses at all levels of expertise can enjoy and benefit from an intensive, mentored classroom and clinical experience. And, as a result, patients and families benefit from more knowledgeable nurses who are attuned to their needs.

- **AGEWISE™ (see also TL 7)**
  
  *Innovation: health outcomes, administrative efficiency, cost effectiveness, users’ experience*

  An innovation in nursing education and practice, AgeWISE,™ is a six-month, nurse residency program in geropalliative care for practicing nurses in the acute care setting (attachment NK 8.u). As cited in the Future of Nursing report, nurse residency programs are important when transitioning into practice or when transitioning into a new specialty [italics added]. The aging demography means that nearly one-half of all hospital admissions are now older adults. Most nurses have never received focused geriatric education, so AgeWISE is helping to instill those core competencies into the practice setting. With a focus on frail older adults in the last two years of life, AgeWISE incorporates palliative care, along with geriatrics, as an approach to care.

  The program, originating from the MGH RN Residency: Transitioning to Geriatrics and Palliative Care, AgeWISE™ is now a national pilot in twelve US hospitals across ten states (2010-2013). The success of the RN Residency (attachment NK 8.v) caught the attention of national nursing leaders from the Center to Champion Nursing in America (CCNA), an initiative of the AARP, AARP Foundation, and Robert Wood Johnson Foundation. The CCNA provided technical and other resources to help disseminate AgeWISE™ to six hospitals across the US through a competitive process. In order to ensure success, CCNA advised the selection of high-performing hospitals, as measured by their being Magnet® hospitals, along with other criteria. The CNO demonstrated strong support for AgeWISE; in November 2011, the CNO approved the expansion of AgeWISE to nurses at an additional six hospitals, bringing the total number to twelve hospitals.

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6 This project was supported by funds from the Division of Nursing (DN), Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under D11HP08359, RN Residency: Transitioning to Geriatrics and Palliative Care, for $654,512. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any official endorsement be inferred by, the DN, BHP, HRSA, DHHS, or the US Government.
Using a train-the-trainer model, the sites sent teams of six nurses to Boston to receive training (attachment NK 8.w and attachment NK 8.x) in the AgeWISE Toolkits, which guided the implementation of their programs. An example of one module from the AgeWISE Toolkit is attachment NK 8.y.

- Nebraska Methodist Hospital, Omaha, NE
- Roswell Park Cancer Institute, Buffalo, NY
- Dartmouth Hitchcock Medical Center, Lebanon, NH
- URMC Strong Memorial Hospital, Rochester, NY
- NYU Langone Medical Center, NY, NY
- St. Joseph’s Regional Medical Center, Paterson, NJ
- UH Case Medical Center, Cleveland, OH
- Northwest Community Hospital, Arlington Heights, IL
- OSF St. Francis Medical Center, Peoria, IL
- Beaumont Hospital, Royal Oak, MI
- Abington Memorial Hospital, Abington, PA
- USD Sanford Medical Center, Sioux Falls, SD

Each AgeWISE site selects six nurses to lead the initiative. Residents receive ninety-six hours of classroom learning (twelve 8-hour days) and are expected to integrate new learning into their clinical settings during the residency period as they seek new ways to improve the care of older adults on their units.

In order to sustain the momentum, the MGH Team conducts monthly conference calls, webinars, and issues a monthly newsletter (attachment NK 8.z). The MGH Team also makes two site visits to the pilot sites for education and mentorship.

AgeWISE™ has several features that distinguish it from all other nurse residency programs: Unlike new graduate nurse residency programs that aim to socialize new nurses in practice, AgeWISE™ residents are experienced registered nurses who work on acute care units such as medical/surgical, oncology, intensive care, and cardiac units. This training is in addition to their previous specialization and aims to develop expertise in geriatrics and palliative care.

The crux of the residency is transformative learning which challenges nurses’ beliefs and worldviews. Transformational learning encourages reflection on existing practice and helps nurses initiate change in the usual nursing practice on their units. Therefore, the site teams are strongly encouraged to avoid “death by PowerPoint,” preferring case studies, dialogue, and presentations.

The residency promotes retention by engaging competent, proficient, and expert nurses in new experiences that promote growth and learning. Nurses with two to five years of experience are
paired with unit colleagues who have 20+ years of experience into “care dyads” that serve to advance innovation and change on the unit.

New nursing knowledge in geropalliative care is being generated by nurses at MGH. (attachment NK8.aa). In fact, an innovative new nursing specialty is emerging through the scholarship of integration and practice.

In addition to attending biweekly classes, residents are required to initiate practice improvement projects on their units. These projects are not proscribed; residents are encouraged to choose projects based on their own needs assessment and interests.

AgeWISE™ shares the rich resources of MGH with others who are also striving to meet the needs of the aging population, in urban and rural America. A 2012 article in the Journal of Nursing Administration fully describes the AgeWISE program (attachment NK 8.bb). AgeWISE is also being presented at the Magnet Conference, Fall 2012 (attachment NK 8.cc).

MGH program leaders make site visits to all AgeWISE sites to provide support and to determine adherence to the program, which is being evaluated using a mixed methods design. Approval has been received from the Institutional Review Board at MGH and the 12 external sites. Quantitative instruments are being used to measure pre/post knowledge, skills, and attitudes; focus groups measure the experience of professional growth related to AgeWISE, and clinical outcomes measure the impact of the team’s performance improvement projects.

Early findings are consistent across sites. Nurses have found the experience of the residency to be transformative. They report that they have reached a deeper level of practice. They feel more knowledgeable and empowered to act on behalf of patients and families, to seek necessary resources to make end-of-life more meaningful.

The process and outcomes data from the National AgeWISE Pilot are currently being analyzed. The experiences of AgeWISE nurses across the country were very similar to those in the RN Residency: Transitioning to Geriatrics and Palliative Care. The feedback from the sites is being carefully synthesized to guide revisions to the program. One of the major revisions will be to create interprofessional opportunities for learning and dialogue, particularly around goals of care for frail elders and their families. Another revision will be to build nurses’ communication skills through
simulated learning. Finally, ethical dilemmas are the third major area where more content is needed. The next generation AgeWISE program is being developed in the Institute for Patient Care and will be piloted at MGH on selected patient care units in the Fall of 2012. Nurses who were RN Residents will assume lead roles as Senior AgeWISE Mentors in the implementation of AgeWISE on their units.

- **Frontline Innovations**

  So far, the innovations that have been described were mainly developed in partnership with staff from the Institute for Patient Care and frontline Staff Nurses, Clinical Nurse Specialists, and Nursing Directors. Yet, much of the innovation work goes on quietly, at the frontline, by Staff Nurses, alone or in conjunction with other nurses and interprofessional colleagues. In this section, a few of these achievements are highlighted to underscore the fact that Staff Nurses at the point of care, have great ideas for improvement, and frequently do push forward ways of working that are more efficient. Sometimes alone, but often in small groups, always with support of unit leadership, they work to make a difference. These snapshots of likely indicate the tip of the iceberg of frontline innovation.

- Meg Lavaca, RN, part of the Quality Committee on the Hematology/Oncology/Bone Marrow Transplant Unit (Lunder 10), created the Leukemia Discharge Instructions Sheet for use by all RNs on her unit.
- In the Cancer Center Infusion Unit (Yawkey 8), Staff Nurses on the unit-based, Practice Committee redesigned the process of admitting patients from the waiting room to their infusion chairs, to now include teaching about fall risk and the need for precautions.
- This same group, devised a system to signal patients at high risk for fall. A laminated yellow leaf on their IV pole signals a high risk for fall; a laminated red leaf signals someone who should not be walking, at all, due to fall risk or type of chemotherapeutic agent.
- Janet Mulligan, RN, suggested using bright pink patient ID bands to identify patients with PICC lines to give staff a visual cue that the arm should not be used for venipuncture or blood pressure measurement.
- The left-ventricular assist device (LVAD) educational program described above has been disseminated by Staff Nurses on the Cardiac Surgery Unit (Ellison 8) to clinical and non-clinical staff in the ambulatory setting, using a train-the-trainer model. They also sponsor “Lunch and Learns” with their colleagues in the ambulatory settings.
- The Cardiac Surgery Unit (Ellison 8) Staff Nurses report nearly 100% Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) certification among their Staff Nurses.
- This same group of Staff Nurses holds interprofessional mock codes to build team competence on their unit.
- The Cardiac Surgery Unit is the Interprofessional Dedicated Education Unit, a joint venture of the MGH Institute of Health Professions and MGH. Staff Nurse Clinical Instructors are assigned one nursing student and a second student from another discipline.
- The Bedside Handoff, described above, is being replicated by a Staff Nurse/Graduate Student on the General Surgery Unit (Ellison 7).
- The General Surgery Unit (Ellison 7) is a Dedicated Education Unit with the College of Nursing at the University of Massachusetts/Boston.
• SharePoint sites are being developed by Staff Nurses on a number of units in order to facilitate a one-stop resource for all administrative and clinical news on a unit. Being able to create a SharePoint site requires taking a class and developing proficiency, posting materials, and keeping it up-to-date.

• Department of Imaging Staff Nurses developed a Consortium for Imaging Nursing in order to build a cadre of peers with whom they can network and share practice ideas.

• Staff Nurses in the Department of Imaging developed a Chemo Precaution Cart to be better prepared to receive and care for persons with chemotherapy infusing.

• These same nurses created a workflow design for patients requiring paracentesis and needing salt poor albumin.

• Neuroscience Unit (Lunder 8) Staff Nurses, anticipating a move to a new building, decided to establish a buddy system for breaks and lunches when they realized “lunch in the back room” would not work in the new architecture. They also valued time off the unit for breaks.

• On the Cardiac Interventional (Access) Unit (Ellison 11), Staff Nurses who serve as Preceptors developed a “New Grad Pocket Guide” of frequently used clinical information for new Staff Nurses.

• Cardiac Interventional (Access) Unit (Ellison 11) Resource Nurses developed an electronic report that provides information on unusual care needs, high risk anticoagulation, discharge or case management issues, urinary catheters, and wounds.

• These same Nurses devised a system to signal IV Nurses who now put magnets on the unit’s white board, next to patient’s initials, indicating the need for the IV Nurse to round on the patient.

• Staff Nurses on the Cardiac Interventional (Access) Unit (Ellison 11) requested new incontinence products; they are piloting them now for the hospital.

• A Staff Nurse, also on the Cardiac Interventional (Access) Unit, who recognized that short-acting medications were changed to long-acting medications on discharge, worked with Pharmacy to stock long-acting medication, so that patients would have the correct medication in hand, on discharge.

• Staff Nurses on the same unit spearheaded new orientation education for Patient Care Associates (PCAs) on specific skills, particularly Safety Rounding.

• Staff Nurses on the Cardiac Medicine Unit (Ellison 10) established the practice of biweekly interprofessional rounds to improve communication.

• Meagan Rudolph Morrison, RN, Staff Nurse on the Psychiatry Unit (Blake 11) developed a sleep kit that uses sensory aides and self-comfort to promote sleep.

• Carol Marcotte, RN, developed and co-taught a class on Therapeutic Touch for the Psychiatry Unit’s (Blake 11) Staff Nurses and Occupational Therapists.

• Karen Clark, RN, Christine McGinley, RN, and Marie Blanchette, RN on the Hemodialysis Unit (Bigelow 10) spearheaded the recycling of the large, plastic containers used to store dialysate that accumulate rapidly throughout the day.

• Deb Guthrie, RN, suggested creating a phlebotomy kit for drawing blood. Previously, unit staff were using IV kits and discarding some of the components. A potential savings of $70,000 was estimated.
• “Cookies and Conversations” held on Gynecology/Oncology Unit (Phillips House 21) is a standing meeting between Nursing and the Chaplaincy every Tuesday at 2:00 pm to support Staff Nurses in their area of practice that involves a lot of suffering.

Finally, tribute is given to MGH nurses who arrange for bedside weddings, for religious rites, birthdays, and other milestones of life — innovating care at the bedside out of respect for human dignity and a shared humanity.
Table 1. Selected Innovations Described in Magnet Document

- **Quiet Times** on the Surgical/Trauma Unit (White 7) from 2pm to 4pm reduced noise from an average of 75db to 65db and reduced entries into patients’ rooms by nearly one-half (EP 1EO).
- **EXCELerated**, designed by the Arthroplasty Care Redesign Team, reduced length of stay (LOS) by 0.8 days for the study population; interventions “spilled over,” reducing LOS 0.6 days for all joint replacement patients (EP 1EO).
- **Work Well, Be Well**, a workplace intervention to decrease work-related injuries, yielded a 33% decreased rate of injury, a 94% reduction in associated lost work days, and a 30% reduction in restricted workdays on pilot units (EP 3EO).
- **Employee Influenza Vaccination**, through multimodal interventions, including 190 RN Flu Champions, boosted flu vaccinations rates to 91% of all employees and to 95.7% of nurses (EP 1EO).
- **Sharps Exposure Reduction Program** resulted in a 41% reduction in the number of exposures per RN Work Hours in needle sticks between CY 2010 and CY 2011 (EP 30EO).
- **Evaluation of Clinical Inquiry Institute**, one of 84 research projects conducted at MGH, found that an intensive education program in EBP significantly improved nurses’ skills and confidence in conducting EBP projects, which remained high over time. As a result of the findings of **Evaluating the Impact of Death and Dying in ICU on New Graduate Nurses**, new nurses will receive greater support and education. Training in **Basic Arrhythmia Knowledge** confirmed the successful of its methods, even three months later (NK 4EO).
- **PRISM**, a system for tracking patients in the perioperative practice setting, markedly enhanced throughput and improved the percentage of on time transfers (NK 9EO).
- **Inpatient Psychiatric Unit Fall Reduction Task Force** reduced falls from 7.2 per 1000 patient days to 0 per 1000 patient days (SE 1EO).
- **Save Our Skin (SOS) Campaign** has provided a standardized approach to pressure ulcer prevention and a deeper dive into monitoring practices. **Family Presence in the CICU** measured staff perceptions before an after implementation of a new guideline and education; interprofessional staff responded positively and changed practice. **IV Tubing Changes**, based upon national guidelines, improved RNs practices relating to standard IV tubing changes (SE 2EO).
- **Anticoagulation for Patients with Limited English Proficiency** highlighted the health disparities for those patients on anticoagulation therapy. The Anticoagulation Management Group also trialed self-testing by following the national guideline for and concluded that the self-testing group was very successful (SE 2EO).
- **Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace** increased participants’ confidence in recognizing, identifying resources, and handling disruptive behavior (SE 5EO).
- The implementation and evaluation of the **Dedicated Education Unit** showed students’ higher degree of satisfaction with RN Instructors than traditional placement settings, as well as the growth achieved by clinical instructors. **Twinning Nurse Leader Model** with nurses from Shanghai Huashan Hospital in China demonstrated (SE 11 EO).
- **Nurses’ Role in Code Status Discussions** reduced moral distress among RNs after rounding with physicians to discuss code status with patients on General Medicine (TL 10EO).
The power of a narrative culture: sharing knowledge through story-telling

— by Mary Ellin Smith, RN, professional development coordinator

Over the past ten years, clinical narratives have become part of the fabric of professional life within Patient Care Services. Narratives are part of the application process for the Clinical Recognition Program, for awards, and every year clinicians write narratives as an integral component of their annual performance review.

While story-telling has been part of tribal culture from time immemorial, Patricia Benner, RN, noted author and nurse researcher, first introduced clinical narratives as a way to share and reflect on clinical practice. Says Benner, “Narrative accounts of practice reveal the clinical reasoning and knowledge that come from experiential learning. Clinical narratives can become a resource to help practitioners understand their own practice, see and share the clinical knowledge of peers, and reveal strengths and impediments of practice.”

Narratives allow clinicians to reflect on past experiences, clarify meaning, gain new insights, discover cues that weren’t known before, and make connections between phenomena that may have been invisible in the moment.

Narratives provide an opportunity for individuals to share stories that have meaning to them and at the same time describe their concerns, intuition, inner dialogues, evolving understanding, feelings of doubt, challenge, and conflict. Narratives reveal what excellent, good, and not-so-good practice look like. Narratives allow clinicians to reflect on past experiences, clarify meaning, gain new insights, discover cues that weren’t known before, and make connections between phenomena that may have been invisible in the moment. Narratives are a vehicle for reflection that can help clinicians see their practice differently.

While putting pen to paper allows clinicians to ‘see’ their practice in a different light, it is also a springboard for dialoguing with colleagues and clinical experts. Through the very important process of dialoguing, clinicians are asked questions that prompt them to probe deeper into their thinking and motivation. They might ask themselves: What were my concerns about this patient in this situation? How was this situation similar to situations I’ve experienced in the past? How was it different? What did I learn? These questions allow clinicians to enter into the clinical situation from a different perspective, to see it in a different way, and perhaps identify different interventions and strategies.

Clinical narratives can be difficult to read when they don’t describe what we consider to be ‘perfect practice.’ But those are the narratives we need to write and read and talk about, because they describe the realities of care and the environment in which care is being provided. We need to be open to all stories and the dialogue that follows in order to create and sustain the highest quality of care.
Patient Care Services welcomed world-renowned author and lecturer, Patricia Benner, RN, PhD, FAAN, September 8, 2005. Benner is a professor in the department of Physiological Nursing at the University of California, San Francisco, and a leading expert on skill-acquisition and clinical judgment. Benner’s work was the theoretical foundation for Patient Care Services’ Clinical Recognition Program.

During her visit, Benner presented at Nursing Grand Rounds where she had an opportunity to dialogue with staff about their clinical narratives. Suzanne Curley, OTR/L, advanced clinician in Occupational Therapy; Donna Lawson, RN, advanced clinician on the Bigelow 11 Medical unit; and Kimberly Stewart, SLP, advanced clinician in Speech Language & Swallowing Disorders, shared their narratives. Benner spoke about the knowledge shared by different disciplines and the need for interdisciplinary discussions about patients, practice, and the environment of care.

Benner met with the Clinical Recognition Review Board to discuss their observations about the program three years post-implementation. She spoke about the opportunity the board has to identify best practices and areas for improvement by reading portfolios submitted during the application process.

Benner met with associate chiefs and directors to discuss the role of leadership in creating an environment for reflective practice and promoting the Clinical Recognition Program. She provided insight into the challenges of ensuring competent skills and helping clinicians grow professionally. She spoke about clinicians becoming disengaged from practice and how leaders can help prevent this during the first years of a clinician’s practice.

Said Benner, “By making the attributes of excellent practice clear and visible, a recognition program brings with it a change in organizational culture.”

Photos by Abraham Beker

Clockwise from top left: Lawson, Benner, Stewart, and Curley
their narratives with colleagues, peers, and clinical experts, they gain new insights, discover cues that weren’t known before, and make connections between phenomena that may have been invisible before. Whether sharing their own stories or hearing someone else’s, discussion gives clinicians an opportunity to view clinical practice from another perspective, and this process reveals insight, wisdom, and best practices.

Narratives are a key tool in the development of reflective practice. Reflection, the ability to carefully consider one’s own practice in order to gain a greater depth of understanding, influences not only our present way of thinking but our future interactions. Clinicians who reflect on their practice and gain insight into their motivation, judgment, and actions go into the next situation more present and aware. This is how a novice becomes an expert; this is how we continuously improve practice and the care we deliver to our patients.

In honor of Medical Nurse Day, Patricia Benner visited MGH on November 15, 2006, to participate in two educational sessions. The morning session gave Dr. Benner an opportunity to hear narratives written by medical nurses and offer expert commentary. The afternoon session was a multi-disciplinary case presentation exploring the importance of teamwork and collaborative practice. I hope you were able to attend one or both of these sessions and hear the compelling stories of your medical nursing colleagues. Listening to these narratives and the lively discussion that followed, I know you would have been moved to share your own clinical practice. Perhaps we can look forward to reading them in a future issue of Caring Headlines.

Update

I’m happy to announce that Maria Rice, RN, has accepted the position of clinical nurse specialist for the Emergency Department, effective November 13, 2006.
A glimpse into the delicate dance that is the art of nursing

My name is Megan Keating, and I believe the nurse-patient relationship is of utmost importance. I've worked as a nurse for one year in the Respiratory Acute Care Unit (RACU), and my experience has been humbling. It's an honor to start my career at MGH where my patients challenge me both medically and emotionally. One patient who had a great impact on me is Mr. G. He came to the RACU with more than just his own needs; his wife was also struggling to understand what her husband was going through.

Mr. G is a 46-year-old man who arrived on our unit with a diagnosis of idiopathic pulmonary fibrosis, a disease that results in scarring and fibrosis of the lungs. Over time, the scarring can build up to where the lungs are unable to provide oxygen to the tissues of the body. Mr. G had been on a medical unit until his respiratory needs worsened and he was brought to the RACU. He presented with a dry cough and shortness of breath. The slightest movement was difficult for him. Simply changing his hospital gown taxed his breathing and caused him to cough uncontrollably. Mr. G was taking medications to suppress his cough and curb his anxiety, but he still had difficulty breathing.

Medication was not the long-term solution. Mr. G was awaiting a lung transplant and fortunate to be at the top of the transplant list. It was important to keep up with Mr. G's medical needs so he'd be stable enough to undergo surgery. But a radical chain of events resulted in Mr. G being diagnosed with pneumonia and a pulmonary embolism, which required him to receive a continuous infusion of heparin to ensure he wouldn't have any issues that would prevent him from receiving a lung.

Mr. G made it clear that if his respiratory status worsened, he did not want to be intubated or put on a ventilator because it would affect his chances of receiving a transplant. Although Mr. G's physical state was diminishing, he was alert and still had all his faculties. I prepared him for pre-op, making sure he received his medications on time to keep him from coughing. I was also there for him emotionally, trying to make his experience on the unit as close to 'normal' as possible.

I knew that nursing would be crucial to Mr. G's coordination of care; I reached out to colleagues in other disciplines. I requested a social work consult to support Mr. G and his family in coping. I requested a psych clinical nursing specialist to help him practice relaxation techniques during coughing spells. As I look back on it, at least a half dozen services brought their expertise...
Over and above nursing care, we're there to provide comfort and hope to patients and families. The art of nursing is like a delicate dance—a fusion of skill and knowledge. This intangible connection can create an environment conducive to healing. Blending nursing responsibilities with patients' wishes is the essence of the art of nursing.

Mr. G was a stoic man. He didn't complain, and he was very appreciative of the care he received. When he was admitted, I went through the usual process: introduced myself, took his vital signs, obtained an EKG, did a head-to-toe assessment, completed the admission paperwork, connected him to a cardiac monitor, and explained patient rounding. Mr. G let me get through all my many tasks before telling me he needed to use the bathroom. He was uncomfortable using a bed pan. While keeping Mr. G's fragile respiratory state forefront in my mind, I wanted to respect his dignity, as well. I knew that with his tenuous respiratory status, walking from the bed to the bathroom would be unsafe. He didn't have the lung capacity to make it even that short distance.

I decided to set up a bedside commode. With the help of another nurse, we assisted Mr. G from the bed to the commode, while the respiratory therapist increased his oxygen to accommodate the transfer. I pulled the curtain closed and told him I'd wait just outside so I could monitor his oxygen saturation. He felt comfortable knowing I was keeping a close eye on him and said he'd use the call bell when he was finished.

This simple intervention of providing Mr. G with a commode was such a boost for him emotionally. As we helped him back to bed, he told me how grateful he was to still have control over some aspect of his life. He felt as if he was losing control of so many things, and I had given him an opportunity to have a little empowerment.

