Dear Friends,

All of us who work in healthcare have chosen a path of service. Those of you on the front lines of patient care are not only skilled clinical experts, but the heart of a collaborative team here at MacNeal. It’s a privilege to recognize our nursing staff and highlight the wonderful work being done each day.

We pride ourselves in the spirit of family at MacNeal – when faced with challenges we work together for the best interests of our patients. We support each other as colleagues. We remain laser-focused on delivering safe, high-quality care. I know that this culture of caring and quality could not happen without you. I am so proud of our nursing staff, your service to our patients, your knowledge, your dedication, and your heartfelt compassion.

Thank you for all that you do.

M. E. Cleary
Chief Executive Officer
IN PURSUIT OF EXCELLENCE
Thank you for your commitment as a MacNeal Hospital nurse. Your time, talents and expertise are a constant source of inspiration, as is the compassionate, data-driven care you provide to our patients every day of the year. On the unit and at the bedside, you demonstrate that professional nurses are vital caregivers and valuable team partners. You respond to unpredictable volume fluctuations with grace and selflessness. You apply evidence-based principles into your daily nursing practice. And through your exemplary efforts, you positively influence every specialty and every department in the hospital and at our care centers. Believe me when I say, your work does not go unnoticed, by patients, families, communities, physicians, colleagues from other specialties, and most importantly, yourselves.

As nurses, your professional practice is grounded in autonomy, accountability, advocacy and authority. The most significant demonstration of your autonomy is how you have enhanced and expanded shared governance by including stakeholders beyond nursing. MacNeal’s Professional Nurse Practice and Clinical Nurse Practice Councils provide a structure and process for the voice of clinical nursing to be heard and supported by nurse leaders and interprofessionals from other disciplines. The transition from our previous model to the revised shared governance model is a testimony of your commitment to the standards of nursing practice, principles, and patient-centered care.

Your knowledge, your skills and, ultimately, your inspiring attitude are the foundation of our nursing practice at MacNeal, in which nurses from every department have a voice, participate in decision-making, construct interventions to improve care and create innovative change. You have blessed our patients, MacNeal Hospital, the professional practice of nursing and yourselves in the journey.

Sincerely,

Kathy Benjamin, MSN, RN
Chief Nursing Officer
TRANSFORMATIONAL LEADERSHIP

It’s relatively easy to lead people where they want to go; the transformational leader must lead people to where they need to be in order to meet the demands of the future. This requires vision, influence, clinical knowledge, and a strong expertise relating to professional nursing practice. It also acknowledges that transformation may create turbulence and involve atypical approaches to solutions.
**ICU Nurses on a Mission to Eliminate Central Line Infections and Delirium**

Nurses in MacNeal Hospital’s Intensive Care Unit are on a mission to see how low they can go...in preventing central line-associated blood stream infections (CLABSI) and ICU-induced delirium.

“We want to be at zero and stay there,” explains ICU Clinical Coordinator Deborah Robbins, RN, BSN. And that’s exactly where they’ve remained since implementing several practice changes in early 2016. “CLABSI increase mortality and morbidity, length of stay and costs,” Robbins adds. “We needed to make a change to prevent central-line infections from recurring.”

The Intensive Care Unit Council selected CLABSI as one of its unit-driven projects after the ICU experienced a rare spike in the potentially deadly infections. “We looked at the entire process from start to finish,” she said. Then, using evidence-based protocols, staff introduced several important practice changes.

For starters, they implemented daily chlorhexidine gluconate (CHG) baths for all patients with central lines. The nurses also introduced new dressing change guidelines with standardized dressing kits and began nurse-to-nurse central line audits at shift change. Another critical intervention: nurses are encouraged to question all blood culture orders, which are now limited to ICU hospitalists. Finally, and perhaps most importantly, nurses advocated for the reduction of central lines whenever possible, opting for peripheral or midline IV access instead, and removing central lines early if they were deemed necessary.