Control was important to Mr. G. He may not remember the head-to-toe assessment I gave him, or the medication review, or the paperwork we had to complete, but he'll remember that I kept him comfortable and thought of his personal needs at a time of great vulnerability.

As nurses we're conditioned to be critical thinkers, understand various interventions, and recall important facts. As a new-graduate nurse, I sometimes see myself as task-oriented, but I'm aware there needs to be a balance between accomplishing tasks and accommodating patients' needs. Over and above nursing care, we're there to provide comfort and hope to patients and families. The art of nursing is like a delicate dance—a fusion of skill and knowledge. This intangible connection can create an environment conducive to healing.

Blending nursing responsibilities with patients' wishes is the essence of the art of nursing.

Mr. G's wife left to go home for the night after spending the day with him making sure he was comfortable and settled. We assured her that he would be well taken care of and that we'd monitor him closely throughout the night. She asked questions and was updated on Mr. G's plan of care. She decided to leave before the change of shift to avoid traffic and get home to their children whom she hadn't seen for a few days while she was at the hospital with Mr. G.

As my shift ended that evening and I gave report to the night nurse, I got the news from Mr. G's physician that a lung had become available. It was time for Mr. G to go to the operating room. I called Mrs. G, who was on her way home and gave her the news. I told her that Mr. G was being prepped for surgery. She was ecstatic. She said she'd go home and get the children and come right back to the hospital to see Mr. G before he went into surgery. Before hanging up, she thanked me for taking time with Mr. G and not losing sight of his emotional needs even with the intense focus on his respiratory care.

I may only have known Mr. G for 12 hours, but in that short time, the rapport I built with him made him comfortable enough to express his fears to me about the lung transplant and his desire to lead the life he'd imagined with his family after the transplant. He confided in me during his most vulnerable time. This is why I believe that the nurse-patient relationship truly sets the tone of care and has a powerful impact on patient trust and satisfaction. Undoubtedly, Mr. G and his story will impact my practice for years to come.

Comments by Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

If the art of nursing is like a delicate dance, then Megan is a very good dancer, indeed. In a very short time, she came to ‘know’ Mr. G's stoic nature and understand his need to maintain control. She tailored her interventions to support not just his physiological needs, but his emotional needs. Megan’s care of Mr. G respected his dignity and privacy and helped him sustain a sense of hope. That Megan is such a ‘good dancer’ so early in her career is a promising indicator of the kind of nurse she will become.

Thank-you, Megan.
Clinical Narrative

End-of-life care inspired by mutual trust and support

My name is Colleen Kehoe, and when I wrote this narrative, I was a nurse on the Bigelow 14 Vascular Unit. Mr. C was a very loved husband and father who had suffered from advanced Alzheimer’s disease for more than 15 years. His wife was his sole caregiver, healthcare proxy, and legal decision-maker. Mr. C was unable to feed himself, take his medications, or make even slight body movements. Despite her small build, Mrs. C was able to lift him from his bed to his chair. She cooked and pureed his meals and spoon-fed him, which often took hours. When she finished feeding Mr. C his breakfast, it would be time for lunch, and the cycle would start all over again. In the evenings, Mr. and Mrs. C’s sons often visited, and they would assist their mother in getting Mr. C back into bed. She would then set her alarm in 45-minute increments so she could wake up during the night to change his position.

This loving routine was carried out while I was Mr. C’s nurse. I was able to provide Mrs. C some respite by tailoring my care to suit Mr. C’s needs. This nurse-family support was mutual, as I made sure to include Mrs. C in the plan of care each day so she could give me insight into what techniques were effective in caring for Mr. C. For instance, when the physician ordered a CT scan with contrast, I feared Mr. C wouldn’t be able to drink all three bottles of the gastrografin preparation. Mrs. C recommended we mix the medication with berry juice, which I then thickened so he wouldn’t aspirate. We took turns spoon-feeding him the preparation, and soon he began to open his mouth without cueing. I knew he’d be able to finish the preparation, and he actually seemed to enjoy the flavor.

Mr. C had been admitted with a urinary tract infection complicated by blood and fungal infections that made him somnolent most of the day. He was anuric (no longer making urine) and as the CT scan confirmed, was in acute renal failure as a result of kidney stones. The urologist explained that Mr. C would need surgery to place stents in the urethra in an attempt to allow the kidney stones to pass. The doctor described the surgery as fairly routine, which it is, normally. But given Mr. C’s advanced Alzheimer’s and the blood infections he was fighting, he was at risk of not surviving...  

continued on next page
the surgery. Unfortunately, Mr. C’s family clung to the word, ‘routine,’ almost to the exclusion of the other stated risks.

When I left the hospital that day, Mr. C’s family was still undecided about whether they would consent to surgery. The urologist hoped he had conveyed the risks strongly enough, but I knew the family was harboring unrealistic hope. When I returned the following morning, Mr. C was on intravenous hydration and not eating in preparation for surgery at 2:00pm. The family had consented to the procedure.

Mrs. C, especially, was reluctant to accept her husband’s mortality. Despite Mr. C being in hospice care outside of the hospital, Mrs. C wanted everything possible done to save her husband. Though I respected her expertise in caring for her husband's daily needs, Mr. C was my patient. I wanted to make sure I was meeting his needs. I requested a family meeting with Mrs. C, the sons, and their family priest. The team agreed that the risks of surgery should be more precisely articulated. The meeting took place two hours before Mr. C was scheduled to have surgery.

At the meeting, the physician and I described several possible scenarios if Mr. C went forward with the surgery. Even if he survived the surgery, the prognosis was not good. The physician shared that if this were happening to her family member, she would forgo surgery given the extent of the illness and co-morbidities.

The family was still focused on whether the surgery would cause Mr. C pain. After an hour, it seemed the conversation was going in circles. The physician had to excuse herself to attend another family meeting. I took the opportunity to have a conversation about what Mr. C would want for his own life.

I asked the family, “What is the goal for your father?”

The son responded that he wanted to take his father home, have him get out of the wheelchair and sit at the kitchen table and eat with the family.

“Given his current condition,” I said, “do you think he could achieve that goal even without surgery?”

The son sadly agreed that it probably wouldn’t be possible given how sick he was.

Knowing Mr. C from previous admissions, I noted that his condition had declined every time he'd come back to the hospital. His baseline had deteriorated during this admission, and there was a chance that surgery could worsen his condition even further. The family asked about other potential effects of surgery. I told them honestly that in my nursing experience, sometimes patients never come off the ventilator when they're intubated for surgery.

Immediately, the son said he didn’t want his father intubated. Somehow, even with all the discussions with physicians and the urology team, the family had never completely absorbed the fact that Mr. C would need to be intubated. Now, talking about the basics of anesthesia and intubation, the family made their decision.

Mrs. C, who hadn't said anything during the entire meeting, put her hand on my shoulder and said, “Can I go feed my husband now?”

I smiled. I knew they had made their decision based on what was best for Mr. C and not a desire to keep him alive at all costs.

When I left work that day, I was proud of how I had handled the family meeting. I had grown a lot since first becoming a nurse when I had to rely on veteran nurses’ advice about what to say during challenging discussions. Four years later, I can honestly say I speak from a place of compassion during these meetings, as I did that day. I knew the family was torn, feeling compelled to do everything possible to save their loved one. But I avoided giving my own opinion and truthfully answered their questions in language they could understand. Instead of undergoing surgery and intubation, Mr. C enjoyed homemade tomato soup surrounded by his nieces, nephews, and grandchildren. Though his days were numbered, his family was aware of his impending death, and they were able to be there for him at his bedside.

**Comments by Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse**

What a poignant story. So often clinicians see first what families and loved ones find too painful to see. End-of-life care is a delicate balance between honesty and compassion, a balance that Colleen struck beautifully in her care of Mr. C. Surgical intervention was not going to cure Mr. C. In fact, there was a greater risk that surgery could end his life or impair his quality of living for the time he had left. Colleen’s conversation with the family was a difficult one, but she didn’t shy away from it. Without imposing her own opinions, she provided information that enabled Mr. C’s family to make an informed decision.

Thank-you, Colleen.
My name is Robert Ferdinand, and I am a nurse in the IV Therapy Department. In early August of 2010, as a member of the PICC Team, I took report from the previous shift and learned there were ten patients awaiting insertion of peripherally inserted central catheters (PICCs). Four were patients awaiting discharge, and six needed PICC placement for IV antibiotic administration. After further review, I saw that the discharge patients weren’t going to be discharged for another couple of days, and no patients on the list were in dire need of a PICC. So I planned to focus on the patients needing PICC placement for IV antibiotic administration. After reviewing each patient’s consult, one patient stood out as a priority.

Mr. H had been admitted to the Phillips House with a cystic fibrosis exacerbation. Placing PICCs in cystic fibrosis patients can be challenging because their veins have been accessed so many times, scar tissue develops at the insertion site. It can be challenging to puncture a vein and thread a catheter through scar tissue.

Upon arriving on the unit, I went to Mr. H’s room to make sure he was available. I introduced myself to him, and he greeted me with a handshake. I immediately noticed that he was very cachectic (a generally weakened state resulting from debilitating chronic illness). I told Mr. H that I was an IV therapy nurse and I was there to insert his PICC line. I told him I wanted to review his medical record and I would return shortly to discuss the risks, benefits, and alternatives to the procedure.

I left the room and reviewed Mr. H’s medical history, laboratory values, radiology reports, allergies, and the ordered treatment regimen. I saw that Mr. H was to receive IV vancomycin every 12 hours for several weeks. I also saw that he had a seizure disorder with a long neurological history and was scheduled for a CT scan with IV contrast. I conferred with Mr. H’s nurse and attending physician to discuss catheter options.
Clinical Narrative (continued)

At first glance, a 4Fr single-lumen poly PerQ-Cath PICC appeared to be sufficient. However, I discussed the CT scan with the doctor who said he’d probably be ordering more than one. So I recommended a power-rated PICC, which can also be used for IV-contrast-administration, and Mr. H wouldn’t have to be stuck a second time.

I expressed my concern that Mr. H appeared cautious and inquired as to the probability of his being ordered to receive total parenteral nutrition, because that would affect which type of catheter I’d use. Before I completed my sentence, the physician said that he intended to order total parenteral nutrition that evening. With that being established, I told the nurse and physician that a dual-lumen PICC would be the minimum requirement for Mr. H.

The physician said he’d prefer a triple lumen so that one lumen could be used for blood draws. I explained that a triple lumen would depend on whether the vasculature in Mr. H’s upper arm could support a triple. I explained that there are guidelines as to how big a catheter we can place. The general rule is that the catheter should be no more than 1/3 the size of the vein to maximize hemo-dilution around the catheter and minimize the risk of developing a thrombophlebitis. Lastly, I explained that in most cases it’s possible to obtain blood specimens from one of the lumens in a dual-lumen PICC. The physician considered this information, and we agreed that a dual lumen would be sufficient for Mr. H’s treatment if his veins were big enough.

I returned to Mr. H’s room and began the informed-consent process. I explained the risks, benefits, and alternatives to Mr. H, and he agreed to have the PICC-line inserted. But he seemed apprehensive. He became anxious and grimaced in fear. I asked if he was okay and, after a short silence, he explained he was scared because the previous PICC-line insertion (at another hospital) had been extremely painful and traumatic.

I assured Mr. H that we use local anesthetic to numb the area, and that I would explain everything I did before I did it. I told Mr. H that if at any point he wanted me to stop, to just let me know, and I would stop immediately. I told Mr. H to let me know if he felt any pain at the insertion site and I’d apply more local anesthetic to the area.

As I continued with the procedure, I told Mr. H that I found a great vein in his upper right arm. He told me he was right-handed and would prefer the insertion in the left arm. I explained that research shows fewer complications with right-sided insertions, and I explained that it would be placed high enough in the arm that there would be no range-of-motion limitations.

Mr. H said, “You’re the expert. I trust you’ll do what’s best for me.” I grinned from ear to ear. Here was a patient apprehensive about a procedure due to a previous experience, and I was able to earn his trust before I even started the procedure.

I continued with the PICC insertion, explaining in layman terms every aspect of what I was doing. Mr. H actually asked questions about the procedure as I worked. After it was over, I explained to Mr. H that he would have a chest x-ray to confirm that the tip of the line was in the correct location.

As I left, Mr. H said, “That was so easy! I didn’t feel a thing.” He looked me in the eye, shook my hand for an extended period of time, and said, “Thank-you,” several more times.

As a nurse, I sometimes forget how much I affect patients’ lives. When clinical situations like this arise, I’m confident in my knowledge, clinical experience, and individualized approach, certain that I’ll give each patient the very best care based on his or her clinical situation and vascular-access requirements.

As a nurse, I sometimes forget how much I affect patients’ lives. When clinical situations like this arise, I’m confident in my knowledge, clinical experience, and individualized approach, certain that I’ll give each patient the very best care based on his or her clinical situation and vascular-access requirements. I know I make a difference in their lives, and I look forward to the next time I get to make a patient’s stay at MGH a little easier.

Comments by Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

If you’re one of those people who thinks all IV nurses do is insert IVs, Robert eloquently dispelled that notion. His advocacy, skill, and foresight in caring for Mr. H show the depth of his clinical expertise and spotlight the important role IV nurses play in the care of patients. Not only did Robert’s clinical competence contribute to a positive stick for Mr. H, his confidence and compassion put Mr. H at ease before he even began. We’re fortunate to have Robert and his IV nurse colleagues making life “a little easier” for our patients.

Thank-you, Robert.
Younger nurses
Continued from page 11
and specialty skill mix to meet the needs of adults, children, and families in a rapidly changing and complex health care environment. The health care system requires well-educated, well-distributed, and well-utilized entry-level and advanced-prepared RNs to practice in settings, from hospitals and front-line primary care to research and informatics.

Looking at challenges to the supply side, RNs who have been postponing retirement because of the economy can be expected to leave hospitals and other practice settings in significant numbers once it improves. That can lead to staffing shortages and fewer experienced nurses in some facilities.

Nursing education also faces challenges as many faculty will be retiring and there are an insufficient number of appropriately prepared nurses to teach.

On the demand side, patients in the baby boomer generation will require more services as they age. And, there will be more demand for primary care services — and RNs and APRNs to provide it — as more people become insured.

NURSESBOOKS

ANA title wins Nursing Book of the Year honor

Since 1959, the American Journal of Nursing (AJN) Book of the Year competition has recognized nursing's most valuable texts. Officials group entries into 16 categories and a panel of nurse experts in those fields chooses the winners. In 2011, NDNQI Case Studies in Nursing Quality Improvement, co-authored by Jennifer Duncan, PhD, RN, Ian Montalvo, MBA, MS, RN, and Nancy Dunton, PhD, won first place in the Professional Development and Issues category.

Like its 2007 and 2009 companion volumes, this 2011 volume provides evidence-based insights and a step-by-step guide on how to use National Database of Nursing Quality Indicators data to improve the quality of care. It examines how to apply to practice the lessons of the book's 11 case studies; includes an overview of quality improvement and a listing of online and written resources; and contains an appendix listing the NDNQI measures by category.

This book and other ANA titles are available for purchase at www.nursesbooks.org or by calling (800) 637-0233.

TESTING NEW MODELS

Innovating for better care

Centers for Medicare and Medicaid Services selects Barbara Blakeney among the first group of "innovation advisors" to help transform health care.

But American Nurses Association (ANA) President Barbara Blakeney, MS, RN, is among the first group of "innovation advisors" selected by federal officials to help transform health care.

The Centers for Medicare and Medicaid Services (CMS) Innovation Center initiative selected 73 advisors, including nurses, physicians, hospital executives, and policy experts representing institutions in 27 states and the District of Columbia.

After an initial orientation phase which was scheduled to begin in late January, the innovation advisors will work with the CMS Innovation Center to test new models of care delivery in their own organizations and communities. They will also create partnerships to find new ideas that work and share them regionally and across the United States.

Funding for this initiative was made possible by the Affordable Care Act. Each innovation advisor’s home organization will receive a stipend of up to $20,000 to support an individual’s activities while serving in this capacity.

Blakeney’s project will incorporate a new “attending nurse” role into the care teams of 11 different units at Massachusetts General Hospital (MGH), where she is the innovation specialist at the MGH Center for Innovations in Care Delivery. The attending nurse will be responsible for ensuring care continuity and progression along the plan of care, from admission to discharge and post-discharge, according to ANA.

It is anticipated that the CMS will replicate its application process for more innovation advisors this spring. For more information, go to http://innovations.ama-assn.org.
Email Regarding Blakeney’s Innovation Advisor Appointment

From: CMS Innovation Advisors Program [IAP@orau.org]
Sent: Friday, December 16, 2011 9:57 AM
To: Blakeney, Barbara
Cc: Teresa.Titus-Howard@CMS.hhs.gov; Gibson, Robert; Mask, Marcia
Subject: Blakeney: Innovation Advisor Program Appointment

Attachments: Blakeney, Barbara.pdf; Advisors Agenda IgniteSession.pdf; IAP Terms of Appointment.pdf; Photo Release.pdf; Salary Certification.pdf; W9.pdf

Dear Dr. Blakeney:

Congratulations! You have been selected to participate as a member of the first cohort of the new Innovation Advisors Program (IAP).

Attached here are the formal appointment letter and the Terms and Conditions of the appointment.

Please sign and return these documents no later than noon on December 22, 2011.

If you wish to decline this offer, please let us know that immediately so that others may be offered the opportunity to participate.

The first meeting for Innovation Advisors is scheduled for January 22-25, 2012. A tentative agenda is attached.

Please reserve your room at the conference hotel by December 27, 2011:

Embassy Suites BWI Hotel
1300 Concourse Drive
Linthicum, MD 21090
Reservations: 1-800-362-2779
Reference: CMMI Block

Once again, congratulations on your selection as an Innovation Advisor. If you have any questions, please contact us at IAP@orau.org.

Sincerely,

Janeen Pointer
Senior Program Specialist
CMS Innovation Advisors Program
ORISE Science Education Program
(865) 574-3172
**The AIM**

To Demonstrate the Attending Nurse’s Role in Process and Practice Improvement at the Clinical Micro System Level

**The Project**

To identify and decrease delays in care (lower costs through improvement) and to enhance the experience of inpatient chemotherapy patients’ (better health care for individuals).

**The Role**

The Attending Nurse is the staff nurse developing and coordinating the team’s strategic clinical plan for the inpatient admission.

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**Waste Identification Assessment**

By December 31, 2012 identify three delays in care and reduce two delays by 10%

Utilizing the IHI In-Patient Waste Identification Tool, ARNs tracked delays in care for the first day for planned chemotherapy patients for two weeks. Delays in care were noted in several areas:

- Patients arrived not well enough hydrated and requiring IVs
- Necessary blood work not done prior to admission—requiring bloods to be drawn and results back prior to next steps
- Access issues—Patients needing PICC lines on admission (average time waiting for PICC was about 4 hours)
- Patients admitted after 2:30 PM often lead to delays in chemo medications getting to the unit. Pharmacy doesn’t mix between 9-11 PM due to staffing issues

**Measure 3** Identify three delays in care and decrease two by 10%

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**Measure One**

To reduce the length of time from admission to chemotherapy beginning (Admit to chemo-in) from the pre-intervention time of 8.4 hours by 20% to 6.72

- Utilizing the IHI In-Patient Waste Identification Tool, Attending Nurses (ARN) tracked for two weeks delays in care for planned chemotherapy patients from the time of admission to the time chemotherapy began (Admit to chemo-in). A hand drawn run chart tracked the time between each step in the process of care required to admit the patient and prepare to administer chemo. Average time for this sample was 7 hours 19 minutes. The median was 6 hours 42 minutes.
- For a few patients the time was under 4 hours. A review of these patients revealed interesting information: namely blood results were already in the charts, chemo orders were written and signed, there were no access issues (Port in place) and the patient arrived by 2:30 PM.
- With the assistance of the Senior Project Manager of PCS Quality and Safety an ongoing run chart was created and tracked several months of pre-intervention data. That data showed an average delay of 6.4 hours at the time of the first intervention. Data was then tracked by oncology clinic type (Sarcoma, Lymphoma and GU primarily).
Measure One Test of Change
Meetings were held with staff from various oncology clinics to present the findings and to enlist assistance to:
- Ensure all patients had blood drawn prior to admission
- Ensure all patients had chemo orders written prior to admission

The Lymphoma clinic staff has partnered with us and has altered their processes to ensure these activities occur in the clinic prior to admission.

- One NP is central to this effort. If she is away, consistency falls as was demonstrated shortly after the measure was implemented.

- Data continues to be tracked for the entire unit as well as by clinic to monitor progress. (See run charts) (Currently under way)

- Split the chemotherapy orders so that IV fluids are started at the time of admission and while waiting for chemo to be mixed and delivered to the unit. Will begin September 10, 2012. Test designed and will be implemented entirely by the ARNs.

**Measure Four ARNs show increasing competence in implementing the process.**

Measure Two
To decrease delays in discharge secondary to constipation (needs to be tracked on the unit no pre intervention data is currently available.)

The "symptom cluster" of nausea, pain and constipation occurs frequently for cancer patients undergoing chemotherapy. Interventions to treat nausea and pain (medications) usually have the side effect of constipation which, in turn can delay discharge.

Test of Change
Nutritionists will assess all chemotherapy patients at admission for a history of constipation and will recommend appropriate nutritional interventions for the duration of the chemotherapy protocol. (August 27, 2012)

The ARNs will call patients prior to admission for a pre-admission assessment one aspect of which will be a bowel pattern assessment. (Development by ARNs Measure 4 ARNs demonstrate growing competence by leading the team in the latter part of the project work)

**Benefits**
- Opportunities to meet and network with senior CMS leaders, to hear and have the opportunity to influence thinking at the national level.
- My own continuing skill development in an area that has been very much strengthened.
- Working with our small group team and mentors has been wonderfully enriching.
- Each session lead to deeper understanding as well as the opportunity to talk through issues and challenges to our individual projects.
- Having the recognition of a CMS Innovation Advisor has helped me gain greater access and influence internally and has opened doors within the larger community.
- This is an excellent vehicle by which to coach and teach improvement science at the clinical level with front line clinicians. By using a case study method but with the "case" determined by the attending nurses not only did we have a front line problem to solve but also one with immediate relevance to day-to-day practice at the unit level.
- Staff engagement at the unit level has been excellent with ARNs and unit leadership taking on more of the functions of project.
Benefits

- I have been reminded through this project that persistence, patience and celebrating small successes are essential to the sustained effort necessary to achieve degrees of success.
- That for every few steps forward there will be a step or two backwards or sideways.
- That help and solutions can come from unexpected places keep your eyes open.
- That resistance can come from unexpected places keep your knees bent.
- That the message must be carefully framed.

Working with others

- Presented the project at Grand Rounds.
- As a result meeting with the Senior MD for quality improvement with the Mass General Physicians Organization (MGPO).
- Meet with the Executive Director of the Boston Public Health Commission to describe program and gain interest.
- Interest in decreasing length of time for hand off from EMTs to ED staff—currently averaging 22 minutes across the city.
- Partnership developing with broader Quality and Safety Staff.
- Working with various Department leaders to discuss engaging more clinical disciplines in this type of clinical problem solving.
- Nutrition
- Physical and Occupational Therapy
- Respiratory Therapy
- Social Work
- The program is scheduled to be presented at a regional nursing research conference as the Keynote November 1, 2012.

Tests of Change

- Clinics ensuring all patients have blood tests done and chemo orders written prior to admission. (Began August 6, 2012)
- Split the chemotherapy orders so that IV fluids are started at the time of admission and while waiting for chemo to be mixed and delivered to the unit. (Start September 10, 2012)
- Shorten time waiting for PICC line access by notifying PICC line team of scheduled admissions at the time the unit is notified by the clinics. Decrease wait time from 3.92 hours by 20% to 3.14% (In development).
- PICC lines inserted at time of clinic visit the morning of admission (In development).
The Center for Innovation in Care Delivery
The Institute for Patient Care

Accent Reduction Program

Through a generous donation from the Hausman Family Trust, The Center for Innovation in Care Delivery, in partnership with Carol Dinnes of the Speech and Language Pathology Department, is conducting a pilot program to enhance communication skills of English as a second language (ESL) nurses by providing strategies/best choices for increased speech intelligibility.

Strong accents can be a powerful barrier to successful integration into the practice environment. Highly competent clinicians as well as team members and patients become frustrated by misunderstood communication leading to potentially dangerous circumstances as well as decreased patient and staff satisfaction. A study that explored differences in rapid response team (RRT) and code blue occurrence rates within the context of nurse-patient linguistic compatibility suggest that “when nurse-patient linguistic compatibility exists, negative changes in patient condition may be identified earlier resulting in activation of the RRT to stabilize or prevent further deterioration in the patient condition.” (Failano, Adams, Neureister, Chang 2011) At its simplest level linguistic incompatibility may present as patients requesting a different nurse because “I can’t understand her/him.” This can be embarrassing and uncomfortable for both the nurse and the patient. Lack of intelligibility can be perceived not only as a language issue but a competence issue as well.

One of the national patient safety goals of the Joint Commission is to improve the effectiveness of communication between care givers. (National Patient Safety Goal #2) The rational for this goal is stated as follows:

“Ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous and understood by the recipient, reduces error and results in improved patient/client/resident safety.” (University HealthSystem Consortium Best Practice Recommendation White Paper 2006)

Multiple factors impact effective communication and as is noted in the rationale above ineffective communication is the most frequently identified root cause of the most serious errors leading to severe harm/death of a patient.

We propose to address one aspect of effective communication, that of intelligibility, by assisting nurses and eventually others in decreasing their accents and increasing their ability to be clearly understood by colleagues and patients.

The goal of the program is to teach strategies/best choices for increased speech intelligibility for the listener.

The students are (initially) nurses for whom English is a second language who wish to strengthen their English speaking skills. Speech therapy standards suggest that students have
at least a 6th grade English reading level and meet certain English proficiency standards. These will be assessed at the potential student’s assessment visit with the Speech Pathologist.

We are seeking up to 6 nurses who meet these criteria to participate in a 12 week program including an initial assessment, weekly group sessions and “homework” assignments.

If you believe you have a motivated staff member who might benefit from the program please consider referring them to this program. Recommendations may be made to Carol Dinnes at cdinnes@partners.

Please contact Carol no later than September 10, 2010. Sessions will begin in late September and run for 12 weeks.
The Hausman Program for Accent Reduction

- A generous donation from the Hausman Family Trust
- Collaboration between The Center for Innovation in Care Delivery and the Speech-Language Department
- End Goal:
  - to enhance communication skills of ESL (English as a Second Language) nurses and, eventually, others, by decreasing their accents and increasing their ability to be clearly understood by colleagues and pts. We provide strategies/best choices to increase speech intelligibility.

Who is a Candidate?

Language Barrier vs Accent Barrier

Why Accent Reduction?

- Safety
- Career goals and advancement
- Personal preference

Health Care Setting

- Pt Safety
  - Your patient is not “breeding.”
  - ...breathing ???
  - ...bleeding ???
- Pt and Family Satisfaction
  - Do you need a ef ceh poksi?
  - Do you Speak Spanish?/Are you Carol Dinnes?
- Staff Satisfaction

Training

- 15 sessions
- 1-2 1-hour sessions per week
- daily home practice

Before and After Handoff Pts Passage

Mrs. Jones is a 46 year old Caucasian woman who presented to the emergency room after experiencing nausea, vomiting and abdominal pain for two days. The patient was in her usual state of health until approximately two days ago. At that time, she noted the sudden onset of nausea, vomiting and abdominal pain after dinner. The abdominal pain steadily increased in severity to approximately ten out of ten intensity by the day of admission.
Approaching the Topic

• Accent is not due to issues of...

  – Intelligence
  – World knowledge
  – Culture; first language
  – Professional skills
  – Work ethic

The Goal of Accent Reduction: Communicative Responsibility

• Shift the burden of communication from listener to speaker
• Considerations:
  – Pt acuity
  – Provider – clinical setting
  – Emergency
  – Time Pressures

Testimonials

• I'm not asked to repeat what I've said as often
  – I am better understood when I talk in person
  – I am better understood when I talk on the phone
  – Patients have not requested a different nurse because of communication issues as often
  – I have greater confidence speaking in public

• I am more conscious of my errors and work on them. The whole program is well prepare, Carol is great, the only problem was, I did not have the disciple to study 15 min everyday, otherwise if you follow every step the students will get the best results, my favor part was an individual session with Carol, my jaw was hurting for 2 days, but my Rs totally improve.

• It has been almost one year since I finished the accent reduction program. I really appreciate your complete assessment on identifying my problem areas. We practiced those areas in the classes. You also gave me the direction to continue practicing after finishing the program. In fact I still review the book and handouts from the program sometimes. My confidence on communication at work has since increased.

• I have greater confidence to talk in public but still some patient asks where are you from? You have an accent !Working in small group was helpful to figure out how they pronounced differently . Sometimes you can learn from them my difficult pronunciation. My speech therapist was great. I thought I was doing good but she was able to identify my difficulties.

To Enroll for March 12th session

Please email or call directly by February 23rd to arrange an initial screening:

Carol Dinnes MA, CCC-SLP Speech Language Pathologist
cdinnes@partners.org
781-485-6124
or
Suzanne Danforth M.S., CCC-SLP Speech-Language Pathologist
sdanforth@partners.org
617-724-0760
Creating an environment for innovation

The Center for Innovation in Care Delivery
The Institute for Patient Care

What is the Center for Innovation?

- The Center for Innovation in Care Delivery’s focus is to bring teams together to identify opportunities, to estimate the impact of change (including workforce demographics, new technologies and regulatory change) and to construct innovation.

Did you know?

“You can’t think outside the box if you’re in it.”

Ed Coakley

Components of the Innovation Process

Creativity  Environment  Innovation

What is innovation?

- Innovation is something different that has impact.
  
  Clayton Christensen

- Innovation is the process of bringing new ideas into productive use.
  
  Rosabeth Moss Kanter

- Change that creates a new dimension of performance.
  
  Peter Drucker
left ventricular assist device (LVAD) is a mechanical device that's implanted in patients to partially or completely replace the function of a failing heart. Some LVADs are intended for short-term use, others for long-term or permanent placement. Patients with LVADs are routinely transferred from the Cardiac Surgical Intensive Care Unit (CSICU) to the Cardiac Step-Down Unit (Ellison 8) where nurses have specialized knowledge to help develop individualized plans of nursing care.

Staff nurses on Ellison 8 are integral members of the inter-professional team and play an important role in preparing LVAD patients for discharge. Patient-education is designed to support patients as well as home-based caregivers. Primary nurses provide consistent collaboration and communication among team members, recognizing the psycho-social and cognitive conditions necessary for patients to manage LVAD therapy.

Clinical nurse specialist, Kate Whalen, RN, wanted to create a skills-development program for clinical staff that was both sustainable and within safe practice parameters. A review of the literature showed very little from which to draw, so Whalen started from scratch.

Whalen and others had attended the five-part program, Creating an Environment of Innovation, sponsored by the Center for Innovations in Care Delivery in 2010–11. The program, which explored the characteristics of an innovative environment—creativity, environment, and innovation—provided Whalen and her team with the inspiration and encouragement to develop a unique new curriculum.

They realized that in order to maintain an ongoing educational program, they needed to develop a core group of nurses with a specific combination of knowledge and skills. The group became content experts, participating in two intensive, industry-level, instructional programs. The same group became versed in the art and science of simulation through the support of The Knight Simulation Program. The greatest challenge was finding relevant evidence, as traditional LVAD education didn’t include simulation. Mindful of innovation concepts and evidence-based practice, and with the support of Knight simulation staff, patient scenarios were created from actual nurse-patient experiences. Props were developed to mirror the technical skills needed to manage LVAD patients. Audible alarms were incorporated into problem-focused scenarios to enhance the realism of the simulation.

The MGH LVAD Education Program is the first of its kind in the country and an excellent example of the synergy that comes from bringing diverse perspectives together to design cutting-edge interventions to advance clinical practice. Innovation, simulation, and evidence-based practice contributed to improved patient care on Ellison 8. An example of all-hands-on-deck teamwork at its best.

For more information about the LVAD Education Program or the Center for Innovations in Care Delivery, call Barbara Blakeney, RN, at 4-7468.
**Ellison 8 Bedside Safety Hand Off Report**

<table>
<thead>
<tr>
<th>S</th>
<th>Off going Nurse &amp; Oncoming Nurse Patient Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Introduce self □ Update bedside white board □ Ask patient’s name while checking armband □</td>
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<table>
<thead>
<tr>
<th>B</th>
<th>Environment of Care</th>
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<tbody>
<tr>
<td></td>
<td>Bed: Low and locked position, side rails up x 2 □ Bed alarm /chair alarm on if needed □</td>
</tr>
<tr>
<td></td>
<td>Suction: Set up at head of bed □ Oral airway □</td>
</tr>
<tr>
<td></td>
<td>Bedside Monitor: All alarm parameters acknowledged □ Rhythm verified and changes reviewed □</td>
</tr>
<tr>
<td></td>
<td>Fall Risk: yes □ no □</td>
</tr>
<tr>
<td></td>
<td>Isolation: contact □ contact plus □ droplet □ airborne □</td>
</tr>
<tr>
<td></td>
<td>Pacemaker: Verification of Mode, Rate, MA, Battery date, change □ Epicardial wires reviewed □</td>
</tr>
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<thead>
<tr>
<th>A</th>
<th>Patient History</th>
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<tbody>
<tr>
<td></td>
<td>Nursing notes and updates provider / MD orders reviewed: (new and pending) □</td>
</tr>
<tr>
<td></td>
<td>Changes reviewed from prior assessment / shift □</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>A</th>
<th>Patient Assessment</th>
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<tbody>
<tr>
<td></td>
<td>IV access: Peripheral &amp; central sites: Change date verified, dressing intact and dated □</td>
</tr>
<tr>
<td></td>
<td>Central: PICC □ IJ □ Subclavian □ Hemodialysis Port -a-cath □ AV Fistula +thrill / bruit □</td>
</tr>
<tr>
<td></td>
<td>Other: Peritoneal dialysis site □</td>
</tr>
<tr>
<td></td>
<td>Infusions/Pumps: IV fluid labeled properly □ Orders match pump settings □</td>
</tr>
<tr>
<td></td>
<td>Wounds: Sternal wound □ Chest tube dressings □ Groin site □ Pressure ulcer □ plan of care □ Changes noted □</td>
</tr>
<tr>
<td></td>
<td>Measurement sticker □ Braden Scale □</td>
</tr>
<tr>
<td></td>
<td>Fluid/electrolyte imbalance: Weight □ I &amp;Os □ Labs results reviewed □</td>
</tr>
<tr>
<td></td>
<td>Neuro: GCS : __ A&amp;O x 3 □ PERLA □ communication / language □</td>
</tr>
<tr>
<td></td>
<td>Cardiac: Rhythm□, BP, □ distal pulses, □ heart sounds □ LVAD (see checklist)</td>
</tr>
<tr>
<td></td>
<td>Respiratory: O2 □ SpO2 □ Lung sounds □ mechanical ventilation settings □ adjuctive devices</td>
</tr>
<tr>
<td></td>
<td>Chest tubes: Pleural / mediastinal □ water seal □ wall suction F.O.C.A. □ (fluctuation, output, color, airleak)</td>
</tr>
<tr>
<td></td>
<td>bulb suction □</td>
</tr>
<tr>
<td></td>
<td>Trach care: Backup trach tube at bedside □ trach care reviewed □</td>
</tr>
<tr>
<td></td>
<td>GI/Abdomen: Bowel sounds □ Last BM □ NPO status □</td>
</tr>
<tr>
<td></td>
<td>Nutrition /Tube Feeding: Tubing labeled properly □ Orders match pump settings □ Diet</td>
</tr>
<tr>
<td></td>
<td>Glycemic management: Reviewed □ blood sugar and SS □</td>
</tr>
<tr>
<td></td>
<td>GU: Foley □ insertion date Voiding □ due to void bladder scan □</td>
</tr>
<tr>
<td></td>
<td>Mobility: Independent □ 1 assist □ 2 assist □ ceiling hoist / lift □</td>
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<tr>
<th>R</th>
<th>Patient Plans</th>
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<tbody>
<tr>
<td></td>
<td>Discharge: Discharge trajectory reviewed □ Patient and family discharge teaching reviewed □</td>
</tr>
<tr>
<td></td>
<td>Patient Specific Needs: Appropriate interdisciplinary team members involved □ Cultural needs addressed □</td>
</tr>
<tr>
<td></td>
<td>Plan of care for day: Reviewed with on coming nurse and patient □</td>
</tr>
</tbody>
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<tr>
<th>T</th>
<th>Closing</th>
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<tbody>
<tr>
<td></td>
<td>Patient concerns addressed at bedside □ Additional related information □</td>
</tr>
</tbody>
</table>

**Thank you!**

<table>
<thead>
<tr>
<th>Date: _________________</th>
<th>Shift change time: _________________</th>
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<tbody>
<tr>
<td>R.N.</td>
<td>R.N.</td>
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<td>R.N.</td>
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**AN EVIDENCE-BASED PRACTICE APPROACH TO NURSING HANDOFF: SBART**

Kate Whalen, MSN, RN, FAHA; Eleanor Blakeney, BSN, CCRN; Mwandishy Smith, BSN, RN; Amanda Gerade, BSN, RN; Christina Gancarz, BSN, RN; Anna Ford, BSN, RN; Angelica Tringale, BSN, RN; Kelly Santomas, MS, RN; Susan Lee, PhD, RN

Ellison 8 Cardiac Surgery Step Down, Intermediate Care
Massachusetts General Hospital, Boston, MA

*S=Situation  B=Background  A=Assessment  R=Recommendation  T=Thank You

## PURPOSE/BACKGROUND

- Nurse-to-nurse handoffs are critical points in care when essential information loss can lead to omissions of care, errors, near misses, unreported use of or inaccurate settings pertaining to adjunctive equipment, resulting in threats to patient safety and well-being.
- The goal of the handoff is to transfer the needed information, within a context of identifying the priorities of care for the incoming nurse.
- A 2012 National Patient Safety Goal is to improve the effectiveness of communication among caregivers.

## METHODS

<table>
<thead>
<tr>
<th>Step 1: Ask a clinical question</th>
<th>Step 2: Find the best evidence</th>
<th>Step 3: Weigh the evidence</th>
<th>Step 4: Implement the findings</th>
</tr>
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<tbody>
<tr>
<td>Does a customized bedside handoff improve communication and safety for cardiac surgery patients, improve patient satisfaction, and improve nurse satisfaction more than usual report practices?</td>
<td>We searched Summaries of Evidence, Guidelines and Standards, Online Databases (CINAHL, Medline, PubMed), Journals, AHRQ, Cochrane Reviews, and the Joanna Briggs Institute.</td>
<td>We used the LEGEND system (Clark, Burnett, Starko-Lynn, 2009) to level the evidence and grade the recommendation.</td>
<td>We used the SBART (Cunningham, 2010; van Eaton, 2010) to level the evidence and grade the recommendation.</td>
</tr>
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## RESULTS

<table>
<thead>
<tr>
<th>Customized S.B.A.R.T.</th>
<th>Bedside Board</th>
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<tbody>
<tr>
<td><img src="image1.png" alt="" /></td>
<td><img src="image2.png" alt="" /></td>
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</table>

## EVALUATION/DISCUSSION

- Nurse satisfaction: Nurses were satisfied with the use of the SBART.
- Patients satisfaction: Feedback from patients suggests that they prefer this method of handoff because they are included in the communication and have enhanced understanding of their care. Patients and families also expressed that the communication boards were very helpful.
- Safety Reports: An analysis of safety reports demonstrated fewer communication errors.
- Challenges: Nurse-to-nurse handovers take more time than usual practice; efforts to assure sustainability are underway.
- Support: Staff Nurses, Nursing Director, Physicians, Patients and Families, Quality & Safety.
Implementation of 2 Nurse Practitioner Inpatient Models

Maria Winne, RN, MS, NE-BC
Barbara Cashavelly, MSN, RN, AOCN
Christine Annese, MSN, RN
Beth Nagle, RN, MSN
Takashi Shiga, MD
Roger Gino Chisari, RN, DNP
Susan Lee, PhD, RN

Opportunities for nurse practitioners in acute care settings are expanding owing to the restricted hours for medical residents. This is coupled with national initiatives to improve the quality of care driven by patients, insurers, and national healthcare organizations that wish to enhance access to healthcare for all Americans. The authors discuss 2 care delivery models that were designed and implemented at Massachusetts General Hospital with nurses acting as full partners in the redesign.

New models of care delivery are providing expanding opportunities for acute care nurse practitioners (ACNPs) in academic medical centers. This is largely due to the need to shift some of the work of medical residents who are restricted to an average of 80 hours a week by the Accreditation Council for Graduate Medical Education (ACGME). The surge in utilization of ACNPs also parallels the 1990s physician hospitalist movement. The first ACNP certification examination was administered in 1995. By 2008, more than 5,000 ACNPs were certified in the United States. An increasing number of nurse practitioners (NPs) are working in acute care settings because, in large part, of the increased acuity levels of hospitalized patients and the need for advanced practitioners to help manage the care of patients with complex acute health conditions. The focus on cost containment and the challenges to shorten length of stay (LOS) are also influencing the rapid growth of the ACNP role. The urgent national agenda to provide high-quality, continuous, accessible, cost-effective care has contributed to ACNP utilization.

The ACNP is educated and trained to provide advanced nursing care to acutely ill patients. ACNPs practice in a variety of settings, including outpatient, acute inpatient, and critical care units. Components of the ACNP role include patient care management for acute, critical, and complex chronic illness, as well as the provision of diagnostic reasoning to formulate a plan of care in conjunction with evidence-based and research-based clinical practice.

This article describes the development and implementation of 2 ACNP models at Massachusetts General Hospital (MGH) in which nurses took leading roles in the design and creation of these collaborative care models. The development and implementation of these ACNP models are aligned with 2 key recommendations put forth by the Institute of Medicine’s *The Future of Nursing: Leading Change, Advancing Health*. The first recommendation is that advanced practice registered nurses (APRNs) should be able to practice to the full extent of their education and training. A second recommendation is to expand opportunities for nurses to lead and manage collaborative efforts with physicians and others to redesign and improve practice.
NP Models in the Literature

Since 2002, a variety of ACNP models have been described in the literature. One example of a successful ACNP model at the University of California San Francisco Medical Center expanded the capacity of the medical service and improved efficiency and quality of patient care. The efficiency of care was improved by the ACNPs because their primary goal was to admit and manage an acute medical population of patients that, in the past, was cared for by the house staff. This change allowed the academic medical service to abide by the limitations set forth by credentialing agencies on the maximum number of patients admitted by medical residents. The quality of patient care was positively impacted by the continuity of the ACNPs. The ACNPs were available throughout the day to interact with patients, families, and the nursing staff, without the distraction of academic learning requirements. Another successful model described by Brown et al was the development of a pediatric critical care NP program. Implemented at Akron Children’s Hospital, the model improved patient flow and continuity of care to the patients and families in the pediatric intensive care unit (ICU). D’Agostino and Halpern described the development and function of critical care ACNPs in an adult ICU at Memorial Sloan-Kettering Cancer Center. Yeager et al reported on the development and implementation of the neuroscience ACNP role at 2 institutions, the University of Virginia Health System and Riverside Methodist hospitals in Columbus, Ohio. These authors underscored less tangible outcomes and benefits seen with the implementation of ACNPs. These benefits included easy accessibility of the ACNP to the staff nurse because the NPs are a constant presence on the unit. Their presence led to improved patient care by expediting the input of clinical orders and fostered prompt open dialogue between the staff nurse and NP related to patient care concerns.

The literature supports the unique value-added contributions that ACNPs have in intensive care inpatient settings. Kleinpell et al reviewed more than 145 articles related to the role of the NP and physician assistant (PA) in ICU settings. The authors found that integrating NPs and PAs in an ICU setting positively impacted patient care. The NPs and PAs were found to more frequently discuss patient care issues with the ICU nurses and interacted more with patients’ families than did their physician colleagues. It was evident that having ACNPs in the inpatient setting led to the enhancement of patient workflow and enriched the education of patients, families, and nursing staff. Kleinpell conducted a 5-year longitudinal study of the role of the ACNP. Through survey research, the author noted expanding practice settings, activities, and procedures performed by ACNPs (eg, performing cardioversions, initiating and adjusting mechanical ventilation, and performing wound care, and debridement) and increased satisfaction of ACNPs with their role.

Academic Hospitalist Service

Development, Design, and Structure

In the spring of 2010, the department of medicine, in collaboration with the medical nursing service, at MGH developed a new model of care called the AHS, with the goal of expediting admissions of acutely ill general medical patients from the emergency department. The AHS consists of a dedicated group of hospitalist physicians, medical students, and ACNPs who collaboratively provide continuity of care to general medical patients. The AHS supports the academic mission of the hospital by providing learning opportunities for fourth year medical students. This model was intended to improve patient satisfaction, positively impact the patients’ LOS, and attain the overall goal of providing safe, quality care.

The AHS (Figure 1) is responsible for 13 regionlized beds located on 2 inpatient units; 8 beds are located on a mixed medical/progressive care unit, and the remaining 5 beds are located on a general medical unit.

The nurse director (manager of direct care on 1 or 2 patient care units) of the medical/progressive care unit assumed a leadership role in paving the way for the introduction of this innovative service. The nurse director worked in collaboration with physicians and administrators to plan and implement a unique service beginning in July 2010. The AHS consists of 1 hospitalist physician, 1 ACNP, and 2 subinterns (fourth year medical students) who cover the service from 7 AM to 7 PM. The physician and ACNP each care for a patient caseload of 5 to 7 patients, on average. From 7 PM to 7 AM, all 13 patients are cared for by a hospitalist. The ACNPs report operationally to the nursing director.
Recruitment and Selection

During the first phase of this process, the team began by describing the desired experience and qualities required by the role of ACNP. The ACNPs would be caring for acutely ill general medical patients who would be admitted directly from the emergency department. They would be responsible for managing patients in collaboration with a multidisciplinary care team to facilitate a comprehensive plan of care and to coordinate resources. It was decided that the best candidates would have experience caring for acutely ill patients on a general medical unit or in an ICU. In addition, it was very important that the candidates have a pioneering mindset, which included the ability to be flexible, adapt well to change, embrace challenges, and be proactive in the ongoing development of this newly formed service. Interviews were conducted by human resources, nurse directors, clinical nurse specialists, and the medical director of the program. By May 2010, 2.5 full-time equivalent employees (FTEs) were hired. Two of the newly hired ACNPs were novice to the advanced practice role, although they were previously expert staff nurses with ICU experience at our institution. The third ACNP had several years of NP experience at another institution in a similar model and worked for several years as a staff nurse on medical/surgical units at our institution.