The results were almost immediate! Since May 2016, CLABSI have dropped to zero and remained there. What’s more, central line use fell 23 percent. The ICU team presented its impressive results at MacNeal’s Quality Fair in October. “This has truly been a team effort,” Robbins said.

**Preventing ICU-Induced Delirium**

Hospital-induced delirium, a sudden and severe change in mental status, affects more than seven million hospitalized Americans each year – and nearly a third of all ICU patients. Especially common in elderly patients, it’s brought on by a mix of medications – and simply being in the hospital. At its most severe, ICU delirium is terrifying, causing hallucinations, delusions and paranoia.

Doctors and nurses across the country – and right here at MacNeal Hospital – are leading the charge to reduce cases of ICU delirium by changing practices in care. “Delirium in the ICU is a type of organ dysfunction that signifies that the brain is temporarily failing,” Robbins explains. “Patients are unable to think clearly and can’t make sense of what is going on around them.”
Not surprisingly, delirium leads to longer stays, more time on mechanical ventilation, long-term cognitive impairment, more frequent discharges to long-term care facilities and higher costs. To identify delirium earlier, nurses have been trained to use the CAM-ICU (Confusion Assessment Method). Patients are assessed every four hours and as needed. If delirium is detected, efforts are made to discover the etiology and minimize or eliminate the factors. Additional education has focused on the introduction of non-pharmacologic measures to manage delirium.

“Therapeutic sedation of mechanically ventilated patients requires a very delicate balance between over-sedation and under-sedation,” she adds. ICU nurses, physicians and pharmacists chose the Richmond Agitation-Sedation Scale (RASS) as the sedation assessment tool. When the physician orders sedation, a RASS goal is represented by a number on the scale. Nurses then titrate the sedation either up or down in response to the patient’s presentation.

Staff also received training on light sedation/new sedation protocols, RASS, and non-pharmacologic interventions. “The Society of Critical Care Medicine advocates keeping the patient ‘Safe, Comfortable and Interactive,’ and I’m proud to say our ICU nurses are proactive, compassionate patient advocates,” Robbins added.

Limiting Restraints in the ICU
Restraining a patient isn’t easy on anyone. It causes angst for nurses, family members and patients, who may feel their freedom and dignity have been curtailed. Restraint use is most common in intensive care units, where patients are more critically ill and may pose a danger to themselves. The most common types include soft mitts, which prevent grasping, and soft wrist or ankle restraints, which may be used to prevent pulling at an IV, or removing a tube or dressing.

In mid-2016, MacNeal Hospital began examining ways to reduce restraint use, and ICU nurse Maria Brutus, RN, BSN, has been its champion. “We’re using evidence-based practices and alternatives whenever possible,” she explains, which includes questioning whether a restraint order from a physician is really necessary.

What’s more, the nurses identified and implemented several important restraint alternatives that have proven highly effective at keeping patients safe. These include physical enhancements to the bed itself, such as lowering the bed, padding the bed rails, installing a temporary gap protector and using mesh-covered enclosures when necessary. Nurses also advocated for the use of bed alarms, which signal caregivers when a patient is trying to leave his/her bed.
For agitated or at-risk patients, nurses implemented the best-practices concept of a “sitter” to check on and calm the patient throughout the day and evening. And for patients with diminished cognitive function, MacNeal nurses researched and introduced patient activity aprons.

Just months after introducing restraint alternatives, Brutus says staff have embraced the new paradigm, and patients and families are grateful. Data collection is ongoing, but early results show restraint use is down overall.

“The goal is to use the least restrictive type of restraint possible – and only as a last resort,” she added. “At MacNeal we’re focusing on restraint use as an exception, not as part of a routine protocol.”
Team Effort: Huddle Redesign Successfully Targets Reducing Falls

A fall can be devastating, especially to patients in the hospital. That’s why reducing falls is a major initiative at hospitals nationwide. Yet nearly one million U.S. patients continue to fall every year, resulting in fractures, internal bleeding and other serious harm, according to the Agency for Healthcare Research & Quality.