Orientation

Integration to the APRN role is dependent upon a successful orientation that maximizes the available educational and clinical resources at our institution. This orientation consisted of 3 phases, including an introduction to the advanced practice role, patient- and family-centered care, and the medical management of acutely ill medical patients. Socialization, networking, and mentorship were essential elements toward the integration of the ACNPs into their new role. The nurse director realized how important it would be for the ACNPs to have a network of colleagues and develop relationships with individuals on whom they could rely for guidance as they journeyed through this process. The 2 novice ACNPs participated in a 4-week orientation and the seasoned ACNP completed her individualized orientation in 3 weeks owing to her past experience as an ACNP on a similar service at a different institution. The educational orientation phase for
all of the NPs included shadow days with experienced ACNPs and physicians medical, oncology, and cardiac services to get acquainted with key individuals. They also learned the admission and discharge processes, order entry, consults, and daily documentation. The AHS ACNPs are not responsible for billing; therefore, this was not a part of their orientation. This type of orientation provided the ACNPs with a wide variety of experiences that facilitated their understanding of the organizational culture, informatics, the consultation process, clinical observations, and role development.

The orientation also included a meet and greet day where the ACNPs met with the nursing director, the clinical nurse specialists, social workers, case managers, nutritionists, and unit secretaries to get to know their team. Each ACNP then worked with the AHS hospitalists for 4 to 7 days before having full responsibility for patient care, an experience that was described as an invaluable part of the orientation process. During this time, ACNPs did not take full responsibility for the care of their patients, rather they co-coordinated plans of care with AHS hospitalists.

**Multidisciplinary Collaboration**

Daily collaboration with many healthcare providers is necessary to provide seamless care for patients. The AHS physician and the ACNP participate in patient rounds along with staff nurses, case managers, nutritionists, and unit secretaries to get to know their team. The ACNP then worked with the AHS hospitalists for 4 to 7 days before assuming full responsibility for patient care, an experience that was described as an invaluable part of the orientation process. During this time, ACNPs did not take full responsibility for the care of their patients, rather they co-coordinated plans of care with AHS hospitalists.

**Oncology Inpatient Nurse Practitioner Service**

**Development, Design, and Structure**

In 2009, the cancer center nurse and physician leaders were charged with developing an inpatient service in response to the changes in the ACGME requirements that would begin at the beginning of the academic year 2011. In 2003, ACGME introduced the 80-hour work week limit for residency programs. Then in 2011, the ACGME implemented more changes to the work-hour guidelines that have governed residency programs. Under these new guidelines, postgraduate year 1 interns are not permitted to work for more than 16 consecutive hours. Postgraduate year 2 residents can work up to 24 consecutive hours. Because of the ACGME requirements, interns and residents work fewer hours at the bedside.

In response to the decreased resident work hours, the newly designed service was necessary to provide medical coverage for 14 medical oncology patients. A multidisciplinary task force convened to evaluate 3 models of practice—a hospitalist model, a moonlighter model, and an NP model (NPM). Hospitalists are physicians whose primary practice is hospital medicine. They are dedicated to the delivery of comprehensive medical care to hospitalized patients. A moonlighter is a physician who has another primary job and works extra shifts as a secondary job. The NPM is a dedicated inpatient NP providing inpatient care. The advantages and disadvantages of each model were discussed in detail. The task force unanimously considered the NPM as the best fit from all perspectives, including quality and safety, patient satisfaction, cost, ability to decrease LOS, and enhancement of the multidisciplinary practice in the cancer center. Maintaining continuity and involvement with their patient’s plan of care was important to the oncology attendings. The task force believed that the NPM would support a collaborative working relationship with the attendings. They would be able to work closely with the inpatient NP with decisions related to their patient’s plan of care. The oncologists have dedicated oncology NPs (ONPs) in their outpatient disease center practice. The ONPs work in collaboration with oncology physicians. Patients are seen by the ONP for a follow-up visit or an urgent care visit. They manage symptoms of disease or treatment. They are a liaison for the patient and family for the rest of the healthcare team to make sure patients receive the best care possible. The role of the ONP has been fully integrated in the outpatient multidisciplinary disease practices in the cancer center. The development of this new inpatient NPM was viewed as an expansion of the successful outpatient oncology NPM to the inpatient setting.

Once the NPM was agreed upon, the task force worked together to design, develop, and implement the OINPS. The group determined the budget, staffing needs, anticipated coverage, and schedules and identified the patient population to be admitted to this service. In June 2010, this newly formed OINPS was implemented.

The OINPS provides consistent care to 14 medical oncology patients. The patients are located on 2 inpatient units—a medical oncology unit and a medical/surgical unit. Patients are admitted from the outpatient multidisciplinary disease practices, oncology infusion unit, emergency department, or...
home. The admitting attending oncologist determines if the patient is appropriate for the OINPS. The oncology inpatient NP (OINP) works with the oncologist initially to admit the patient and then daily to determine the plan and goals of care for the patient. The OINP focuses on the care of patients admitted for acute symptoms or medical management related to disease progression, treatment-related adverse effects, or end-of-life care. Patients diagnosed with a solid tumor can be admitted to the OINPS. All patients admitted to the OINPS are required to have a stable cardiopulmonary status. Patients who become unstable are transferred to the general medical service after discussion with the attending oncologist and medical senior resident.

The OINPs report operationally to the nurse director of the medical oncology unit (Figure 2). The clinical director of the service serves as their supervising physician. The OINPS has both full-time and part-time NPs. The OINPs work 12-hour shifts only. There are 2 OINPs on the 7 AM to 7 PM shift, 1 OINP on the 3 PM to 3 AM shift, and 1 OINP on the 7 PM to 7 AM shift. A 3 PM to 3 AM shift was implemented a few months into the program to accommodate the increased workload of admissions that occur later in the afternoon.

**Recruitment and Selection**

In the spring of 2010, recruitment commenced with the goal of establishing an OINPS by June 2010. Prior experience as an RN or an NP in an acute care inpatient setting was considered a prerequisite for employment. Similar for all ACNPs roles, a master’s degree in nursing, NP certification, and preparation in either the adult or acute care educational track were essential. Candidates were also required to have oncology experience.

Similar to the AHS, we also decided that it was important that candidates were interested in being part of a new endeavor, willing to take a chance on an uncharted role and program. Candidates who were motivated, self-directed, flexible, and ambitious and possessed leadership abilities were chosen. We realized that this program was new and we would learn as the program grew and developed. We acknowledged that there would be some challenges and possible changes with the development of the program. The NP team needed to be resilient to be able to grow and have the ability to adapt to change and develop their role with the program. Interviews were conducted by human resources, the nurse director, and the clinical director of the program. By May 2010, 9.5 FTEs, both full-time and part-time NPs, were hired. Each individual had acute care experience and some oncology experience.

**Orientation**

The new OINPs underwent an in-depth, 8-week educational orientation program. The educational orientation program included “shadowing” various colleagues—inpatient medical resident teams, ONPs in the outpatient oncology clinics, and those in the

Figure 2. OINPS model. OINPS indicates Oncology Inpatient Nurse Practitioner Service.
step-down cardiac unit. A curriculum was developed that included topics such as infectious diseases, renal and oncologic emergencies, chemotherapy, and pulmonary and cardiac diagnoses. The educational sessions were taped, and the PowerPoint presentations, along with the recordings, were posted on an online site. They also learned the admission and discharge processes, order entry, consults, daily documentation, and billing procedures.

**Multidisciplinary Collaboration**

Collaboration with all disciplines is essential for providing exceptional care for oncology patients. The OINPs are collaborative with other members of the team but function autonomously. They speak with the attending oncologist each morning to discuss the status of the patient and plan of care. The OINPs round on each unit with all of the disciplines: staff nurses, charge nurses, case managers, physical therapists, social workers, dieticians, and the nurse director. Rounds include discussion of the patients’ clinical issues and needs, goals of care, discharge needs, and any other pertinent issues that need to be addressed in the team rounds.

**Future Directions and Next Steps**

The OINPs is so successful in the first year that an additional 14 beds will be added to the OINPS, totaling 28 beds and requiring the addition of 3 NPs. Additionally, a physician hospitalist will be added to cover the night shift. The patient population admitted to the OINPS will expand to include patients with bone marrow transplant/leukemia and solid tumors.

**Commonalities of the AHS and the OINPS**

**Orientation and Continuing Education**

After assisting the NPs to obtain credentialing and acute cardiac life support certification, a comprehensive, tailored orientation program was provided to all NPs in both the AHS and the OINPS. An ACNP education program previously developed by staff in the Norman Knight Nursing Center for Clinical and Professional Development was customized for the NPs in the new services. The new NPs were directed to use a Web-based platform that included videos and slide presentations to facilitate their orientation and training.

**Simulation**

Simulated learning was another component of orientation. Clinical simulation is an active learning strategy that is now widely used to provide an opportunity for deliberate practice to foster experiential learning and the application of clinical knowledge. The simulation sessions were also intended to facilitate the NPs’ transition from RN role to the provider role.

A 4-hour program was developed by nursing simulation staff, nurse directors, and physicians to provide exposure to specific clinical experiences. The simulation was run using a full-scale, high-fidelity, computer-integrated, and physiologically responsive patient simulator. The program included 4 scenarios that were created to replicate medical emergencies that the NPs would likely encounter in practice—pulmonary embolism, urosepsis, gastrointestinal bleed, and hypercalcemia. Each NP had the opportunity to independently manage 1 of these patients, whereas the other NPs observed the scenario from an adjoining room. All NPs participated in the post-scenario debriefing, during which the simulation staff reviewed video-recorded segments of the scenario and encouraged participants to reflect on the scenario and their performance. This reflection and discussion with staff and peers led to a deeper understanding of their actions, assumptions, and communication with family and other healthcare members. At the end of the debriefing, the physician provided a brief presentation on the recognition and management of the specific medical emergency as well as indications for calling in medical expertise. This program provided the NPs with an opportunity to acquire knowledge and skills in a risk-free, experiential learning environment to improve the quality of care and promote safety for the patient. The simulation sessions were also intended to facilitate the NPs.

**Conclusions**

The opportunity to develop and implement 2 ACNP models helped create and shape the direction of innovative models of patient care. The role of the ACNP continues to evolve and grow in this ever-changing healthcare environment. Although the 2 models described here are designed and structured differently, the primary role of the NP in each model is to manage patients’ care.

This article describes the ways in which nurses acted as full partners in leading the redesign of the care delivery models in their departments. Both models provide improved accessibility to ACNPs by patients, families, nurses, and the healthcare team. Furthermore, the models contribute to continuity of care because the ACNPs, through their continual and consistent presence on the units, are expert at knowing the patients, families, and staff. The ACNP models make significant contributions in the coordination of care for a wide range of patients, using the full extent of education and training. Although there are
relatively little data on these models, we have received anecdotal positive feedback from highly satisfied patients, families, physicians, nursing staff, and case managers. Length of stay is the primary metric that is reviewed monthly. The data have shown that the ONP service has decreased their LOS by 1.5 days. The AHS has decreased their LOS by 0.9 days, although the results are not totally attributable to the ACNPs because a hospitalist and an ACNP share the patient caseload on a daily basis. Robust models that place advanced practice nurses on units with strong physician support are well positioned to meet the 6 quality aims—safe, effective, patient-centered, timely, efficient, and equitable care.4

Acknowledgments
The authors acknowledge Jeanette Ives Erickson, RN, DNP, FAAN, senior vice president for patient care and chief nurse; Theresa M. Gallivan, RN, MS, associate chief nurse; and Jacqueline Somerville, RN, PhD, former associate chief, MGH, for their insightful leadership on the project.

References
The IHI STAAR Initiative:
Overview of the Orthopedics and Urology Front Line Units
May 2010

Overview: IHI STAAR Initiative

The State Action on Avoidable Rehospitalizations (STAAR) Initiative is led by faculty and staff from the Institute for Healthcare Improvement in cooperation with state leaders.

The IHI STAAR initiative is a 4-year, multi-state effort to reduce avoidable re-hospitalizations.

STAAR focuses on creating an ideal transition for patients from the hospital to home:
1. The aim of this initiative is to reduce 30-day readmission rates by 30 percent and
2. Increase patient and family satisfaction with optimal transitions and coordination of care.

During this collaborative, participants will (1) develop skills to design safe and reliable transition processes, (2) more effectively engage patients and families to be better self-managers, and (3) effectively coordinate care at discharge across disciplines and care settings.

Overview: Phase 1

Although the process improvement work starts with a hospital-based team, IHI expects participants to engage representatives from skilled nursing facilities, home health agencies, ambulatory practices, as well as patients and family caregivers as members of hospital-based “transitions” teams.

- The initial phase of the work is a two-year project focused on:
  - A multi-state learning community to improve transitions of care; and
  - Targeted technical assistance to address systemic barriers to reducing avoidable re-hospitalizations

Overview: Four key changes

The STAAR initiative suggests four key changes to create an ideal transition home and specifies changes that can be tested:

1. Enhanced Assessment of Patients
   a. Conduct a standardized assessment and predict home-going needs
   b. Reconcile medications upon admission
   c. Initiate a standard plan of care based on the results of the assessment
2. Enhanced Teaching and Learning
   a. Identify the learner(s) on admission (e.g., the patient and family caregivers)
   b. Redesign the patient education process to improve patient and family caregiver understanding of self-care
   c. Use “Teach Back” daily in the hospital and during follow-up calls
3. Patient and Family-Centered Handoffs
   a. Reconcile medications at time of discharge
   b. Provide customized real-time information to next provider(s)
4. Post-Acute Care Follow-Up
   a. High-risk patients: Prior to discharge, schedule a face-to-face follow-up visit (Home care, PCP, TEC, transition nurse, or physician office visit), to occur within 48 hours after discharge
   b. Moderate-risk patients: Prior to discharge schedule follow-up phone call within 48 hours and schedule a physician office visit within 5 days

Ellison 6 / White 6: STAAR Aim Statement

AIM: By October 2010, MGH will reduce the all-cause readmission rate for patients discharged from Ellison 6 and White 6 to 5.5% on each unit.

Baseline: 7.5% of patients discharged from Ellison 6 and 6.3% of patients discharged from White 6 were readmitted to MGH within 30-days (10/1/2008 and 7/3/2009)

Goal: 5.5%

<table>
<thead>
<tr>
<th>Month</th>
<th>Number</th>
<th>Admissions</th>
<th>Readmissions</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>300</td>
<td>30</td>
<td>15</td>
<td>5.0%</td>
</tr>
<tr>
<td>May</td>
<td>320</td>
<td>32</td>
<td>16</td>
<td>5.0%</td>
</tr>
<tr>
<td>June</td>
<td>340</td>
<td>34</td>
<td>17</td>
<td>5.0%</td>
</tr>
<tr>
<td>July</td>
<td>360</td>
<td>36</td>
<td>18</td>
<td>5.0%</td>
</tr>
<tr>
<td>August</td>
<td>380</td>
<td>38</td>
<td>19</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Excludes: Chemotherapy, Radiation therapy, Rehabilitation, Emergencies by CMS 8 principal diagnosis code, discharge rates of death

IHI STAAR:
Ellison 6 & White 6 Front Line Team

- **Team Leader:** Joanne Empolini, CNS
- Kathleen Myers, Nurse Director, MSN, RN
- Jill Pedro, CNS, RN
- Mary McDonough, CNS, RN
- Bob Dorman, PhD, PI
- Joan Ryan, RN, Case Management
- Joanne Davis, RN, Case Management
- Kristin Sybert, RN, Case Management
- Pablo Gomery, MD, Urology
- David Ring, MD, Orthopedics
- Day-to-day leader: Yanine Mata Jackson, MHS
Ellison 6 / White 6: Improving the transition from hospital to home

While one of the goals of the STAAR initiative is to decrease readmissions, our readmission rate 1 is already low:

- Most recent data show that 7.4% of patients discharged from Ellison 6 and 5.7% of patients discharged from White 6 were readmitted to MGH within 30 days (last twelve months ending Feb-2010)
- While there may not be much opportunity to decrease the units’ readmission rate, the Discharge Process can be reviewed and enhanced to provide better patient education and improve patient satisfaction at the time of discharge.
- Questions:
  - Could patient and family discharge education be improved?
  - Is discharge education done in a timely manner? Or is it rushed?
  - Does the whole team agree with the anticipated discharge date?
  - Do patients understand who they should follow up with if there are questions / issues post discharge?

1) All cause, all payer readmission rate. Source: TIE encounter; 31-Day Readmission Excludes Chemotherapy, Radiation therapy, Rehabilitation, and Dialysis by ICD-9 principal diagnosis code. Also excludes Discharge status of death

Ellison 6 / White 6: Tests of change

- Our first tests of change:
  - Anticipated discharge dates: posted on white board in patients’ rooms for all disciplines to see
  - Readmission rates: daily/weekly chart review of patients readmitted into MGH
  - Lovemore education: RN focus on documenting that education has taken place, including teach back
  - Wound care education: update content, include teach back
  - Patient and family satisfaction

- Future tests of change under consideration:
  - Follow-up on teaching discharge paperwork and prescriptions white board in each patient room twenty four hours prior to discharge (????)
  - Pre-Operative Teaching vs. No Pre-Op Teaching: Compare patients who attend the Total Joint pre-op education to a group of patients who do not attend these sessions. Our hypothesis is that the patients who have attended the pre-op education are more prepared for discharge than those who do not attend a class.

Compare the groups using a specific set of follow-up questions.

Ellison 6 / White 6: Lessons learned and ideas

- Communicate clear directions on signs and symptoms to watch for and whom to call
- Categorize patients based on readmission risk (e.g. wound condition at discharge or co-morbidities) and design a follow-up plan accordingly (scheduling early follow-up if necessary)
- Communicate a clear plan of discharge date from MD (and document in progress note)
- MDs to document when patient can return to work, drive, etc...
- Use a camera to take pictures of wounds at discharge
  - Place in record, send to VNA, and give to patient

Ellison 6 / White 6: Wound Care Management Plan

Pilot started in April 2010
Based on initial patient feedback, format has changed and is being tested.

This pilot covers:
- Patient education on wound care
- Identifying signs/symptoms
- Teach Back
- Whom to call if symptoms develop

**Wound Care Management Plan**

<table>
<thead>
<tr>
<th>What does your wound look like today?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you feel?</td>
</tr>
<tr>
<td>Did you have problems with the incision?</td>
</tr>
<tr>
<td>Why do you think your wound isn’t getting better?</td>
</tr>
<tr>
<td>What other areas of your care were important to you?</td>
</tr>
<tr>
<td>How are you feeling?</td>
</tr>
<tr>
<td>What other areas of your care were important to you?</td>
</tr>
<tr>
<td>How do you think your wound isn’t getting better?</td>
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<tr>
<td>What other areas of your care were important to you?</td>
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<td>How do you feel?</td>
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<td>Did you have problems with the incision?</td>
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<tr>
<td>What other areas of your care were important to you?</td>
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</table>
Ellison 6: Lovenox teaching upon discharge

Lovenox education: RN focus on documenting that education has taken place, including teach back. Weeks are randomly selected to check whether 100% of patients are receiving Lovenox education and that documentation is occurring.

<table>
<thead>
<tr>
<th>Week</th>
<th># Patients discharged on Lovenox</th>
<th>Patients had Lovenox teaching</th>
<th>Patients had Lovenox documentation</th>
<th>% Goal: 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/22</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
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<tr>
<td>2/15</td>
<td>1</td>
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<td>1</td>
<td>100%</td>
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<tr>
<td>1/29</td>
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<td>1</td>
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<tr>
<td>1/18</td>
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<td>n/a</td>
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<td>12/7</td>
<td>2</td>
<td>1</td>
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<td>12/15</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>75%</td>
</tr>
</tbody>
</table>

HCAHPS: Additional questions during this hospital stay

Q19) Did doctors, nurses or other hospital staff talk to you about whether you would have the help you need when you left the hospital?

E6: For the six months ending in Jan 2010, E6 was at 97% (N=79). For the month of January, E6 was at 100% (N=16)

W6: For the six months ending Jan 2010, W6 was at 94% (N=67). For the month of January, W6 was at 97% (N=14)

Q20) Did you get the information in writing about what symptoms or health problems to look out for after you left the hospital?

E6: For the six months ending in Jan 2010, E6 was at 95% (N=72). For the month of January, E6 was at 96% (N=16)

W6: For the six months ending in Jan 2010, W6 was at 91% (N=67). For the month of January, W6 was at 90% (N=10)

White 6: Lovenox teaching upon discharge

Lovenox education: RN focus on documenting that education has taken place, including teach back. Weeks are randomly selected to check whether 100% of patients are receiving Lovenox education and that documentation is occurring.