“Preventing patient falls is a top priority at MacNeal Hospital,” explains Kathleen Benjamin, MSN, RN, Chief Nursing Officer. “Our organization’s mission is to be the safest provider of care.” A daily huddle reinforces MacNeal’s commitment to safety. But in March 2015, it became clear the daily huddle wasn’t delivering on its promise – particularly with regard to patient fall injuries. As CNO, Benjamin set out to change that.

Together with Chief Medical Officer Charles Bareis, MD, and other key huddle members, Benjamin discovered the existing huddle structure lacked appropriate leader stakeholders, clear and focused communication on data, solution-driven closure and a consistent, effective process to cascade goals to clinical nurses and other staff. “We envisioned a newly designed huddle that would communicate organizational safety learning, goals and plans, beginning with front-line leadership,” she said, “and one that would cascade to clinical nurses and others to influence their daily practice.”

The group’s first priority was decreasing preventable harm rates from falls, calculated as falls with injuries per 1,000 patient days. In May 2015, an interprofessional work team named HIT for Huddle Improvement Team joined forces with representatives from nursing, supportive services, administration and business departments. Their first assignment was conducting a gap analysis comparing the efficiency and effectiveness of MacNeal’s daily huddle against other hospitals.

Over the next several months, the team assessed the strengths, weaknesses, opportunities and threats of the existing huddle, culminating in the development of a Daily Leadership Huddle Template. “The revised Leader Huddle Template described elements to drive safety and quality effectiveness,” Benjamin said. “It included identification of safety risks and ‘Great Catches.’” The new template gained immediate traction when, in July 2015, a fall with injury occurred in the hospital’s Transitional Care Unit. A broad discussion ensued, with a number of important changes made to the nursing practice model. These included positioning high-risk patients in low beds; reviewing the Hendricks Assessment Tool; identifying high-risk medications; assessing patients’ emotional needs and impulsivity; and coordinating a unit-based strategy to ambulate and meet bathroom needs. In addition, mesh-tented enclosure beds are now used to prevent falls and provide a safer environment whenever necessary.

“The method to cascade safety information from the Leader Huddle to the clinical nurse was new to the organization and to nurse practice,” Benjamin added. The new template allowed for unit-specific huddles conducted with autonomy, authority, and specific objectives tailored to align with the unit-specific care delivery model. The huddle redesign proved highly effective: Between the second quarter of 2015 to 2016, falls with injury plummeted by more than 70%.

“The redesign aligned with the overall organization’s mission, vision and values to position safety as a key focus, prioritized by our CEO and enhanced in our Nursing Strategic Plan,” she added. “It was supported by nurse leaders and made actionable by clinical nurses. But most importantly, it led to important changes in nursing practice that resulted in positive outcomes for our patients.”
Mentors Matter: 18-Year MacNeal Veteran Reaches a Pinnacle in Her Career

In October 2016, Erika Gleeson, MSN, RN, NP-C, CEN, CCRN, landed her dream job as a family nurse practitioner at MacNeal Hospital’s Immediate Care Center in Berwyn. Gleeson is one of two nurse practitioners to staff the center, which focuses on treating medical problems that, while not life-threatening, require care within 24 hours. The 17-year MacNeal veteran enjoys the autonomy of advanced practice nursing, something she may not have considered without the many hospital mentors who’ve inspired her along the way.

Gleeson’s career at MacNeal began as a patient care technician in the Emergency Department back in 1999. While pursuing a nursing degree, she became a nurse extern, received tuition assistance and eventually completed an Associate Degree in Nursing (ADN) in 2001. That’s when she met Natalie Bonner, RN, MSN, a colleague and a friend who would leave an indelible mark on Gleeson by encouraging her to aim higher and pursue her professional dreams.