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<th>Patients had Lovenox documentation</th>
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<td>7</td>
<td>4</td>
<td>3</td>
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IHI STAAR: Project Structure

Project Planning team:
- Multi stakeholder team including leaders and staff in the hospital, pharmacy, non-acute services, home care services, and PCPs
- Provides ideas and oversight for the initial pilot unit work and to establish a dissemination strategy for hospital-wide implementation

Front-Line Improvement Teams:
- Focus on one of the key changes to identify areas of opportunities/failures in the current processes and select a process to work on
- Conduct regular tests of changes to improve transitions home during testing phase (Oct 2009 to Oct 2010)
- Meet regularly to plan, share learning and assess progress
Schedule and Objectives – Day 1 – Monday, May 24, 2010  MGH

0730  Registration and Breakfast
       CNY Building 114 D1 Conf. Room
       Gaurdia Banister, PhD, RN

0800  Welcome
       Executive Director, Institute for Patient Care

0810  Introduction and Overview of Program
       Marita Titler, PhD, RN, FAAN

0820  Who’s at the Institute?
       Marita Titler and Susan Lee, PhD, RN
       ▪ Allow participants to share their projects and goals for the institute

0915  Taking the Lead
       Marita Titler
       ▪ Understand use of mentorship
       ▪ Describe the role of the nurse leader in EBP
       ▪ Strategize project delegation and support for staff nurses to promote success
       ▪ Discuss effective management of communication
       ▪ Describe components of the Toolkit

1015  Planning for Success: Characteristics of Innovations that Support Adoption
       Marita Titler
       ▪ Prioritize topics for evidence-based practice
       ▪ Identify characteristics of an innovation that lead to project success

1030  Break

1045  Finding the Evidence
       Carole Foxman, MA, MS, AHIP
       ▪ Develop advanced skills in electronic search strategies
       ▪ Locate web-based resources

1145  Lunch on Site
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
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</thead>
<tbody>
<tr>
<td>1245</td>
<td>Synthesis and Use of the Evidence</td>
<td>Jennifer Moore</td>
</tr>
<tr>
<td></td>
<td>- Understand different grading schemas for levels of evidence</td>
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</tr>
<tr>
<td></td>
<td>- Understand various evidence summaries (e.g., systematic reviews, meta-analysis, health technology assessment, etc.)</td>
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</tr>
<tr>
<td></td>
<td>- Discuss issues when making difficult decisions regarding use of evidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Discuss localization of practice protocols</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Develop strategies for managing the evidence</td>
<td></td>
</tr>
<tr>
<td>1415</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>1430</td>
<td>Action Plans</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>- Discuss the benefits of using an action plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Describe the critical elements of an action plan</td>
<td></td>
</tr>
<tr>
<td>1500</td>
<td>Applying the Principles</td>
<td>Facilitators: Titler and Lee</td>
</tr>
<tr>
<td></td>
<td>- Practice Critique of research</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Critique of the Evidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group 1 qualitative (Marita Titler)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group 2 quantitative (Diane Carroll, PhD, RN, FAAN)</td>
<td></td>
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<tr>
<td>1600</td>
<td>Adjourn</td>
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</tbody>
</table>
# The Clinical Inquiry Institute: An Evidence-Based Approach

## Schedule and Objectives – Day 2 – Tuesday, May 25, 2010  MGH

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730</td>
<td>Registration and Breakfast</td>
<td>CNY Building 114 D1 Conf. Room</td>
</tr>
<tr>
<td>0800</td>
<td>Participant Discussion</td>
<td>Marita Titler</td>
</tr>
<tr>
<td>0830</td>
<td>What Does the Evidence Suggest?</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>- Critique of evidence (e.g. Practice Guideline and website)</td>
<td></td>
</tr>
<tr>
<td>0930</td>
<td>Diffusion of Innovations – An Overview</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>- Understand Rogers’ model of Diffusion of Innovations as a basis for the Translation Research Model for implementation</td>
<td></td>
</tr>
<tr>
<td>0950</td>
<td>Piloting the Practice Change</td>
<td>Jennifer Moore</td>
</tr>
<tr>
<td></td>
<td>- Discuss the importance of piloting the change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Describe strategies to effectively pilot a change</td>
<td></td>
</tr>
<tr>
<td>1030</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>1045</td>
<td>Strategies: Communication is Key to Success</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>- Describe strategies to improve communication about evidence-based practice (e.g. opinion leaders, change champions, facilitators, and core groups)</td>
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</tr>
<tr>
<td></td>
<td>- Outline concepts in developing educational materials</td>
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<tr>
<td>1130</td>
<td>Strategies: Users of Innovation</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>- Discuss strategies to improve practitioners’ use of an EBP protocol (e.g., audit-feedback, performance gap assessment, academic detailing/outreach, etc.)</td>
<td></td>
</tr>
<tr>
<td>1215</td>
<td>Lunch on Site</td>
<td></td>
</tr>
<tr>
<td>1315</td>
<td>Strategies: The Social System</td>
<td>Jennifer Moore</td>
</tr>
<tr>
<td></td>
<td>- Discuss strategies to successfully integrate EBP within the social system (e.g. policy/procedures, documentation, orientation, competency review, linkages with senior leadership)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Discuss the organizational structure used to support evidence-based practice (e.g. policies, documentation, QI, etc.)</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Presenter(s)</td>
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<tr>
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<td>--------------------------------------------------</td>
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<tr>
<td>1345</td>
<td>Evaluation Methodology Plans</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>▪ Describe data collection methods and instrument development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Discuss psychometric issues in instrument development for Quality Management monitoring</td>
<td></td>
</tr>
<tr>
<td>1445</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>1500</td>
<td>Applying the Principles</td>
<td>Marita Titler and Diane Carroll</td>
</tr>
<tr>
<td></td>
<td>▪ Critiques of Research</td>
<td></td>
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<tr>
<td></td>
<td>▪ Critique of the Evidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group 1 quantitative (Carroll)</td>
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</tr>
<tr>
<td></td>
<td>Group 2 qualitative (Titler)</td>
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<tr>
<td>1600</td>
<td>Adjourn</td>
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</tbody>
</table>
# The Clinical Inquiry Institute: An Evidence-Based Approach

## Schedule and Objectives – Day 3 – Wednesday, May 26, 2010  MGH

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730</td>
<td>Coffee/Registration</td>
<td>Founders 325</td>
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<tr>
<td>0800</td>
<td>Be Creative – Can This Be Taught?</td>
<td>Marita Titler and Liz Johnson</td>
</tr>
<tr>
<td></td>
<td>▪ Use two creative thinking techniques</td>
<td></td>
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<tr>
<td>0900</td>
<td>Developing an Educational Program for Staff Nurses</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>▪ Describe a staff nurse educational program on evidence-based practice</td>
<td></td>
</tr>
<tr>
<td>1000</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>1015</td>
<td>Nurse Leader’s Role in Facilitating EBP</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>▪ Discuss the leadership role in supporting EBP initiatives.</td>
<td></td>
</tr>
<tr>
<td>1045</td>
<td>Sustaining Practice Change</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>▪ Discuss strategies for sustaining practice changes.</td>
<td></td>
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<tr>
<td>1100</td>
<td>Exemplars of EBP</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>▪ Report EBP projects from various sites</td>
<td></td>
</tr>
<tr>
<td>1145</td>
<td>Lunch on Site</td>
<td></td>
</tr>
<tr>
<td>1245</td>
<td>Exemplars of EBP at Mass General</td>
<td>Liz Johnson, CNS</td>
</tr>
<tr>
<td></td>
<td>▪ Report current EBP projects underway</td>
<td>1:00 Hannah Lyons, CNS</td>
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<tr>
<td></td>
<td>▪ Share strategies for success with current EBP projects</td>
<td>1:15 Marion Phipps, CNS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1:30 Mary Beth Singer, NP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1:45 Barbara Cashavelly, Nsg. Dir.</td>
</tr>
<tr>
<td>1345</td>
<td>Break</td>
<td></td>
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<tr>
<td>1400</td>
<td>Organizational Infrastructure Supporting EBP</td>
<td>Marita Titler</td>
</tr>
<tr>
<td></td>
<td>▪ Describe the MGH organizational structure used for EBP</td>
<td>Lynda Brandt (Infrastructure)</td>
</tr>
<tr>
<td></td>
<td>▪ Discuss MGH governance and inward look at where MGH is and where going</td>
<td>Diane Carroll (Support with IRB; CITI Certification)</td>
</tr>
<tr>
<td></td>
<td>▪ Discuss support and resources available for EBP projects</td>
<td>Liz Johnson (Building CNS Capacity)</td>
</tr>
<tr>
<td></td>
<td>▪ Summarize the benefits to MGH of having an evidence-based practice program</td>
<td>Carole Foxman (Treadwell)</td>
</tr>
<tr>
<td>1445</td>
<td>Participant Discussion and Wrap up</td>
<td>All</td>
</tr>
<tr>
<td>1600</td>
<td>Program Evaluation, Wrap-up, CEU Awards</td>
<td>Local Faculty</td>
</tr>
</tbody>
</table>
Evidence Based Practice Mentors

April 2010

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Ananian, Lillian</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Birkemose, Patrick</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Blanchard, Tom</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Brandt, Lynda</td>
<td>RN, Clinical Project Specialist</td>
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<tr>
<td>Carroll, Diane</td>
<td>RN, PhD, Nurse Scientist</td>
</tr>
<tr>
<td>Cruz, Connie</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Empoliti, Joanne</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Gavaghan, Susan</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Johnson, Elizabeth</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>LaSala, Cynthia</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Lee, Susan</td>
<td>RN, PhD, Nurse Scientist</td>
</tr>
<tr>
<td>Lussier-Cushing, Mary</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Lyons, Hannah</td>
<td>RN, CNS</td>
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<tr>
<td>Madden, Janet</td>
<td>RN, CNS</td>
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<tr>
<td>McKee, Christine Grady</td>
<td>RN, CNS</td>
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<tr>
<td>Mulligan, Janet</td>
<td>RN, Nurse Director</td>
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<tr>
<td>Peterson, June</td>
<td>RN, Staff Development Specialist</td>
</tr>
<tr>
<td>Roche, Kate</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Slicis, Donna</td>
<td>RN, CNS</td>
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<tr>
<td>Smith, Mary Ellin</td>
<td>RN, Staff Development Manager</td>
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<tr>
<td>Snyderman, Colleen</td>
<td>RN, Nurse Director</td>
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<tr>
<td>Stengrevics, Susan</td>
<td>RN, CNS</td>
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<td>Wrigley, Pam</td>
<td>RN, CNS</td>
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April 2011

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Role</th>
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<tbody>
<tr>
<td>Badolato, Gail</td>
<td>RN, Staff Nurse</td>
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<tr>
<td>Beauchamp, Kathryn</td>
<td>RN, CNS</td>
</tr>
<tr>
<td>Bilodeau, Mary-Liz</td>
<td>RN, NP</td>
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<tr>
<td>Blakeney, Barbara</td>
<td>RN, Innovation Specialist</td>
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<tr>
<td>Bleiler, Carolyn</td>
<td>RN, Staff Nurse</td>
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<tr>
<td>Bowes, Cynthia</td>
<td>RN, NP</td>
</tr>
<tr>
<td>Capasso, Ginger</td>
<td>RN, PhD, NP</td>
</tr>
<tr>
<td>Cohen, Audrey Kurash</td>
<td>SLP, Clinical Specialist</td>
</tr>
<tr>
<td>Cerpial, Chelby</td>
<td>RN, CNS</td>
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<tr>
<td>Delaney, Brenda</td>
<td>RN, Clinical Content Manager</td>
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<td>Doran, Mary</td>
<td>RN, NP</td>
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<td>Fillo, Kate</td>
<td>RN, Staff Nurse</td>
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<tr>
<td>Fitzgerald, Patricia</td>
<td>RN, Nursing Director</td>
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<tr>
<td>Foisy, Kim</td>
<td>RN, Clinical Educator</td>
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<tr>
<td>Gall, Gail</td>
<td>RN, NP</td>
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<tr>
<td>Goldsmith, Tessa</td>
<td>SLP, Assistant Director</td>
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<tr>
<td>Gray, Jennifer</td>
<td>RN, Clinical Lead</td>
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<td>Grella, Patricia</td>
<td>RN Clinical Lead</td>
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<td>Grennan, Kerry</td>
<td>RN, NP</td>
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<td>Gryglik, Christine</td>
<td>RN, CNS</td>
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<td>Joyce, Stephen</td>
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<td>Kelly, Nancy</td>
<td>RN, NP</td>
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<td>Kinnealey, Mary Ellen</td>
<td>RN, Clinical Lead</td>
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<tr>
<td>Leslie, Gail</td>
<td>RN, Clinical Specialist</td>
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<tr>
<td>Levin-Russman, Elyse</td>
<td>LICSW, Social Worker</td>
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<tr>
<td>McDermott, Ann</td>
<td>RN, Project Manager</td>
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<tr>
<td>Murphy, Erin</td>
<td>RN, APRN</td>
</tr>
<tr>
<td>Patry, Jennifer</td>
<td>RN, Staff Nurse</td>
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<tr>
<td>Phelan, Helene</td>
<td>RN, Staff Nurse</td>
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<tr>
<td>Phillips, Kathryn</td>
<td>RN, NP</td>
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<td>Ross, Andrea</td>
<td>RN, NP</td>
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<td>Stuler, Shelley</td>
<td>RN, Clinical Lead</td>
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<tr>
<td>Sumner, Laura</td>
<td>RN, Staff Development Specialist</td>
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<tr>
<td>Walsh, Mary Ann</td>
<td>RN, Project Support</td>
</tr>
<tr>
<td>Whalen, Kate</td>
<td>RN, CNS</td>
</tr>
</tbody>
</table>
Introducing a novel approach to preparing our nursing workforce: A nurse residency in geropalliative care
An Evidence-Based Nurse Residency Program in Geropalliative Care

Susan M. Lee, PhD, RN, Edward E. Coakley, MS, MEd, MA, RN, Constance Dahlin, ANP, BC, ACHPN, FPCN, and Penny Ford Carleton, MS, MPA, MSc, RN

Abstract

As U.S. baby boomers age and the older population doubles by 2030, unprecedented numbers of older adults will need and benefit from nursing care that is evidence-based and tailored to their needs and preferences. To address this need, Massachusetts General Hospital developed the RN Residency: Transitioning to Geriatrics and Palliative Care program. Guided by two national curricula, the RN Residency program was designed to expand the disease model of geriatrics to a functional, emotional, and social perspective of aging, in which palliative care is an integral component. This article describes the RN Residency program, which was designed to improve the effectiveness of nursing assessment, interventions, and outcomes for older adults and their families.

The older population in the United States is growing rapidly. One in five Americans will be age 65
years or older by 2030. Research findings suggest that although 80% of Americans wish to die at home, fewer than 25% actually do (National Hospice and Palliative Care Organization, 2009). Among U.S. adults age 65 years and older, approximately 50% die in hospitals, often after stays in intensive care units and life-prolonging treatments (Last Acts, 2002). Another 25% die in nursing homes, a number expected to grow (Last Acts). The technological advances and complexity of health care do not always match the needs and preferences of the older population. New models of care for older Americans are needed and a new workforce needs to be developed that understands the issues of aging and the current complexities of the health care system (Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans, Board on Health Care Services, 2008).

To address these needs, the authors developed the RN Residency: Transitioning to Geriatrics and Palliative Care (RN Residency) program.

The RN Residency program emerged out of two system-wide visions: improving care to older adults and improving care to patients at the end of life. This article describes the RN Residency program, which was designed to develop geropalliative care nursing knowledge and competence and to improve the quality of care to older patients and their families.

BACKGROUND

Massachusetts General Hospital (MGH) is a 907-bed academic medical center located in Boston, Massachusetts. Each year, MGH admits more than 46,000 inpatients. Older adults account for roughly 41%, or 18,000, of those admissions. In 2004, MGH made a commitment to improving care for older adults through its affiliation with the Hartford Institute for Geriatric Care and its Nurses Improving Care to Healthsystem Elders (NICHE) program (Nurses Improving Care to Healthsystem Elders, 2009). NICHE is a national geriatric nursing program involving 270 hospitals in the United States and Canada, the goal of which is to educate and promote the critical role that nurses play, within a systems context, in providing care to older adults. A NICHE affiliation affords nurses access to a wide array of evidence-based resources that can be used to tailor nursing interventions that will improve outcomes for older adults and their families. The NICHE program at MGH, called 65Plus, is an interdisciplinary model involving, but not limited to, nurses, patient care assistants, therapists, social workers, and chaplains. Among its many initiatives, 65Plus offers a 2-day educational program, Best Practices in Acute Care for Older Adults, to multidisciplinary clinicians, who receive contact hours for participation.

In this way, 65Plus works to improve awareness and knowledge of several patient care disciplines to create an environment that is sensitive and responsive to the needs of older adults and their families.

The MGH Palliative Care Service is one of the oldest palliative care services in the United States. Educated and competent nurses who have palliative care knowledge and skills enhance the formal palliative care program. For older patients with chronic disease who may be at the end of life, nurses trained in palliative care can significantly improve the dying experience for both patients and their families. Ways in which staff nurses enhance the formal palliative care service were exemplified in the Merging Palliative Care and Critical Care Cultures Quality Demonstration Project, funded by the Robert Wood Johnson Foundation. In this project, physicians and nurses partnered to integrate palliative care into the medical intensive care unit in situations in which there was little likelihood of recovery (Billings et al., 2006). Informed by that experience, two of the nurses who participated in the Merging Project have taken leading roles in the RN Residency program.

A popular ongoing educational program at MGH is the End-of-Life Nursing Education Consortium (ELNEC) program, which is offered twice yearly. ELNEC provides 2 days of training to nurses in end-of-life care. In addition to these projects, the creation of the Center for Innovations in Care Delivery has been the catalyst for looking at new models for delivery of care to older patients within MGH and the larger integrated health system. The idea and framework for the RN Residency program originated from and is implemented by the Center for Innovations.

RN RESIDENCY PROGRAM

The RN Residency program, the first program of its kind in the United States, provides registered nurses opportunities to learn and apply current, evidence-based geriatric and palliative nursing knowledge at MGH. In a combination of didactic teaching and clinical experience, the program aims both to strengthen the nursing workforce by increasing knowledge, skills, and competencies in the specialties of geriatrics and palliative care and to improve the quality of nursing care to older patients and their families. The program has been funded for 3 years by the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration and will train 90 nurses. The program is currently completing year two.

The RN Residency program pairs a less experienced nurse (resident) who has been out of school for 2 to 5 years with an experienced nurse (preceptor) who is age
45 years or older and works on the same patient unit. The learning in the RN Residency program was designed for these two distinct cohorts of nurses. Preceptors, recognized for their experience and embedded knowledge, are trained in an accelerated 4-month clinical and didactic program with other experienced nurses. Next, residents are trained in a 9-month clinical and didactic program with other less experienced nurses. The residents and preceptors then unite as “care partners” to advance geropalliative care on their units by applying their new knowledge and conducting small, unit-based projects.

A program director and three faculty, all having graduate nursing preparation, are the key personnel. Other expert faculty are enlisted from departments throughout the hospital, including speech and language pathology, physical therapy, occupational therapy, chaplaincy, ethics, wound care, and neuroscience.

Recruitment
Each year, one preceptor class is offered to 15 registered nurses and one resident class is offered to 15 registered nurses. Among the many units from which registered nurses are recruited are oncology, neurosciences, orthopedics, medical-surgical, emergency, critical care, and ambulatory care. Eligibility criteria for residents are 2 to 5 years of experience as a registered nurse, current employment for a minimum of 32 hours per week, a strong interest in geropalliative care, recommendation by the nursing director, and a verbal promise of a minimum of a 2-year commitment to continuing employment. Those who are eligible to participate as preceptors are registered nurses age 45 years or older who are currently employed for 24 hours or more per week and identified by the nurse director as proficient or expert, as defined by Benner (1984), and recognized as possessing emerging qualities of mentors, such as effective communication skills, a positive attitude, patience, good listening skills, and a belief in the value and potential of others.

Content
The content of the RN Residency program was intentionally designed to expand the disease model of geriatrics to a functional, emotional, and social perspective of aging. Two national curricula were used, the John A. Hartford Fundamental Geriatric Curriculum and the ELNEC Curriculum (End-of-Life Nursing Education Consortium, 2009). The geriatric components of the curricula focus on geriatric syndromes, such as delirium, pain, polypharmacy, and falls. “Geriatric syndromes” is a fairly new term used to describe prevalent, multifactorial conditions among older adults that are associated with significant morbidity and poor outcomes (Capezuti et al., 2008; Inouye, Studenski, Tinetti, & Kuchel, 2007). Geriatric syndromes are not diseases per se, but common conditions that require new methods of assessment and intervention if the health care system is to improve outcomes for older adults.

Since the initiation of the program, the John A. Hartford Fundamental Geriatric Curriculum was replaced with NICHE Introduction to Gerontology, found at http://nicheprogram.org/tools/training/Introduction_to_Gerontology. These concepts were contained in the slide decks, pre- and posttests, and lecture guides that were available online and in formats that could be edited for local use.

The palliative care components of the curriculum, such as grief, loss, bereavement, and imminent death, focus on alleviating suffering. The authors scheduled 60- to 90-minute blocks of time to address these topics, which were taught by palliative care nurses. The palliative care philosophy requires that faculty devote adequate time for students to fully process the content, exploring their own beliefs and values. The content prompts an assessment of one’s own existential beliefs.

The Table provides a crosswalk of the teaching modules as they align with the domains from the Clinical Practice Guidelines for Quality Palliative Care (National Consensus Project for Quality Palliative Care, 2009). The National Consensus Project for Quality Palliative Care represents five national palliative care organizations whose members collaborate to create and disseminate Clinical Practice Guidelines for Quality Palliative Care. The guidelines are constructed around eight domains of care that are essential to high-quality palliative care: (1) the structures and processes of care; (2) the physical domain; (3) the psychological and psychiatric domain; (4) the social domain; (5) the spiritual, religious, and existential domain; (6) the cultural domain; (7) the imminently dying domain; and (8) ethics and the law. An RN Residency program faculty member served as the Chair of the Revisions Task Force of the National Consensus Project for Quality Palliative Care, and the participants were fortunate to have this expertise available.

Content was used from several texts (Capezuti et al., 2008; Ferrell & Coyle, 2006; Matzo & Sherman, 2004; Tabloski, 2006) and current literature. Classes were held one day per month. A variety of teaching methods were used, including case studies, discussion, focus groups, narrative writing, journaling, reflective practice, centering, mind-body strategies, film clips, slides, and lectures.

EVALUATION
A strong formative evaluation component was integrated into the design of the RN Residency program, in-
Earn 2.3 Contact Hours

CURRICULUM CROSSWALK ACROSS THE NATIONAL CONSENSUS PANEL DOMAINS OF PALLIATIVE CARE, END-OF-LIFE NURSING EDUCATION CONSORTIUM MODULES, AND JOHN A. HARTFORD FUNDAMENTAL GERIATRIC CURRICULUM MODULES

<table>
<thead>
<tr>
<th>National Consensus Panel Domains of Palliative Care</th>
<th>End-of-Life Nursing Education Consortium Modules</th>
<th>John A. Hartford Fundamental Geriatric Curriculum Modules</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structure and Processes</td>
<td>Nursing Care at the End of Life</td>
<td>Geriatric Syndromes</td>
</tr>
<tr>
<td></td>
<td>Achieving Quality Care at the End of Life</td>
<td>Communication</td>
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<td>3. Psychological and Psychiatric</td>
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<td>4. Social</td>
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<td>Elder Abuse</td>
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<td>5. Spiritual, Religious, and Existential</td>
<td>End-of-Life Nursing Education Consortium Other</td>
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<td>Chaplaincy and Spiritual Assessment</td>
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<td>6. Cultural Aspects of Care</td>
<td>Cultural Considerations in End-of-Life Care</td>
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<td>7. Care of the Imminently Dying</td>
<td>Preparation and Care for the Time of Death</td>
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<td>8. Ethics and Legal Aspects of Care</td>
<td>Ethical and Legal Issues</td>
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Including class evaluations, focus groups, informal discussions, online surveys, and formal research instruments. The use of rapid cycle change helped the authors to respond to critiques and make adjustments to the content and teaching methods by the next class to keep nurses’ engagement high. Summative evaluation will be completed at the end of year three. Following is a discussion of some of the findings of the formative evaluation and lessons learned (Sidebar).

**Year One**

In year one, the Hartford and ELNEC content was delivered as written. Evaluation feedback showed that the content the nurses received sparked their imagination and increased their motivation to deliver care in new ways. “I’m feeling invigorated about my nursing practice!” wrote one resident. Another wrote, “I enjoyed sharing this experience with other nurses who have the same interest and enthusiasm regarding geropalliative care.” A third added, “I like learning about giving better patient care to elders and patients and families at end of life.” Feedback also showed that the course content was helpful, but that the nurses needed more.

Therefore, the authors continued to use the 20 modules as topical guides, but added to them key research findings that represented the state of the science. Bringing research evidence to nurses helped them to be a part of the research-to-practice translation process. “Now with every one of my patients, geriatric or not, I . . . plan walking ‘dates,’ a specific [time] in the day that I or a pa-
tient care associate will walk the patient because activity is so important.”

Another finding in year one was that the residents were becoming overwhelmed with information and how to apply it on their units. To address nurses’ experience of feeling overwhelmed, the authors piloted a mind-body intervention to improve coping skills and resilience (Arcari, Lee, Lepoutre, & Coakley, 2009), an experience many participants reported as transformative. “I like the mind-body sessions; they help me cope with everyday nursing,” remarked one resident. Another stated, “My favorite part was the mind-body piece. I really was able to think about nursing in a different light.” Some transferred this learning to patients, “I often find myself using these techniques, especially when dealing with a patient/family.” This program helped move the residents beyond a task-driven practice toward an integrated practice in which nurses learned to center themselves to be more fully present to patients and families.

Nurses in both groups stated that they enjoyed cohort learning with other nurses who are at the same level of expertise. Many nurses made comments such as, “I liked having a group forum where nurses in my age group and at my experience level were able to discuss our thoughts and practices. . . . I liked being involved in a greater project than just my unit-specific ones.”

One of the major developments in gerontological nursing over the last 5 years has been the new emphasis on assessment. Because disease presentations are atypical, because comorbidities and geriatric syndromes often cloud the clinical picture, and because much gets blamed on age itself, a careful assessment using standardized assessment tools has arguably become a hallmark of gerontological nursing. These standardized approaches to functional assessment, cognitive assessment, and mobility assessment are new to most nurses and present a learning curve. Using data from clinical assessments to inform tailored approaches to nursing care advances the nurse from one-size-fits-all care to care that makes sense.

Older adults are not a homogeneous group. Although the conceptualization of young old (age 65 to 74 years), middle old (age 75 to 84 years), and old old (age 85 years and older) is helpful in assessing overall risk, a comprehensive nursing assessment is essential, especially in acute care, where the average length of stay is 5 to 6 days. Therefore, asking questions such as “What are the likely risks for this older adult (i.e., skin breakdown, falls)?” and “What interventions are appropriate?” is crucial to delivering exquisite nursing care to older adults. The authors used role-play to try out these assessment skills in the classroom setting.

Year Two

The authors piloted weekly geropalliative care rounds on the unit with a gerontological nurse practitioner to reinforce the learning at the nurse-patient level. The gerontological nurse practitioner was able to challenge thinking, encourage reflective practice, and share her clinical understanding. She asked, “What are the priorities for this patient today?” Situation-specific learning was extremely effective.

In year two, the teaching methods were also changed to increase interaction. Colleagues throughout the hospital were enlisted to teach 1-hour modules so that participants could benefit from their expertise and become acquainted with expert resources. Preceptors and residents felt supported as they integrated new knowledge into practice, and they continue to call on faculty, such as the palliative care nurse practitioner, the pain management nurse, and psychiatric clinical nurse specialists, for help with patient and family situations.

Although the primary focus of the RN Residency program was on acute care of older adults, the authors believed that exposure to other settings that provide care to older adults would improve the program. Therefore, they reached out to other entities within the integrated health system to recruit nurses to the RN Residency program. This effort led to several surprising results as well as a new model of education. In year two, the RN Residency program began to include case managers and other registered nurses across geriatric health settings, including nursing home, subacute facility, home care, and hospice. This inclusive effort created a rich classroom environment; in addition, cross-setting education may help to create new relationships that can facilitate
older adults’ transitions, a known source of risk and discontinuity.

The authors realized the great potential for this model of cross-setting education because nurses have so much knowledge to share. For example, acute care nurses are challenged with devising ways to keep older adults safe and prevent falls. Long-term care nurses, however, work in restraint-free environments and have created successful strategies for safety and prevention of falls. This is just one example of ways that nurses can translate successful strategies learned from other settings into practice.

**Year Three**

An ongoing challenge to the success of the RN Residency program was sustaining the momentum and facilitating communication with the participants during the weeks between classes. Initially, the authors encountered barriers to creating an electronic meeting site, but finally found a suitable intranet site onto which they uploaded articles, slides, resources, contact information, photos, and a blog. They wanted to continue an ongoing dialogue with the residents and preceptors as the program evolved. Therefore, in year two, a centralized repository for content and announcements was developed; this will be expanded in year three.

In year three, the plans are to ensure sustainability after the funding period, complete a summative evaluation, develop the theoretical underpinnings of geropalliative care, disseminate the study findings and theory, and continue to look for opportunities for continuing professional development of nurses who care for older adults across settings.

A parallel program at MGH is advancing the work of creating and implementing geriatric care protocols that support nurses in their practices. The authors learned that developing nursing knowledge, practice change, and the environment to support them is a process that will take several years.

**CONCLUSION**

An RN Residency program is an effective way of engaging and developing practicing nurses, no matter where they are on their career trajectories. Cohort learning provided a forum for nurses to discuss their practices with peers and mentors and helped them to articulate the aspects of their practices that they value. Taking time to reflect on practice and share in this dialogue is crucial to nurses evolving their own thinking and advancing their practices to higher levels. The hospital benefits from nurses who are more knowledgeable, more sensitive, more focused, and even more committed to providing care that is tailored to the specific needs of older adults and their families.

This program and the lessons learned through formative evaluation may be useful to others. High-quality curricula and guidelines exist, and their authors often make these resources available for free or for a nominal cost. Adopting or adapting existing materials, with permission from the author, yields a considerable time and cost savings.

This model of educating nurses across geriatric settings is a promising one, especially in an integrated health care system. Nurses from each setting brought a new perspective to the classroom that enhanced everyone’s learning through fruitful dialogue and case study analysis. Developing expertise in geropalliative care requires an understanding of care across settings so that the needs of older adults and their families can be best met.

**REFERENCES**


Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T., Gray-Miceli, D., &
HOW TO OBTAIN CONTACT HOURS BY READING THIS ISSUE

Instructions: 2.3 contact hours will be awarded for this activity. A contact hour is 60 minutes of instruction. This is a Learner-paced Program. Vindico Medical Education does not require submission of the quiz answers. A contact hour certificate will be awarded 4-6 weeks following receipt of your completed Registration Form, including the Evaluation portion. To obtain contact hours:

1. Read the article: “An Evidence-Based Nurse Residency Program in Geropalliative Care,” on pages 536-542, carefully noting the tables and other illustrative materials that are provided to enhance your knowledge and understanding of the content.
2. Read each question and record your answers. After completing all questions, compare your answers to those provided within this issue.
3. Type or print your full name and address and your social security number in the spaces provided on the Registration Form. Indicate the total time spent on the activity (reading article and completing quiz). Forms and quizzes cannot be processed if this section is incomplete. All participants are required by the accreditation agency to attest to the time spent completing the activity.
4. Forward the completed Registration Form with your check or money order for $15 made payable to JCEN-CNE. Payment must be in U.S. dollars drawn on a U.S. bank. CNE Registration Forms are accepted up to 24 months from date of issue.

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This activity is co-provided by Vindico Medical Education and THE JOURNAL OF CONTINUING EDUCATION IN NURSING.

Objectives: After studying the article, “An Evidence-Based Nurse Residency Program in Geropalliative Care,” in this issue, the participant will:

1. Identify strategies to create a nurse residency program in geropalliative care.
2. Describe the learning components of a successful nurse residency program.
3. Describe the challenges of implementing and sustaining a nurse residency program.
4. Identify types of information gained from a variety of methods of formative evaluation.

doi:10.3928/00220124-20091119-02

An Evidence-Based Nurse Residency Program in Geropalliative Care

1. Efficient strategies to build a nurse residency such as those described in this article may include which of the following:
   A. Designing original curricula.
   B. Including self-selected participants with different backgrounds.
   C. Using nationally recognized experts as faculty.
   D. Adapting existing evidence-based curricula.

2. Which of the following is known as a geriatric syndrome:
   A. Alzheimer's disease.
   B. Medication side effects.
   C. Falls.
   D. Cataracts.

3. The authors used rapid cycle change in their formative evaluations for the purpose of ongoing:
   A. Continuity.
   B. Engagement.
   C. Expertise.
   D. Communication.

4. When nurses felt overwhelmed with the content and how to integrate it into their practices, why do you suppose the authors implemented a mind/body intervention, instead of just cutting back on the amount of content presented:
   A. The authors wanted to make certain that the nurses could function in a task-driven practice environment.
   B. The authors believed that mind/body interventions would increase resilience among the nurses and make them more confident and effective in their practices.
   C. The authors determined that knowledge in the domain of geropalliative care nursing was not familiar to the participants.
   D. The authors believed that all content was essential and did not want to make any curriculum changes.

5. Which of the following is an example of situation-specific learning:
   A. Patient rounds on the unit with a geriatric nurse practitioner.
   B. Internet-based lectures.
   C. Specific topical film clips.
   D. Presentations by clinical experts.

6. Based on the formative evaluation of the RN Residency program, which of the following was an ongoing challenge:
   A. Moderating the excitement and involvement of past residents.
   B. Lack of willingness of the residents to discuss their practices.
C. Use of the standardized geriatric protocols in place to support the residents.
D. Facilitating communication with the residents after the educational intervention.

7. Each of the following is an important benefit of cross-setting education described in the article. What would be the ultimate goal of including nurses from multiple settings within an integrated health system for a program that focuses on geropalliative patients:
   A. Improving the quality and continuity of geropalliative care for older patients across transitions.
   B. Improving nurses’ knowledge, skills, and competencies in geropalliative care.
   C. Improving nurses’ understanding of each other’s roles and settings.
   D. Sharing a common understanding of the standard of care for geropalliative care patients.

8. Mary is a 60-year-old, experienced nurse in the intensive care unit. She graduated from a diploma program 38 years ago and a baccalaureate program 30 years ago. She may be challenged by the content of geropalliative care for which of the following reasons:
   A. Palliative care is widely integrated into the intensive care setting.
   B. She recalls information from her formal education in geriatrics or palliative care.
   C. Recommended assessment skills were not a part of her educational experience.
   D. She has had little experience in the care of older, dying patients.

9. “What are the likely risks for this older adult and which interventions are appropriate?” is an example of the critical thinking around which of the following concepts:
   A. Targeted interventions.
   B. Use of age-appropriate protocols.
   C. Rules-based care.
   D. Patient care/time management skills.

10. Dr. Lesley Reece, a nursing educator, will know that she did her job when a nurse says, “Now with every one of my patients, geriatric or not, I plan walking ‘dates,’ a specific time in the day that I or a patient care associate will walk the patient because activity is so important.” This statement demonstrates that the nurse:
   A. Understood the concept of deconditioning.
   B. Changed his or her practice as a result of the education.
   C. Learned to delegate tasks.
   D. Implemented the concept of frequent contact with older patients.

**EVALUATION**
Must be completed for contact hour certificate to be awarded.

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<td>• Describe the learning components of a successful nurse residency program.</td>
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<td>• Describe the challenges of implementing and sustaining a nurse residency program.</td>
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<td>• Identify types of information gained from a variety of methods of formative evaluation.</td>
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Code: JCEN 1209
Leading the nation in geropalliative care with AgeWISE

When the The RN Residency: Transitioning to Geriatrics and Palliative Care Program first received funding from the Health Resources and Services Administration in 2007, no one anticipated it would become the sought-after national model it is today. The RN Residency Program is a six-month program that trains nurses in geropalliative care. During its three-year funding period at MGH, more than 100 nurses completed the program, which employs a three-pronged approach: education, clinical practice, and retention.

The RN Residency Program is designed to:
- strengthen the nursing workforce by improving knowledge, skills, and competencies in geropalliative care
- improve the quality of nursing care to older adults and their families
- retain both senior and junior nurses

This innovative program caught the attention of nursing leaders across the country, including Brenda Cleary, RN, director of the Center to Champion Nursing in America, who convened a special committee to accelerate national dissemination of the program. The Center to Champion Nursing in America is a joint initiative of AARP, the AARP Foundation, and the Robert Wood Johnson Foundation dedicated to ensuring that the country is producing highly skilled nurses who can provide accessible, affordable, quality health care, now and in the future. And since older adults account for about 50% of all hospitalized patients, it makes sense to share this program with as many nurses as possible.

In an effort to package the RN Residency Program in a way that would lend itself to duplication by other hospitals, the name was changed to AgeWISE, and some small changes were made to the curriculum to make it more accessible to a wider audience. To kick off expansion of the program, the MGH AgeWISE team (comprised of Barbara Blakeney, RN; Ed Coakley, RN; Constance Dahlin, RN; Deborah D’Avolio, RN; Dorothy Jones, RN; and Marion Rideout, RN, under the leadership of Susan Lee, RN) organized a four-day summit, held here in Boston, November 9–12, 2010.

With support from the Center to Champion Nursing in America, the AgeWISE team invited nurses from academic medical centers across the country to apply. Only applicants from Magnet-designated, NICHE-certified hospitals were considered. Ultimately, 36 nurses from six hospitals were invited to participate:
- NYU Langone Medical Center in New York City
- The University of Rochester Medical Center’s Strong Memorial Hospital in Rochester, New York
- University Hospitals Case Medical Center in Cleveland, Ohio
- St. Joseph’s Regional Medical Center in Paterson, New Jersey
- Sanford University of South Dakota Medical Center in Sioux Falls, South Dakota
- Nebraska Methodist Hospital in Omaha, Nebraska

Throughout the summit, participants received ‘train-the-trainer’ education on numerous geropalliative topics and heard presentations by MGH faculty and guest lecturers.
Early on, Brenda Cleary provided context by asking some provocative questions, such as: “What happens when all the registered nurses over the age of fifty retire from the workforce? What will that do to the quality and safety of patient care? Will that loss of knowledge be devastating to organizational performance and productivity?” She reminded us that AgeWISE is in alignment with the recent IOM recommendation to implement nurse residency programs and the Initiative on the Future of Nursing that advises state boards of nursing, accrediting bodies, government and healthcare organizations to support nurses’ completion of residency programs following completion of pre-licensure or advanced-practice degree programs or when transitioning to new clinical practice areas.

Other speakers were equally impressive. Muriel Gillick, MD, professor of Ambulatory Care and Prevention at Harvard Medical School/Harvard Pilgrim Health Care, spoke about, “The Denial of Aging.” Ellen Robinson, RN, clinical nurse specialist in Ethics, talked about, “Decision-Making in the Sunset of Life.” Angelika Zollfrank, MDiv, supervisor of Clinical Pastoral Education, spoke about “Spiritual Distress among Elders.” Noted researcher, Angelo Volandes, MD, shared information on the use of video aides to assist in end-of-life decision-making. Participants left the program with the tools and information they’ll need to implement AgeWISE programs in their own institutions. Over the next two years, each site will offer two, six-month residency programs as they receive on-going training from the MGH AgeWISE team through video- and telephone-conferencing and on-site visits.

At this critical time in the evolution of health care, AgeWISE is a unique and important program. It honors the embedded wisdom of senior nurses while drawing attention to the unique knowledge necessary to care for the complex needs of older adults. For more information about AgeWISE, contact Susan Lee, RN, AgeWISE project director, at 4-3534.
Introducing a novel approach to preparing our nursing workforce:

A nurse residency in geropalliative care
MODULE Number: 2

Physical Aspects of Care
MODULE 2: Physical Aspects of Care

Purpose
The purpose of this module is to describe the physical aspects of geropalliative care.

Introduction
Because the goal of palliative care is to alleviate suffering, the assessment, prevention, and management of physical aspects of care are extremely important. Geriatric syndromes are unique to older adults and are important considerations in geropalliative care. Pain is the most common physical symptom but equally distressing are dyspnea, nausea, fatigue, weakness, anxiety, depression, and bowel and bladder irregularities. Altered pharmacokinetics and polypharmacy complicate the choice of and response to drugs. In the hospital setting, chronic conditions may pale in comparison to the total hip replacement, for example, but astute practitioners of geropalliative care understand the need to consider how surgery will impact those conditions. We need to accelerate the adoption of knowledge to provide better care to our older adults, a medically complex population.

Implementation
Based upon the knowledge needs of your participants, we recommend you select and schedule topics that are most aligned with the goals that you have jointly targeted for your residents and for your pilot units. The concepts of frailty, iatrogenesis, chronic comorbid conditions, altered pharmacokinetics should be emphasized. In particular, focus on the unique nursing interventions that will provide safe passage during hospitalization. Nurses should take ownership of their unique and considerable contributions to prevent iatrogenesis, or as medicine phrases it, “Do no harm.” The IOM’s To Err is Human cites medical error as the 8th leading cause of death in the US. Helping nurses to learn and adopt safe practices for older adults and to cultivate a culture and a context of an elder friendly environment are the only ways we are going to keep older adults safe. Because most practicing nurses have never been formally educated in these areas, the content and context of these modules are extremely important. However, nurses have intuited much of this knowledge in their careers; they will “pick it up” very quickly. They may say, “We know this already.” Our response is, “Are you doing it? If not, why? What are the barriers? What’s it going to take to implement these excellent practices?” The challenge is to put this evidence into practice. The adoption of these practices will require sustained effort. Direct the teaching to early adopters who will be champions of the work on their units.
Assessment is “the new black.” By this we mean that assessment is the hottest thing in geriatric care; it is sweeping the country. Standardized assessment must become the standard of care. We have chosen just a few of the many new assessments available. Consider using the “SPICES” assessment for all older adults on your unit. Pre-print the assessment on index cards and collect this data anonymously on all older adults. After one month’s time, sum the positive scores on each element to arrive at a snapshot of the needs of older adults on your unit. This exercise is a great way to learn more about your older adult population. Perhaps, nurses can guesstimate ahead of time the percentage of the older adult population with each condition with a prize for the closest approximations.

**Suggestions for Scheduling Content Experts**

Module 2 has more content than any of the AgeWISE modules. It includes 2 ELNEC modules and 10 NICHE modules. You will want to distribute these over the course of the 12 class days. Much of your planning will depend upon your content experts’ availabilities. Always remember to keep plenty of time for discussion. Ask your content experts to speak for 45 minutes and reserve 15 minutes for questions. You may want to lead a follow-up discussion using transformative questions to initiate deeper learning on these topics.

- What do we need to do to make this happen? Who can help us? What are the resources on our unit? What are the barriers? What is the most important next step?
- Each of these topics is very important. Ask your participants to identify the most important new practice that needs to be implemented on their units. Enlist the support of your nurse manager/directors but remember to allow the participants to drive the change. It’s the only kind that sticks. AgeWISE must be frontline, bottom-up driven.
Foundational Knowledge

Schedule subject matter experts to teach the following module(s):

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<thead>
<tr>
<th>ELNEC Modules:</th>
<th>NICHE GRN Curriculum Modules:</th>
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<tr>
<td>• Module 2: Pain Management</td>
<td>• Module 2: Age-Related Changes in Health</td>
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<td>• Module 3: Symptom Management</td>
<td>• Module 4: Falls</td>
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<td>• Module 6: Function</td>
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<td>• Module 8: Medications</td>
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<td>• Module 9: Nutrition, Hydration, and Oral Health</td>
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<td>• Module 10: Pain</td>
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<td>• Module 11: Pressure Ulcers and Skin Tears</td>
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<td>• Module 12: Restraints</td>
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<td>• Module 13: Sleep</td>
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<td>• Module 14: Urinary Incontinence</td>
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Learning Objectives and Strategies

Upon completing the study of this topic, learners will be able to:

A. Understand the principles of pain assessment and management.
   1. Read NCP Domain 2: Physical Aspects of Care
      – Describe important physical symptoms.
      – Describe the importance of assessment, intervention, and evaluation.
National Consensus Project Domains and Corresponding National Quality Forum Preferred Practices

<table>
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<tr>
<th>DOMAIN 2: PHYSICAL ASPECTS OF CARE</th>
<th>PREFERRED PRACTICE 12</th>
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<td>ƒ Measure and document pain, dyspnea, constipation, and other symptoms using available standardized scales.</td>
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PREFERRED PRACTICE 13

ƒ Assess and manage symptoms and side effects in a timely, safe and effective manner to a level that is acceptable to the patient and family.

2. Read AACN Nurse Competencies 7, 8, 9, and 10.

3. Watch the movie Terms of Endearment.
Consider and discuss:
— The barriers to receiving effective pain management,
— The general public’s perspective on and perception of death.

4. Read the following chapters in Conversations in Palliative Care.
— Chapter 8: Pharmacologic Management of Pain,
— Chapter 9: Non Pharmacologic Management of Pain, and
— Chapter 11: Symptom Management.
Consider and discuss:
— Clinician-related barriers to patients receiving effective pain management;
— Clinicians’ perspectives on and perception of pain as it relates to dying and death.
B. Discuss the differences between management of these symptoms in hospice and palliative care versus conventional care.

1. Read NCP article “Preferred Practices for Physical Aspects of Care.”
   Consider the importance of structured tools for symptom assessment and evaluation.
   Discuss the symptom assessment and/or evaluation tools presently in use at your organization
   – How often are these tools used on your units?
   – How are such tools useful to you as the patient’s nurse?
   – What additional information and/or changes would you make to these tools?

2. Read EPERC Fast Facts No. 27: Dyspnea at End of Life
   Consider the challenges of treating pain and dyspnea in the older adult.
   **Reference:** EPERC – End of Life Palliative Care Resource Center. *Advancing End of Life Care through an Online Community of Educational Scholars*. Available online at http://www.eperc.mcw.edu.

3. From the perspective of symptom palliation, consider each of the following scenarios. What would be the focal issues in a nursing care plan?
   – Edna is a 70 year old female patient with end stage lung cancer with bone pain and dyspnea. She currently is very functional, with normal CBC and electrolytes. She has pain at night. She is on no other medications and has no known allergies.
   – Fred is an 80 year old male patient with end stage heart failure with fatigue, dyspnea, and chest pain. He has a 5 year history of the disease. He is already on diuretics, oxygen, and nitroglycerin. He is allergic to gabapentin and sulfa. His BUN is high and his Hct is low.
4. **Hourly Patient Rounding**

   Hourly patient rounding has been a popular trend over the past few years. Inouye’s article (see annotated bibliography below) describes quite eloquently that there are shared risk factors for geriatric syndromes. Based upon the body of evidence on hourly rounding (there is no robust evidence but what there is and common sense suggest that older persons will benefit by increased surveillance, pain assessment, repositioning, and toileting), we advocate the practice and believe that a three item intervention (pain, position, potty) will, in fact, yield 1) better pain management, 2) fewer pressure ulcers, 3) less incontinence, 4) fewer catheter-associated UTIs, 5) fewer falls, 6) greater patient and family satisfaction, and 7) less delirium. We look forward to testing these hypotheses with you over the next 18 months.
Additional Readings


Geriatric Resources

The following essential resources, provided by the Hartford Institute for Geriatric Nursing, are freely accessible and can be found at http://consultgerirn.org/resources

Geriatric Components Mapped to Functional Health Patterns (FHPs)

FHP #1: Health Perception—Health Maintenance
- *Try This* General Assessment Issue 16.2: Beer’s Criteria for Potentially Inappropriate Medication Use in the Elderly Part 2—2002 Criteria Considering Diagnoses or Conditions
- *Try This* General Assessment Issue 2: Katz Index of Independence in Activities of Daily Living (How to Try This Article and Video)

FHP #2: Nutrition—Metabolic
- *Try This* Dementia Series D11.1: Eating and Feeding Issues in Older Adults with Dementia: Part I Assessment
- *Try This* General Assessment Issue 20: Preventing Aspiration in Older Adults with Dysphagia (How to *Try This* Article and Video—and Spanish)
- *Try This* 9: Assessing Nutrition in Older Adults (How to *Try This* Article and Video)

FHP #3: Elimination
- *Try This* General Assessment Issue 11.1: Urinary Incontinence Assessment in Older Adults: Part I—Transient Urinary Incontinence (How to *Try This* Article and Video)
- *Try This* General Assessment Issue 11.2: Urinary Incontinence Assessment in Older Adults: Part II—Persistent Urinary Incontinence

FHP #4: Activity—Exercise
- *Try This* Dementia Series D4: Therapeutic Activity Kits
- *Try This* Dementia Series D6: Wandering in the Hospitalized Older Adult (How to *Try This* Article and Video)
- *Try This* Specialty Practice SP3: Cardiac Risk Assessment of the Older Cardiovascular Patient: The Framingham Global Risk Assessment Tools
FHP #4: Activity—Exercise (continued)
  − Try This Specialty Practice SP4: Vascular Risk Assessment of the Older Cardiovascular Patient: The Ankle-Brachial Index
  − Try This Dementia Series D1: Avoiding Restraints in Patients with Dementia (How to Try This Article and Video)
  − Try This General Assessment Issue 8: Fall Risk Assessment (How to Try This Article and Video)

FHP #5: Sleep—Rest
  − Try this General Assessment Issue 6.1: The Pittsburg Sleep Quality Index (How to Try This Article and Video)
  − Try This General Assessment Issue 6.2: The Epworth Sleepiness Scale

FHP #8: Cognitive—Perceptual
  − Try This Dementia Series D8: Assessing and Managing Delirium in Persons with Dementia (How to Try This Article and Video)
  − Try This General Assessment Issue 7: Assessing Pain in Older Adults (How to Try This Article and Video)
  − Try This Specialty Practice SP1: Assessment of Nociceptive versus Neuropathic Pain in Older Adults
  − Try This Dementia Series D2: Assessing Pain in Persons with Dementia (How to Try This Article and Video)
  − Try This General Assessment Issue 12: Hearing Screening in Older Adults—A Brief Hearing Loss Screener
Annotated Bibliography

Inouye, S., Studenski, S., Tinetti, M.E., & Kuchel, G. (2007). Geriatric syndromes: Clinical, research, and policy implications of a core geriatric concept. *Journal of the American Geriatrics Society, 55*, 780-791. This article takes a little more effort to read and understand but should be read and presented by faculty, at the very minimum. This article describes the shared risk factors for geriatric syndromes. This is a critical concept to nurses’ understanding their impact and how, through one intervention, nurses are altering the course of hospitalization. For example, let’s take the example of nursing rounds. On a routine basis, nurses (or assistants) speak with patients and walk them to the bathroom. This singular act will address all five geriatric syndromes discussed—it will help to prevent incontinence, falls, pressure ulcers, delirium, and functional decline, not to mention that patients/families will feel better cared for by routine surveillance. Note that we included this article in two places.