“Natalie practiced in both the ED and ICU,” Gleeson explains. “Her nursing practice included patients of all ages in all ED areas, and she mentored me to practice the same.” Over the years, Bonner encouraged Gleeson to become a charge nurse, work in triage, answer the Emergency Medical Services radio – and eventually continue her education. She also achieved numerous certifications in quick succession: Emergency Communications Registered Nurse (ECRN); Trauma Nurse Specialist (TNS); Critical Care Registered Nurse (CCRN); Pediatric Advanced Life Saving Instructor (PALS); Certified Emergency Nurse (CEN); Emergency Nurse Pediatric Course (ENPC) Instructor; and ACLS instructor.

And with an added nudge, Gleeson became one of the first nurses to achieve Clinical Advancement, a clinical ladder program for nurses engaged in certification, participation in shared governance and demonstration of excellence in clinical practice. Eventually, she took a position in the Critical Care Unit, where she expanded her clinical horizons and her skills, becoming a member of the Rapid Response Team and a valuable resource on rapid transfusion pumps, invasive lines, central venous pressure, arterial line monitoring and arrhythmias.

Over the years, other mentors – Ann Seliga, BSN, RN, CMSRN, Director of ICU; Deborah Robbins, RN, BSN, ICU Clinical Coordinator; and former Chief Nursing Officer Angie Skalla, MBA, BSN, RN, NEC-BC – encouraged Gleeson to continue the momentum. She was nominated for two major awards – the Clinical Excellence Award and Compassionate Caregiver Award – and with her advanced skill set, took a position as manager on the Telemetry Unit, 35 South. In 2014, with Skalla’s full support, Gleeson applied for and was awarded a Family Nurse Practitioner Master Program scholarship. She completed her MSN in December 2015, and today she’s thriving in her autonomous nursing practice. On the flip side, Gleeson has made significant contributions of her own to MacNeal nursing by mentoring and precepting new hires, new graduates and nurses transitioning to work in the Emergency Department. She also leads a council for advanced practice nurses at MacNeal.

“\n
“I enjoy trying new things and seeing how I can be effective in providing quality care,” Gleeson explains. “While I enjoyed my role as a nurse manager, I missed bedside nursing. I really wanted to pursue an MSN to care for patients. I’m proud to say I now have the authority and the knowledge to really help people to be healthy in my daily practice. I’m forever grateful to the people who have mentored me along the way.”
STRUCTURAL EMPOWERMENT

Solid structures and processes developed by influential leadership provide an innovative environment where strong professional practice flourishes and where the mission, vision, and values come to life to achieve the outcomes important for the organization. MacNeal nurses work in an empowering environment that fosters commitment to organizational goals.
Certified: MacNeal Encourages Nurses to Achieve Professional Milestone

As healthcare becomes increasingly more complex, the value of nursing certification as a mark of excellence is more important than ever. Certification demonstrates to patients, peers and administrators that a nurse’s knowledge and skills meet rigorous standards. Certified nurses have influence; they feel a greater sense of accomplishment in their work, and they command a higher salary.

But the single most important benefit of nursing certification is that it leads to better patient care. The American Nurses Credentialing Center reports that nurses certified in wound care know more about classifying pressure ulcers. What’s more, fewer patient falls occur on intensive care units with a higher number of certified nurses on staff. And oncology-certified nurses have greater knowledge about managing pain.

That’s why, shortly after she was named Chief Nursing Officer in 2013, Kathleen Benjamin, MSN, RN, made it her mission to raise the bar of nursing practice at MacNeal by increasing the number of certified nurses. To garner support, she wrote about it in the nursing newsletter and discussed it at nursing forums; she presented her priorities to the Professional Practice Council; and she secured the commitment of hospital senior leadership. Then she enlisted the help of Patricia Peck, BSN, RN, CMSRN, MacNeal’s very own certification champion.