Mid Range Nursing Theories

Kolcaba, K. (2001). Evolution of the mid range theory of comfort for outcomes research, *Nursing Outlook, 49*(2), 86-92. Faculty may want to read this highly theoretical, classic article in order to present salient elements of the theory of comfort which is a goal of palliative care.

Lenz, E.R., Pugh, L.C., Milligan, R.A., Gift, A., Suppe, F. (1997). The middle-range theory of unpleasant symptoms: An update. *Advances in Nursing Science, 19*(3), 14-27. This article nicely frames the patient’s experience of multi-symptoms. When nurses understand what the authors call the multiplicative effects of multi-symptoms, they will better understand the importance of an impeccable history and assessment. Nurses can and do provide a lot of teaching around symptom management and in the palliative care setting, work with a multidisciplinary team to address these issues. In older adults, symptom management using medications, particularly those with anticholinergic and other sedating effects, puts older persons at higher risks for falls. “Start low, go slow” is always the mantra when adding medications to the regimen. Remind nurses that there are many simple interventions for symptom management that we assume patients know and are doing, when that is not the case.
**Formative Evaluation of Module 2**

1. **What was successful?**

2. **Where are the gaps?**

3. **Comments:**
Dear Colleagues:

It has only been three weeks since the AgeWISE Summit, and we in Boston are already missing you. We were thrilled to meet you! Our new colleagues, as well, have already achieved so much and we are looking forward to hearing from you in our webinars.

Congratulations to AgeWISE nurses for the tremendous achievements of their AgeWISE residency programs and their very interesting reports.

On the final day of the Summit, we put everyone to work, posing two questions:

1. How would you know an AgeWISE nurse if you saw one?
2. What should every AgeWISE nurse know?

We hope that answers to these questions will help expand upon our early work of AgeWISE competencies and interventions.

After a preliminary review, we found that attendees suggested over 135 competencies and 30 interventions. Once we synthesize the data, the total numbers may change.

Based on your feedback, I want to share with you a glimpse of an AgeWISE nurse. Please see p.2 of this issue.

Susan Lee, PhD, RN
AgeWISE Program Director
Geropalliative Care

A Concept Synthesis

Susan M. Lee, PhD, RN  Edward E. Coakley, MS, MA, MEd, RN

The aging demography of the United States and other first-world countries is increasing the demands for palliative care. Palliative care is a philosophical stance as well as an interdisciplinary model of care delivery, the goals of which are to prevent and relieve suffering and to support the best quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. The palliative care needs of older adults are not unlike those of younger adults but are confounded by a variety of phenomena related to aging. The purpose of this article was to describe a concept synthesis of geropalliative care. Using Walker and Avant’s method of concept synthesis, an electronic database search yielded 68 articles, the synthesis of which along with other evidence yielded 9 attributes of geropalliative care. To date, geropalliative care has been described from a disease perspective. The findings of this article begin to explicate the unique philosophical stance of geropalliative care as well as critical attributes that must be considered to provide the safest and best quality care to older adults and their families during the last 2 to 5 years of life.

KEY WORDS
concept synthesis, geriatric palliative care, geropalliative care

BACKGROUND AND SIGNIFICANCE

The catalyst for this “scholarship of integration” was the implementation of a nurse residency program in geropalliative care in an academic medical center. The purpose of the RN Residency: Transitioning to Geriatrics and Palliative Care was to increase nurses’ knowledge and competencies in caring for older adults during their last 5 years of life. The residency program was intentionally designed to expand the disease model of geriatrics to a functional, emotional, and social perspective of aging, in which palliative care was an integral component. The underpinning philosophy is aligned with the prevailing trajectory model of palliative care, which describes an approach to end of life as one in which palliative care plays a larger role and curative care plays a lesser role as the person approaches death.

The experiences of the core faculty who taught geriatrics and palliative care to RNs gave rise to new connections and meaning between the content of geriatrics and palliative care. Initially, areas of overlap were evident. For example, both geriatrics and palliative care emphasize the importance of interdisciplinary teams, patient- and family-centered care, alleviating suffering, and supporting the best quality of life. Eventually, new wisdom and insight were gained about the critical attributes of palliative care for older adults and the usefulness of palliative care as an organizing framework for care, irrespective of disease states. These observations evolved from nursing praxis and initiated the concept synthesis of geropalliative care. Although geriatric palliative care literature exists, no related theoretical framework was evident. Theory development in palliative care nursing is an essential step to advancing disciplinary knowledge for practice.

Palliative care is a philosophical stance as well as an interdisciplinary model of care delivery, the goals of which are to prevent and relieve suffering and to support the best quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. The palliative care needs of older adults are not unlike those of younger adults but are confounded by a variety of phenomena related to aging. The purpose of this article is to describe a concept synthesis in which we identified nine critical attributes of geropalliative care that differentiate the palliative care of older adults from that of younger or middle-aged adults.

The global aging demography will affect the United States such that one in five Americans will be 65 years or older by 2030. Dubbed the “silver tsunami,” or “the squaring of the population,” the number of older adults...
is expected to double by 2030. Although much has been written about the demands that will be placed on an unprepared healthcare system supported by a shrinking workforce, less has been written about the increased need for palliative care for older adults. There is a compelling need to identify the unique palliative care needs and preferences of older adults and to develop a healthcare workforce who can meet those needs. The demographics of age will challenge healthcare systems in many countries. There is a general agreement that more research is needed in the area of geropalliative care, and Goldstein and Morrison suggest areas of research foci that will fill gaps in current knowledge. Simultaneously, there is a need to clarify the underpinning philosophy of palliative care in the geriatric population.

**METHODS**

**Concept Synthesis**

Walker and Avant’s method of concept synthesis was used to define the concept of geropalliative care. Concept synthesis is a creative strategy in which phenomena are grouped in new ways. Concepts can be developed from observation, clinical experience, qualitative and quantitative data, or a combination thereof. Concept synthesis differs from concept analysis. The former is useful when few or no concepts are available or when the attributes are unknown; the latter is useful when the concept is already available in the area of interest.

Several assumptions were identified. First, geropalliative care is more than the sum of geriatrics plus palliative care; thus, the overlapping of phenomena would not suffice to accurately describe the concept. Second, all principles of palliative care apply to older adults but what is described in this article are those attributes of palliative care that are specific to older adults to provide safe and effective palliative care. They are not an exhaustive list but an early conceptualization. Finally, older adults are not a homogeneous group. The palliative care needs of older adults likely vary by age, which Callahan describes as young-old (65-74 years old), old-old (75-84 years old), and very old (85+ years old), as well as comorbidities, functional ability, cognitive status, and so on.

**Data Sources**

A search of CINAHL, MEDLINE, and PsychINFO databases between 1996 and 2010 was conducted using the key words palliative care and geriatrics. Articles were limited to English language with an abstract. Duplicate articles were deleted. The search yielded 68 records. Of those, 46 helped to identify or clarify the critical attributes of geropalliative care. Also examined were definitions by the World Health Organization and professional organizations, position statements, texts, and practice guidelines.

**Data Analysis**

The overall goal of concept synthesis is to reach theoretical saturation by becoming thoroughly familiar with a topic by using all potential sources of data. The focal concept of geropalliative care was tentatively chosen, and the literature was searched to answer the question, “What are the unique attributes of geropalliative care?” Phrased another way, “How is palliative care different for older adults than younger adults?” The steps in concept synthesis—searching, categorizing, reducing, and verifying—were followed in an iterative process, using qualitative, quantitative, and observational data.

The 68 articles identified in the search were thoroughly read and loosely categorized at the broad, topical level, if they provided any clarification to the focal concept of geropalliative care. During a second reading, clusters of phenomena, such as pain, delirium, communication, and so on, were identified and categorized using a constant comparative method. The levels of analysis were phrases in the literature. The phenomena were coded into 15 broad categories, which were further scrutinized to determine whether a hierarchical structure existed. Overlapping phenomena were reduced to higher-order concepts; frailty, polypharmacy, altered pharmacokinetics, dementia, delirium, and atypical presentations were reduced to the higher-order concept of geriatric syndromes for the sake of parsimony, yielding nine critical attributes (Table 1), each discussed below.

Decisions were made not to reduce some attributes to more generic headings, such as social, financial, and so on, to preserve more of the rich details so that our findings would be usable by clinicians in practice. Broad attributes were renamed to incorporate their multidimensions, when present. The pain literature, for example, encompassed assessment, reporting, management, and risks associated with pain medications. Qualitative decisions were made to rename all of these aspects into one attribute, that is, that older adults are at “higher risk for ineffective pain management” by virtue of underreporting, underassessing, and undertreating, as evidenced by research findings. Similar rationale was used when naming the attribute of “risk for ineffective communication,” designed to encompass the multidimensions of communication with older adults and their surrogates.

The literature was reviewed a third time to verify the identified attributes, requiring at least two sources per attribute. The authors “dwelt with the data” during which time further observations were made in practice. On verification, the attributes did not fit into any existing theory,
suggesting that geropalliative care was a new field. The findings were presented to palliative care nursing experts for verification. This resulted in further iterative work by returning to the literature and recoding.

**RESULTS**

We describe the nine critical attributes of geropalliative care (Table 1) that we propose distinguish geropalliative care from palliative care of adults younger than 65 years.

### TABLE 1: Nine Critical Attributes of Geropalliative Care

<table>
<thead>
<tr>
<th>Critical Attributes</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High risk for ineffective pain management</td>
<td>Pain in older adults is underassessed, underreported, and undertreated, especially in those with cognitive impairment.</td>
</tr>
<tr>
<td>2. Unpredictable trajectories</td>
<td>Older adults experience less predictable trajectories of illness.</td>
</tr>
<tr>
<td>3. Geriatric syndromes</td>
<td>Older adults are prone to geriatric syndromes, defined as common multidimensional conditions, which are associated with morbidity and mortality. The concept of homeostasis provides the framework for frailty. Polypharmacy and altered pharmacokinetics increase the risk for adverse drug effects. Delirium and dementia, alone or in combination, adversely affect prognosis. Atypical presentations demand meticulous assessments.</td>
</tr>
<tr>
<td>4. Chronic comorbid conditions</td>
<td>Chronic conditions increase complexity and the risk of preventable complications.</td>
</tr>
<tr>
<td>5. Shrinking social networks</td>
<td>Older adults experience shrinking social networks due to death of spouse, partners, and peers; reduced mobility and energy; cessation of driving; distance of family members, likely resulting in less social support.</td>
</tr>
<tr>
<td>6. Insurance limitations</td>
<td>Out-of-pocket costs are highest for persons with chronic health conditions or functional impairment. These persons are at risk of prescription medication omission or dose cutting.</td>
</tr>
<tr>
<td>7. Multiple settings</td>
<td>Older adults are more likely to be cared for across multiple settings, such as acute, subacute, long-term, home, and hospice settings, posing risks of discontinuity of the palliative care plan from one setting to the next.</td>
</tr>
<tr>
<td>8. Risk for ineffective communication</td>
<td>Older adults are more likely to experience ineffective communication due to sensory and/or cognitive deficits; the nature of decision making and communication with healthcare workers transfers with increasing age to surrogates.</td>
</tr>
</tbody>
</table>

High Risk for Ineffective Pain Management

The search results yielded the largest findings in the category of pain assessment and management, also the most rigorous, being predominantly research findings. Pain among older adults is commonly underreported, underassessed, and undertreated often because of misconceptions by patients, family, and providers. Kaasalainen et al identified the following misconceptions about pain in the elderly: (1) pain is misconceived by many to be a normal part of aging, (2) older people especially those with cognitive decline have decreased pain sensitivity, (3) opioid analgesics are too dangerous, and (4) the absence of pain reporting indicates that pain is not present. These beliefs are not correct and are barriers to effective pain management.

If misconceptions pose a threat to effective pain management among older adults, so does the real probability of adverse drug effects because of altered pharmacokinetics, polypharmacy, and multiple comorbidities. The issue of balancing adverse effects with adequate analgesia among older adults is complex. However, because undermanaged pain among older adults is prevalent across settings, all providers caring for...
older adults need knowledge of effective pain assessment and management to prevent unnecessary suffering. Older patients, particularly those with cognitive impairment, are less likely to receive adequate pain management even with similar disease burdens. The criterion standard for pain assessment is self-report, which can be reliable even with mild to moderate cognitive decline. Observational tools are emerging for older adults with severe cognitive impairment, two of which demonstrated validity in a recent systematic review—the Pain Assessment Checklist for Seniors with Limited Ability to Communicate and the DOLOPLUS2. The high risk for ineffective pain management is listed as the first critical attribute of geropalliative care because of the sheer volume of literature in the area. The remaining critical attributes are not in any rank order.

Unpredictable Illness Trajectories

A commonly held myth is that older people will remain healthy and robust until they die, a myth that Gillick asserts prevents older Americans from planning for the future. Lynn and Adamson describe a framework that categorizes three end-of-life (EOL) trajectories among older adults (Figure 1) that could be the basis of advance care planning discussions.

In the first trajectory, the course of illness begins when the older adult is at a high level of function and health, and it is characterized by a short period of decline. Eventually, the disease is overwhelming, and older adults experience a sharp decline in weeks to months. This trajectory is most often associated with cancer, and hospice care can play an important role in EOL care. About one-fifth of all deaths follow this pattern.

In the second trajectory, the course of illness begins when the older adult is at a moderate functional level, is typically long, and is punctuated with several episodes of acute hospitalization, after which patients never regain their prehospitalization states. Associated conditions are congestive heart failure and chronic pulmonary disease. Death is unpredictable and often comes suddenly from an exacerbation. About one-fifth of all deaths fit this pattern. Referrals are increasingly made to palliative care for patients with chronic diseases, but because death is so unpredictable, referrals to hospice are often made very late.

In the third trajectory, the course of illness begins when the older adults is at a lower functional level. There is a long, steady decline, which often leads to institutional care for conditions such as dementia, stroke, and frailty. About two-fifths of all deaths fit this pattern. Dementia has historically not been viewed as a terminal disease, although it is now beginning to be viewed as such, and because the period of decline is so prolonged, referral to hospice has been unlikely. The final one-fifth of all deaths fall into “other” categories.

Geriatric Syndromes

Geriatric syndromes are commonly associated with geriatrics and palliative care. Geriatric syndromes are not disease states, per se, but common conditions in older age that are associated with increased mortality and morbidity. Also called the hallmarks of geropalliative care, geriatric syndromes include dementia, delirium, urinary incontinence, falls, pressure ulcers, sleep disorders, mealtime difficulties, vision and hearing problems, polypharmacy, and frailty. Although they are not life-limiting, they threaten quality of life among older adults, often increase length of stay among hospitalized older adults, and are frequently the cause of admission to a residential care home.
syndromes are ubiquitous in the setting of geropalliative care and have far-reaching implications for practice. All geriatric syndromes impact and confound geropalliative care, specifically:

- Frailty is defined as a physiologic state of increased vulnerability to stressors that results from decreased physiologic reserves, and even dysregulation, of multiple physiologic systems.\(^2^2\) Frailty, which affects 40% of adults older than 80 years, leads to narrow windows for intervention, after which the spiraling cascade of decline may not be reversed.
- Polypharmacy and altered pharmacokinetics. Polypharmacy, the use of multiple medications and/or the administration of more medications than are clinically indicated, or representing unnecessary drug use,\(^2^3\) is a risk factor for morbidity and mortality. Compared with younger and middle-aged adults who are receiving palliative care, older adults are more likely to be taking medications for comorbid conditions and are more likely to have adverse drug effects. In addition to polypharmacy, pharmacokinetic parameters, states Brown,\(^1^2\) such as distribution, metabolism, and elimination, will be affected by age-related physiological changes such as increased body fat, decreased muscle mass, decreased plasma proteins, and reduced hepatic and renal function. Polypharmacy and altered pharmacokinetics are inherent in geriatrics.
- Dementia, a terminal illness, has been defined as a complex of symptoms characterized by progressive global deterioration of cognitive functioning,\(^2^4\) and is associated with a shorter life expectancy, greater functional decline, and higher mortality. It is important to realize that persons with dementia are at increased risk of having a symptom burden that is both greater and longer lasting.
- Delirium is an acute confusional state,\(^1^8\) that frequently occurs in the palliative care setting. Its cause is multifactorial and not clearly understood. In one study, older adults with persistent delirium were three times as likely to die in the following year.\(^1^8\)
- Atypical presentations are common among older adults who frequently present to the emergency department with delirium, signaling infection, or other disease processes.\(^2^5\)

**Chronic, Comorbid Conditions**

Palliative care has its roots in the setting of cancer but is becoming more commonplace in the setting of chronic conditions, of which most older Americans have at least one (82%) or two (65%) chronic conditions, and some will have three (43%) or four (24%).\(^2^6\) Compared with younger and middle-aged adults who are receiving palliative care, older adults are more likely to have comorbid conditions and functional dependence.\(^2,^1^7\) The risk of an adverse event rises dramatically with the number of chronic conditions,\(^2^4\) and each of these chronic conditions needs to be integrated into a plan of care.\(^2^7\)

Furthermore, because clinical trials focus on single conditions, less is known about the actions of new drugs on persons with comorbid conditions or those taking multiple medications.\(^2\) In the case of frailty, older adults have little reserve so that they can tolerate far less insult in terms of disease burden or medications before decompensating. Therefore, chronic, comorbid conditions add complexity and risk to the management of older adults receiving palliative care.

** Shrinking Social Networks**

Shrinking social networks mean fewer resources to support older adults with their palliative care needs.\(^2^8\) Very old adults have likely experienced losses such as death of peers, family members, and pets; the cessation of driving; and the onset of disability, frailty, or incontinence, all of which threaten social integration.\(^2^9\) Older adults, particularly baby boomers, will have fewer children to care for them, and those children will likely be working, raising families, and living greater distances from their parents.\(^3^0\) Elders with small social networks are at risk for self-neglect, developing dementia, and institutionalization.\(^2^0,^3^1-^3^3\)

**Insurance Limitations**

Experts agree that Medicare, a highly successful program for hospital and hospice care, has been profoundly inadequate for older adults who are frail, those with chronic conditions, and those who need supportive assistance in their homes.\(^1^6,^1^7\) Lynn\(^1^8\) writes that our current system forces people to “patch together” their own care because supportive care does not exist for Medicare recipients, particularly for the 4.5 million older adults with Alzheimer disease (www.nia.org), as well as those requiring nursing home care, which is not considered skilled care.

Older adults, especially those with chronic health or functional impairment, have higher out-of-pocket costs than younger adults.\(^3^5\) In 2008, one-quarter of all Medicare beneficiaries reached the coverage gap (also known as “doughnut hole”) in the Part D prescription drug plan,\(^3^6\) meaning they had to pay 100% of prescription costs for a period. Therefore, older adults receiving palliative care are at risk for unmet functional and other needs, higher out-of-pocket costs, and medication nonadherence due to their inability to afford prescription drugs.

**Multiple Settings**

One of the features of Medicare, suggests Gillick,\(^1^6\) is that the diagnosis-related group system of care incentivizes early discharge, which result in multiple transitions. Transitions result in discontinuity, so that it is unlikely that the palliative care plan, which began in the acute
care setting or subacute setting, would follow older adults across settings.15,37 “Medicare undermines the goal of comfort. The result is needless suffering as well as a high price tag.”16(p103) Medicare pays for acute illness and end of life, but not the chronic care in between. A new generation of advanced practice palliative care nurses is leading innovative models of palliative care designed to implement treatment plans that stay with patients across settings.36 Although still in their infancy, these new models hold promise.

**Risk for Ineffective Communication**
Communication is a cornerstone of palliative care, the process by which support systems, team approaches, bereavement counseling, and understanding needs, values, and preferences of patients and families are ascertained. However, communication changes with advancing age. Older adults are more likely to experience impaired communication due to sensory and/or cognitive loss. In geropalliative care, as in geriatric healthcare, clinicians are more likely to include family in all conversations. Decision making often involves surrogates as patients age.

**Irrespective of Disease**
The roots of palliative care began in cancer care, but a trend now is toward chronic care, particularly addressing symptom distress and quality of life in persons with congestive heart failure39 and chronic obstructive pulmonary disease. An even newer trend in the literature is the shift away from the “life-limiting illness” criterion toward a “limited life span” criterion by virtue of advanced age, irrespective of disease. This philosophy rests on the position that quality of life is the most important consideration for older adults and that all efforts should be directed to enhancing well-being and quality of life in the latter years. It rests on ethical principles of beneficence and nonmaleficence.40 In the setting of chronic diseases including Alzheimer disease, where there are no effective curative treatments, the emphasis should be on symptom management.41 Other nurse authors agree that “Geriatric palliative care is an approach to care for chronically ill and frail older adults.”42(p33) In a 2004 concept analysis of palliative care, Meghani13 predicted that the future of palliative care will be “completely independent of any advanced progressive illness criteria” because its potential goal is the “humanization of the patient-family care experience for all care recipients.”43(p550) Some physicians also subscribe to this philosophy.16,17

**Attributes of Geropalliative Care**
Geropalliative care is both a philosophical stance and a structured, interdisciplinary model of care delivery that guides care to patients and families during the last 5 years of life, irrespective of disease. Geropalliative care encompasses the core moral values of palliative care while recognizing that nonmaleficence and beneficence require specific knowledge of age-related phenomena to optimize the last years of life for older adults and their families. The goal of geropalliative care is to promote well-being to older adults and their families through interventions that reduce suffering and enhance quality of life. The critical attributes of geropalliative care include high risk for ineffective pain management, geriatric syndromes, and chronic, comorbid conditions, all within the context of unpredictable EOL trajectories, shrinking social networks, insurance limitations, multiple settings, risk for ineffective communication, and beneficial in the absence of disease.