Raising the Bar for Nursing Practice

Peck, who earned her nursing degree in 1989, admits she hadn’t really challenged herself professionally until she made the life- and career-changing decision to pursue board certification in 2007. Her inspiration came from watching several nurse leaders do the same a year earlier. But Peck didn’t want to do it alone. Instead, she recruited 27 of her peers to join her. Since there was no review course offered locally, she created her own study course. Then she petitioned hospital administration for financial assistance. They graciously funded the review materials and provided a library study room. The enterprising Peck next gathered content experts in areas like gastrointestinal, neurology, and respiratory. She convinced three physicians and multiple nurse experts to teach the classes and helped design their courses around the Academy of Medical-Surgical Nurses study material. In short order, Peck created a home-grown board-certification course that rivaled any others out there – and proved highly effective.

Of the 27 nurses that signed up, 10 took the exam in October 2007 – with a 90% pass rate. “It felt good to put those letters after my name,” she explains. “I felt proud, and I was proud of the other nurses who joined me.” But Peck didn’t stop there. The enthusiastic certification champion has continued to pay it forward. “Over time I learned that the three barriers to taking the exam are location of the exam, materials needed to prepare for the exam, and the cost of the exam,” she explains. In true form, Peck has helped overcome them all. She’s hosted the paper-and-pencil exam at MacNeal more than seven times since 2007. She’s also secured funding from the hospital to cover study materials – and the test itself by contracting with the Medical-Surgical Nurse Certification Board’s (MSNCB) FailSafe program.
“Since 2007, Pat has assisted 123 nurses in getting board-certified in medical-surgical nursing,” Benjamin said. “Her pass rate of 90% has endured, and is better than the national pass rate of 82%.” Peck’s tireless efforts gained national attention in 2015, when she became the inaugural recipient of the Academy of Medical-Surgical Nurses CMSRN of Distinction Award for exemplifying the mission, vision and core values of the Medical-Surgical Nursing Certification Board. Best of all, the percentage of board-certified nurses at MacNeal has skyrocketed: from 19.96% in 2013, when Benjamin introduced the initiative, to 39% in 2016. One unit in particular, 45 South, a 24-bed medical-surgical unit under the management of Rosenda Barrera, MSN, RN, set its sights on exceeding the Magnet 75th percentile of having 27.27% of its nurses certified. As of mid-2016, the unit soared to the 90th percentile with 44.4% of its nurses attaining certification.

“In today’s healthcare environment, nurses are called upon to care for more complicated patients and provide more sophisticated care,” Benjamin adds. “Certification helps ensure that their expertise and clinical judgment keep pace – and result in the very best care we can provide our patients.”
From Novice to Expert: Graduate Nurse Program Aims for Successful Transition to Practice

Any veteran RN will tell you the transition from student nurse to practicing nurse isn’t easy. There are clinical challenges to contend with, an institutional culture to adapt to and situations that classes didn’t prepare them for. Not surprisingly, these stresses can add up to clinical errors, job dissatisfaction and high employee turnover.

“There are so many variables,” explains Nancy Silva, MSN, RN, APN-BC, CCNS, CCRN, Clinical Nurse Specialist. “Nursing school instructors can’t possibly cover everything, so graduate nurses encounter things they haven’t done before.” To improve the experience of new graduate nurses at MacNeal – and reduce turnover rates – Silva and Amanda Haberman, MS, RN, ACNS-BC, were called upon by nursing leadership to redesign MacNeal’s new graduate program in early 2016.

Haberman, who had transitioned from The Ohio State University Wexner Medical Center, was familiar with that organization’s nurse internship program, which incorporated Patricia Benner’s theoretical framework of “novice to expert.” Silva had expertise in nursing retention, so together, the two created a new program that focused on giving graduate nurses exactly what they need to succeed – based on the guidelines of the American Nurse Credentialing Center. “Content is based on organizational culture, quality outcomes, nursing professional development and evidence-based nursing practice,” Silva added. Monthly competencies include communication, critical thinking and clinical reasoning and ethics. They also include evidence-based practice, informatics, interprofessional collaboration, patient-centered care, quality improvement, role transition, safety, stress management and time management. The 12-month program is mandatory for all graduate nurses.

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“The New Graduate Program gives MacNeal the opportunity to assist new nurses to expand their knowledge base in a nurturing environment and provide the support that is so vital during the first year in their profession,” adds Marcie Calandra, DNP, MS, RN, CNS, APRN-BC, Executive Director of Professional Services and a program content expert. “The program enhances their unit-based orientation and promotes the need for constant learning and best practices, which is the core of nursing.”

Monthly presentations are made by representatives from multiple disciplines that address topics and introduce resources most relevant to the nurses’ needs. In February 2016, the first cohort of new graduates from 2015 and early 2016 entered the program. Each month, new graduate nurses are assimilated within the existing cohort; all must attend 80% of meetings to successfully graduate. Feedback is reviewed regularly by the clinical nurse specialists, and enhancements are made where needed. Participants say they especially enjoy the hands-on learning, debriefing sessions where they can vent, and the camaraderie of their peers. “The response has been overwhelmingly positive,” Calandra said. And it shows: The turnover rate in the new graduate cohort is significantly better than the national average and other similar hospitals by comparison.
EXEMPLARY PROFESSIONAL PRACTICE

Exemplary professional practice entails a comprehensive understanding of the role of nursing; the application of that role with patients, families, communities, and the interdisciplinary team; and the application of new knowledge and evidence. The goal is more than the establishment of strong professional practice; it is what that professional practice can achieve.
Time is Brain: MacNeal Nurses Lead Interprofessional Collaboration to Improve Stroke Care

When it comes to treating stroke, “time is brain.” The earlier blood flow is restored in a blocked vessel, the better the outcome. The American Heart Association/American Stroke Association guidelines recommend the administration of tissue plasminogen activator (tPA) in 60 minutes or less. Faster treatment means fewer complications, including death. But in late 2014, the average door-to-tPA time at MacNeal Hospital – a Primary Stroke Center – topped out at 83 minutes. Prompted by concern from nursing leadership in the Emergency Department (ED) – and with strategic approval to develop a culture of learning among the varied healthcare providers at MacNeal – the interprofessional Stroke Performance Improvement Committee worked together to lower that number to the recommended 60 minutes or less 100 percent of the time.

“We took an all-hands-on-deck approach,” explains Clinical Nurse Stroke Program Coordinator and Committee Chair Cheryl Jastrzebski, MSN, RN, CNRN, CMSRN. An initial analysis found that while arriving stroke patients received urgent care within the recommended timeframe, there was no structure in place for the sequential scope of care for tPA-eligible patients. With the help of clinical nurses, the Stroke Committee developed a proposed action plan to improve the care model. “Key to this was providing ED nurses and providers an organized, consistent process to treat stroke patients,” she said. Enhancements included alerting the Emergency Department of the pending arrival of suspected stroke patients with vital information like the patient’s last-known well time, the family contact, home medications and results of the Cincinnati Stroke Scale provided.

This information provided a new paradigm for initiating the Code Stroke prior to patient arrival. What’s more, ED nurses who carry Emergency Communication Registered Nurse licensure would be given the authority and autonomy to activate the alert before a patient arrives in the ED. CT time was another major piece of the puzzle. The cumbersome order, “CT of the Head in the Acute Stroke Orders” was shortened to “CT Stroke Alert,” more succinctly stating that the images required a radiologist’s immediate attention.

The last piece involved the rapid dispensing of tPA. Clinical nurses advocated for a stroke-specific pharmacy extension, “3966,” to order tPA. Emergency Medicine Clinical Pharmacist Jennifer Splawski, PharmD, then developed a flow sheet detailing how tPA could be ordered and delivered within 10 minutes.
The flow was vetted; the ED clinical nurse specialist organized an annual ED competency session, and the new nursing practice was put in place in March 2015. By the end of the first quarter of 2015, door-to-tPA times dropped by 11 minutes on average, and since then have been well under 60 minutes more than 95% of the time. First-quarter 2016 results showed an average of 54 minutes.