**DISCUSSION**
This concept synthesis of geropalliative care is a creative strategy to organize and understand knowledge in new ways to align practice with the needs and preferences of older adults and their families in the last 5 years of life across settings and irrespective of disease. Charcot said, “We see what we know,”44(p417) and knowing then becomes the moral imperative in caring for older adults. Clinicians need to know and understand homeostasis, which is narrowed homeostatic reserve, frailty, geriatric syndromes, the layering effects of multiple chronic comorbidities and medications, and so on. Older adults require vigilance—clinicians who are anticipating, expecting, recognizing, preventing, and treating commonly occurring syndromes and illness presenting in atypical ways. Standardized assessments exist and are nationally available for dementia, delirium, function, mobility, incontinence, frailty, sleep, pressure ulcers, pain, falls, nutrition, pain, executive dysfunction, eating and feeding issues, and many others.45 Ferrell and Coyle46 state that “Suffering is a human response to actual or potential illness, and the relief of suffering is at the core of nurses’ work as a profession.”46(p246)

The focus of this article, the “what” of geropalliative care, is a step toward conceptual clarity. We acknowledge that this concept is implicit in existing literature and texts that describe the “how.” Nevertheless, making geropalliative care explicit through concept synthesis may help us to better face the challenges before us—aging boomers, increasing technology, spiraling healthcare spending, a threatened Medicare fund. Finally, and most importantly, geropalliative care is person- and family-centered, meaning that their values, needs, and preferences are the directives for care.

**References**


The National AgeWISE Pilot

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AgeWISE is a 6-month nurse residency program designed to prepare hospital nurses to meet the needs of older adults, a population that comprises nearly 50% of all US hospital admissions. The goal of AgeWISE, now being piloted in 12 hospitals in the United States, is to produce a tested and refined national model for building geropalliative care capacity among hospital nurses.

The 2011 Institute of Medicine (IOM) report, The Future of Nursing: Leading Change, Advancing Health (Future of Nursing), calls for nurses to assume leadership positions and to serve as full partners in healthcare redesign and improvement efforts. The present and future challenges of caring for America’s aging population bring unprecedented leadership opportunities for nurses to assume new roles and responsibilities, such as care coordination, and to innovate new models of care that are better aligned with the values and preferences of older adults and their families. Older adults comprise, on average, 50% of all US hospital admissions. Recent findings confirm that hospitalization is a sentinel event for frail elders, often leading to a cascade of decline.

Although fewer older adults are dying in hospitals, more of them are receiving aggressive medical care at end of life, actions that may not be aligned with their personal wishes. Palliative care, a newer specialty, offers older patients and their families a concurrent approach to chronic and life-limiting illness. Through an interdisciplinary approach, palliative care focuses on improving quality of life. Older adults will have greater access to palliative care when bedside nurses have this specialized knowledge.

A critical need exists to build geriatrics capacity among the hospital nursing workforce as evidenced by less than 1% of all US nurses holding geriatrics certification. The overwhelming quality and safety issues in clinical care are best addressed by nurses possessing state-of-the-science knowledge and implementing evidence-based interventions that will enhance safety and well-being, such as hourly rounding and improved communication among the healthcare team. Given that the majority of US nurses received a paucity of geriatric content in their nursing programs, nursing’s moral covenant with society demands that geriatrics-focused continuing education be strengthened nationwide. The knowledge generated in geriatrics and palliative care during the past 20 years needs to be readily available at the bedside, for the good of the patient.

The National AgeWISE Pilot

The Future of Nursing reports that major changes in the US healthcare system and practice environment will require equally profound changes in the education of nurses both before and after they receive their licenses. Nurse leaders at Massachusetts General Hospital (MGH), inspired by the spirit of the Future of Nursing, created and disseminated AgeWISE, a nurse residency program in geropalliative care, defined as patient-centered care of frail older
adults in their last 2 to 5 years of life. AgeWISE translates a body of research knowledge to the bedside using transformative learning strategies in the classroom setting and nurse-driven, performance improvement in the clinical setting. Nurse residency programs, promoted when nurses transition to new specialties, can be an effective way to fill a critical knowledge-practice gap among practicing nurses. Acute care nurses across adult specialties are trained to be geropalliative care nurses, working alone or in collaboration with palliative care consult services and in their existing specialty areas (eg, critical care nursing). In this article, the authors discuss the creation and dissemination of AgeWISE, which is currently being pilot tested in 12 hospitals (see Table, Supplemental Digital Content 1, http://links.lww.com/JONA/A81) across the United States.

Background

AgeWISE was adapted from the RN Residency: Transitioning to Geriatrics and Palliative Care (RN Residency), a program funded by the Health Resources and Services Administration from 2007 to 2010. RN Residency was implemented as a multi-generational program designed to build geropalliative capacity in the nursing workforce, retain nurses, and improve the care to older adults and their families. Geropalliative care has the potential to alleviate suffering and improve quality of life for older adults who are living with frailty or chronic illness, such as Alzheimer’s disease or heart failure, from which they will not recover. Over the 3-year funded period, 108 nurses completed RN Residency at MGH, resulting in deepened commitment to providing high-quality nursing care to frail, older adults using newly acquired competencies. RN Residency recruited care dyads, consisting of a more experienced nurse paired with a less experienced nurse, from many adult units throughout the hospital. The care dyads worked to integrate new knowledge into practice at the unit level as well as to provide mentorship for practicing nurses. A major message of RN Residency was the critical role that nurses play in shaping the care environment for older adults—nutrition, early mobility, safety, effective communication, and frequent human interaction—so that function is preserved, and healing can occur.

Summative evaluation of RN Residency demonstrated a significant improvement in job engagement. Job engagement has been highly correlated with nurse retention, which was one of the goals of the residency. The majority of residents reported that they felt empowered and more confident in discussing end-of-life issues with patients, families, and other members of the healthcare team. The residents reported feeling reinvigorated in their careers and more attuned to the unique needs of older patients, often sharing clinical stories of how they successfully implemented new knowledge and skills. Residents also reported forming deeper connections with older patients, what Newman calls “expanding consciousness—a process of becoming more of oneself, of finding greater meaning in life, and of reaching new heights of connectedness with other people and the world.” Watson calls this a “deep awakening” of understanding of humanity, human dignity, and wholeness. Specific skills such as mindfulness, listening, authentic presence, and creating a healing environment resonated with RN residents.

RN Residency was fundamentally unique. Unlike most nurse residency programs that aim to socialize novice nurses into their 1st professional positions, Residency fills a critical knowledge-practice gap, bringing knowledge in geriatrics and palliative care to the bedside. The teaching methods veer from didactic, “on-the-run” teaching, instead engaging nurses in transformative, participatory learning that is more likely “to stick.” Utilizing the rich resources of embedded knowledge and wisdom embodied in the expert nurses to engage and mentor the competent nurses and enlisting a group of 10 nurses per clinical unit may lead to new care delivery models, enhanced teamwork, and a more open culture that supports new geriatric practices.

The success of the RN Residency was, in large part, due to the teaching method used—transformative learning. Now considered standard in adult education, transformative learning is a way of actively engaging learners to rethink what they know. The authors assert that transformative learning may be the best way to help nurses “let go” of tradition-based practices in geriatrics—that is, use of side rails, restraints, urinary catheters—and to advocate that patients’ eyeglasses, hearing aids, shoes, and mobility devices be brought to the hospital setting to keep them safe, promote mobility, and prevent delirium. Advances in practice sometimes occur only after nurses examine their beliefs that underpin current practice.

Nursing leaders in the Center to Champion Nursing in America (CCNA), an initiative of the Robert Wood Johnson Foundation, American Association of Retired Persons (AARP), and AARP Foundation, recognized the potential impact of the RN Residency nationally, not only for its benefits to the nursing workforce but also for older patients and their families. Providing technical and other resources, the CCNA encouraged the authors to disseminate the
residency program—renamed AgeWISE—to hospi-
tals nationally.

**Description of the Pilot**

Nurses at MGH who had developed and imple-
mented the RN Residency transitioned to similar
roles on the MGH AgeWISE core team. The core
team was assisted by a national advisory commit-
tee, convened with the assistance of CCNA leaders.
It was decided that 6 geographically dispersed hos-
pitals would be selected to pilot AgeWISE in 2011.
An additional 6 hospitals would be added in 2012.
The authors decided to create AgeWISE as a unit-
level intervention, recruiting 10 champions from
each participating unit. The assumption was that to-
gether the 10 nurses would be more likely to ad-
vance and sustain a unit culture that supported more
erlder-sensitive care than 1 or 2 alone could.

**Pilot Site Criteria**

To facilitate success, the advisors suggested that
only top-performing hospitals be included in the
pilot. Therefore, Magnet hospital designation was
the 1st criterion for participation. A 2nd criterion
was that the pilot hospitals be Nurses Improving
Care to Healthsystems Elders (NICHE) member
hospitals, demonstrating a strong commitment to
building geriatric capacity and access to all NICHE
curricular materials. Additionally, hospitals were re-
quired to commit resources and demonstrate their
capacity to implement 2 successive 6-month residencies. AgeWISE would be implemented at each site
by 6 nurses fulfilling unique roles in the program
(Table 1). Hospitals were required to enlist the as-
sistance of local faculty committed to using trans-
formative learning methods, the bedrock of the
AgeWISE program.

**Recruitment of Pilot Sites**

The MGH AgeWISE core team disseminated a pro-
gram announcement through various digital mail-
ing lists. The AgeWISE pilot was announced at a
meeting of the 30 state teams at the CCNA. Hos-
pitals were invited to submit proposals, the curric-
ulum vitae of the proposed AgeWISE site team
members, a support letter from the chief nursing
officer, and a brief description of their organiza-
tion. Site teams are responsible for implementing the AgeWISE residency at their hospitals. Advisory
board members assisted the MGH AgeWISE core
team in reviewing and scoring the proposals using
an established grading scheme. The top-ranking
sites were selected: 6 for the 2011 cohort and 6 for
the 2012 cohort. In total, approximately 36 hos-
pitals inquired about the program. Once the sites
were accepted, the AgeWISE program director at
MGH held preliminary conference calls with site
teams to brief them on the program and to answer
questions.

**Initial and Continuing Training**

The overall design of the AgeWISE pilot uses a
train-the-trainer model. The MGH AgeWISE core
team provides initial and continuing training to the
site teams who are expected to plan and implement
the residency at their hospital. The initial training
occurs at the AgeWISE Summit, a 4-day training

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**Table 1. Roles and Responsibilities of the AgeWISE Site Teams**

<table>
<thead>
<tr>
<th>Role</th>
<th>Requirements</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site director</td>
<td>PhD-prepared nurse</td>
<td>Promotes faithful implementation of the AgeWISE residency, specifically the use of transformative learning; procures adequate resources for the residency</td>
</tr>
<tr>
<td>Site coordinator</td>
<td>MS-prepared nurse</td>
<td>Performs all duties associated with project management; promotes adoption of best practices; sustains the momentum</td>
</tr>
<tr>
<td>Senior nurses²</td>
<td>Older, experienced (age 45+ with 20+ years of experience) expert nurses</td>
<td>Champions the AgeWISE projects on their units; promotes adoption of best practices</td>
</tr>
<tr>
<td>Nurse manager</td>
<td>No specific requirements (varies per hospital)</td>
<td>Supports the AgeWISE residency by ensuring nurses are scheduled to participate; promotes the adoption of best practices as championed by the AgeWISE nurse residents</td>
</tr>
<tr>
<td>Site researcher</td>
<td>PhD-prepared nurse</td>
<td>Submits IRB proposal; participates in formative and summative evaluation with MGH Core Team</td>
</tr>
</tbody>
</table>

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conference held in Boston, Massachusetts. The 1st day of training, “Introductions,” is aimed at introducing participants to the AgeWISE program as well as to each other. AgeWISE aims to foster a learning collaborative promoting sharing between sites. The 2nd 2 days of training, “Immersion,” reenacts 2 classroom days of AgeWISE education by modeling transformative learning related to a number of geropalliative care topics. The 4th day, “Implementation,” focuses on assisting site teams to plan for their programs when they return to their organizations.

The site teams plan two 6-month residencies over a 12-month period. The site teams enlist expert faculty from their own hospitals or their local academic nursing partners. Once the sites have started their residency programs, the core team makes site visits to provide additional training and mentoring. A variety of interventions are used to sustain the momentum: monthly telephone conference calls, webinars, and newsletters. Both the core and site teams rotate the responsibility for presenting monthly webinars to promote knowledge sharing regarding best practices, successes and challenges.

AgeWISE Nurse Residents

The AgeWISE residency program requires that 10 nurses from each participating unit complete the 6-month training in care dyads—a more experienced nurse partnering with a less experienced nurse. Together, these care dyads are responsible for attending all classes and working together to complete a performance improvement initiative on their unit. The unit-level intervention was designed to provide a critical mass of nurses who would advance a geropalliative care agenda for their unit. Lessons learned from RN Residency suggested that the residency program would be most effective if more nurses participated from a single patient care unit.

The AgeWISE residency continued the tradition of the RN Residency of holding biweekly class days over 6 months. During that time, the residents are expected to create and implement performance improvement projects on their units. AgeWISE residents attend 96 hours of classes in the program. The recruitment for the AgeWISE residents varied among sites; some residents were chosen by their nurse managers, whereas others self-selected. During the pilot, approximately 240 nurse residents will participate in the AgeWISE residency along with 36 site team members.

AgeWISE Toolkit

AgeWISE is an implementation model, incorporating existing, cutting-edge, evidence-based curricula, delivered in a transformative way to the learner, thereby enhancing the adoption and sustainability of knowledge into nursing practice. The AgeWISE toolkit was developed not as a prescriptive curriculum but as a portfolio of learning activities easily customizable to guide each site team in the implementation of AgeWISE. The toolkit was centered on the 8 domains of palliative care defined in the national consensus project: (1) the structures and processes of care domain; (2) the physical domain; (3) the psychological and psychiatric domain; (4) the social domain; (5) the spiritual, religious, and existential domain; (6) the cultural domain; (7) the imminently dying domain; and (8) the ethics and the law domain. To those 8 domains, the authors referenced geriatric topics from the NICHE geriatric resource nurse curriculum as well as topics from the end-of-life nursing education consortium. Specific modules—communication with physicians, patients, and families and a simulation scenario—were added to empower nurses with more effective language and skills, particularly around end-of-life discussions. Each module focuses on expanding nurses’ understanding of where they are located in the big picture of healthcare. Most importantly, the teaching emphasizes the crucial role nurses play in making the hospital experience better and safer for each older patient and family. Conceptual work was also included in order to explicate the philosophical underpinnings of the emerging specialty of geropalliative care.

Recognizing that each site was unique, the toolkit was designed to be flexible and easily tailored to the specific needs of each site. For example, some sites have been NICHE member hospitals for many years, suggesting nurses may have received ongoing geriatric education. Those site teams may choose to emphasize the palliative care needs in the older adult population. Site teams could utilize their clinical metrics in falls, pressure ulcers, urinary catheter use, and so on, to determine the clinical learning needs. Beyond the content area needs of each site, the education method of transformative learning is emphasized throughout the toolkit. Site teams are encouraged to reserve about one-third of classroom time for case studies and discussion, which were highly valued by previous residents.

Evaluation

The AgeWISE conceptual framework suggests that, in the setting of excellence (Magnet and NICHE hospitals), nurses who participate in AgeWISE, taught within the context of transformative learning and expert mentorship, will improve the quality of care to older adults and their families (patient-level outcomes),
achieve new competencies in their jobs (nurse-level outcomes), and positively impact the health system and improve nurse retention (systems-level outcomes). AgeWISE uses realistic evaluation,16 chosen to explicate not only the process variables of the program, but also the contextual variables that may serve to explain the degree of success achieved at each site. The 3 levels of outcomes, that is, nurse-level, unit-level, and organizational-level, are currently being evaluated through survey research, focus groups, observation, and administrative data. The AgeWISE pilot has received approval or exempt status from the institutional review boards (IRBs) at MGH as well as each pilot site.

Discussion

AgeWISE provides nurses on several levels opportunities to assume leadership positions and to serve as full partners in healthcare redesign and improvement efforts. On a national level, the creation of a broad learning collaborative provides opportunities to create and disseminate best practices that address pressing problems in the acute care setting. One early webinar presentation by a site team described how its hospital environment successfully became restraint-free. Another webinar presentation by a site team described how nurses on 1 unit raised Hospital Consumer Assessment of Healthcare Providers and Systems17 scores through multilevel interventions. When staff nurses become aware that staff nurses at other hospitals were able to impact care delivery in such monumental ways, they are empowered and motivated to do the same on their units. This model for change is likely more effective than the top-down model that prevails.18 In fact, The Advisory Board, frowning upon successive campaigns for mission-critical priorities, views frontline accountability as a stronger model.18 AgeWISE focuses on the pivotal role of frontline nurses and invites them to practice at a new level of practice, empowered with new competencies. AgeWISE provides nurses at the bedside opportunities to innovate practice changes and create new care delivery models and policies, thus meeting the IOM recommendation that nurses see policy as something they can shape rather than something that happens to them.1

Acknowledgments

The authors thank Jeanette Ives Erickson, DPN, RN, FAAN, senior vice president for Patient Care and chief nurse at MGH, for her leadership and support in this project as well as the chief nursing officers and teams at the pilot sites for their efforts on behalf of AgeWISE. They also thank Susan C. Reinhard, PhD, RN, FAAN, senior vice president for Public Policy, AARP, and chief strategist, CCNA, for her support in the dissemination of AgeWISE.

References

Important Notes
Seating for concurrent sessions is on a first-come, first-served basis. Pre-selection of sessions during registration does not guarantee seating; however, it aids in the planning of room assignments to accommodate attendance.

~NEW~ Some concurrent sessions will repeat during the final concurrent time block on Friday, October 12. The decision of which session to repeat will be based on registration data so be sure to indicate your session preference during registration. This will ensure the most popular sessions are put in the largest rooms and may be repeated on the final day of the conference.

Education Tracks
To help you focus your selections, we have created the following program tracks based on components of the Magnet model:

- EPP – Exemplary Professional Practice
- NKII – New Knowledge, Innovations, and Improvements
- TL – Transformational Leadership
- SE – Structural Empowerment

~NEW~ Key Words
To assist with session selection key words have been added to the descriptions.

Wednesday, October 10

11:30 AM – 12:30 PM

C001 - Theater in the Round: Using Role-Playing to Improve Patient Satisfaction Scores
Track: EPP
Key Word(s): Patient satisfaction
As "pay for performance" evolves, acute care hospitals are challenged to bring about improvement in patient satisfaction scores and engage all employees in exemplifying a culture of service. Role-playing has proven to be a creative way of assisting with this initiative for one hospital.

Learning Objectives
#1: Describe how role-playing can be a powerful learning strategy to promote positive patient outcomes
#2: Explain how role-playing can enhance communication and attitudinal skills, and offer a platform for discussion

Author(s): Janine Sharer, MS, RN - UPMC St. Margaret, Pittsburgh, PA

C002 - Advancing the Profession: Creating a Comprehensive Model of Best Practices Internationally
Track: EPP
Key Word(s): International, Cultural Competence
This presentation will focus on the experience of an advanced practice oncology nurse serving as an international clinical expert. Details of planning and developing content for an international nursing audience as well as aspects of cultural sensitivity, ethical decision-making, and fostering measurable patient outcomes will be highlighted.

Learning Objectives
#1: Describe the development of a best practices clinical model for international nursing colleagues
#2: Develop a leadership style founded on expert clinical care resulting in measurable patient outcomes

Author(s): Susan Behrend, RN, MSN, AOCN and Lisa Fischetti, RN, MSN, OCN - Fox Chase Cancer Center, Philadelphia, PA

C003 - EP 1: A How-To Matrix for Evaluating Your Professional Practice Model
Track: EPP
Key Word(s): Data / Outcomes, Nursing Model
This session will describe an evidence-based, "how to" matrix that can be used by nurses at all levels and from all settings to evaluate their professional practice model. A practical approach to address a key component of Magnet Source of Evidence, EP1 will be discussed.

Learning Objectives
#1: Identify the essential elements in a comprehensive matrix designed to evaluate PPM effectiveness
#2: Describe process and outcomes of matrix use and applicability to important aspects of EP1

Author(s): Maura McQueeney, BSN, MPH, NE-BC and Kathleen Stolzenberger, PhD - Middlesex Hospital, Middletown, CT

Edited 5/11/2012  SUBJECT TO CHANGE
The implementation of a pilot peer review education and competency program enhanced nurses' knowledge and skills to support engagement in peer review activities. This session will share how data analysis and the action plans developed enabled nurses to better understand the peer review process.

**Learning Objectives**

#1: Describe the competency and education program utilized to enhance nurses' understanding of peer review

#2: Discuss use of data to develop a peer review competency and education program.

**Author(s):** Mary Kate FitzPatrick, MSN, CRNP-BC - The Hospital of the University of Pennsylvania, Philadelphia, PA

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**C095 - Reach for the Stars Through Participation in NDNQI Research**

Track: NKII

**Key Word(s):** Data / Outcomes, Research

Magnet organizations demonstrate achievement of Magnet model component New Knowledge, Innovations, and Improvement through conduct and use of research. Since 2009, an average of 98 Magnet organizations participated in eight NDNQI studies. We will discuss how to join an NDNQI study, resources needed, and outcomes from selected studies.

**Learning Objectives**

#1: Discuss how organizations can participate in NDNQI research studies

#2: Discuss outcomes of selected NDNQI studies.

**Author(s):** Diane Boyle, PhD, RN - University of Kansas, Kansas City, KS; and Catima Potter, MPH - University of Kansas School of Nursing, Kansas City, KS

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**C096 - Ready, Set, Go! Innovation and Peer Support Launch Our Patients to a Successful Discharge**

Track: NKII

**Key Word(s):** Communication, Technology

The patient discharge process ensures the patient not only receives the knowledge and skills necessary for self-care, but can verbalize and demonstrate vital self-care measures. This session will describe an innovative education methodology, using technology appealing to the adult learner.

**Learning Objectives**

#1: Describe innovative strategies to promote a successful patient discharge process.

#2: List the steps to conduct peer audits and peer coaching to sustain positive outcomes.

**Author(s):** Debra Polster, MS, APN, CCRN, CCNS; Virginia "Ginger" Morse, PhD, RN, NEA-BC; and Kelly Poirot, BSN, RN, PCCN - Advocate Illinois Masonic Medical Center, Chicago, IL

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**C097 - The Massachusetts General Hospital AgeWISE™ Pilot**

Track: NKII

**Key Word(s):** Gerontology

Frail, hospitalized elders are at increased risk of incurring harm and receiving care that is not aligned with their needs and preferences. In response, Massachusetts General Hospital has developed and disseminated MGH AgeWISE™, a six-month nurse residency program for practicing nurses in geropalliative care, to twelve hospitals nationally.

**Learning Objectives**

#1: Describe how a nurse residency program educates and rejuvenates practicing nurses through transformative learning

#2: Describe how nurses are advancing patient- and family-centered care for older adults and their families

**Author(s):** Susan Lee, PhD, RN - Munn Center for Nursing Research, Boston, MA; Anne Marie Borden, MPH, RN - Massachusetts General Hospital, Boston, MA; and Deborah Conley, MSN, APRN-CNS, GCNS-BC, FNGNA - Nebraska Methodist Hospital, Omaha, NE

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**C098 - Advancing Patient Safety Using Simulation-Enhanced Education and Nurse-to-Nurse Mentoring**

Track: SE

**Key Word(s):** Education

This HRSA-funded project represented a partnership between an academic health center and community hospitals and supported the development, implementation, and evaluation of a simulation-enhanced curriculum to practice skills and apply critical thinking in the care of low-volume, high risk patient populations, within a safe and controlled environment.

**Learning Objectives**

#1: Identify components of a successful educational needs assessment

#2: Discuss the results of the study and implications for practice across nurse-to-nurse relationships