“Most importantly, nurses at all levels throughout MacNeal achieved a better understanding of all the components of stroke care and developed a unified awareness of how each individual’s contributions determined the team’s success and positively affected the patient’s outcome,” Jastrzebski added.

Additional Enhancements to Stroke Care
In the event a suspected stroke patient presents to MacNeal’s ED when a neurologist is no longer on duty, ED nurses contact a neurologist located off-site at Rush University Medical Center through the TeleStroke Network. A sophisticated telemedicine platform equipped with a high-definition camera allows the physician to speak face-to-face with patients and their families, and even allows for a check of the patient’s pupils. But it is the MacNeal ED nurse who performs the NIH stroke scale, provides one-on-one care throughout the encounter in the Emergency Department and facilitates the TeleStroke encounter if needed, explains Claudia Santoyo, RN, BSN. “In fact, as part of our Primary Stroke Center designation, our nurses are required to perform up to 12 hours of continuing education related to stroke care, signs and symptoms every year,” she said. “They possess the critical thinking skills to recognize the signs and symptoms of stroke, evaluate abnormal labs and assist with the administration of tPA.”

Once a stroke patient is stabilized at MacNeal, he or she is admitted to the hospital’s Joint Commission-certified Stroke Unit, 42 South, where all nurses follow specific stroke protocols to ensure the best possible outcomes. For instance, all 42 South nurses are now certified in advanced cardiac life support and proficient in identifying arrhythmias, including atrial fibrillation – a leading risk factor for stroke.

“We print out rhythm strips every four hours, read them and put them in the patient’s chart,” explains Elizabeth Dickey, RN, who’s played an instrumental role in educating her colleagues. As an added layer of protection, the unit is supported by a centralized telemetry floor staffed around the clock by telemetry technicians. “That has proven very helpful because when a patient has to leave the floor for testing, the technicians can monitor their rhythm remotely,” she adds.

What’s more, 42 South nurses have been well-trained in medication management, including the administration of Cardizem and blood pressure medication. And to help prevent choking and aspiration, nurses now perform dysphagia screenings on all new admissions. If the patient fails the screening, the nurse arranges for a consultation with a speech-language pathologist and places a temporary order to withhold food and fluids. Stroke-specific training is renewed yearly. “Having a stroke care protocol in place eliminates the guesswork and has led to better patient care and outcomes,” Dickey adds.
Right Care, Right Time, Right Place: PACT Program Focuses on Patients Facing Serious Illness

Nurses are no strangers to difficult conversations. They come with the territory. One of the most challenging is talking to a patient or family about end-of-life care. “They’re difficult, but they’re necessary,” explains Erika Hernandez, BSN, RN, CVRN, Nurse Manager of MacNeal Hospital’s Telemetry/Observation Unit 31 South. Unfortunately, those conversations don’t happen often enough in U.S. hospitals. Years of research have shown that patients and families facing serious illness struggle with unmet needs, leading to physical, psychosocial and financial burdens for patients and caregivers alike.

In the summer of 2015, 31 South nurses proposed that more could be done to meet these needs. Based on feedback from patients and families, the group advocated for a protocol that would adequately address patients nearing the end of life. The protocol, they said, should include standard criteria to identify patients who would benefit from hospice or palliative care and education to make them aware of their options. Not only would this result in the most appropriate care for patients, it would spare family members the turmoil of having to make difficult decisions “in the dark.”

Additional benefits would include reduced readmission of chronically or terminally ill patients and lower mortality rates on the unit as a result. “Publicly reported hospital mortality rates are skewed by chronic or terminally ill patients who are more appropriate for hospice care,” she said. Armed with a desire to improve the patient (and family) experience, an interprofessional group of MacNeal caregivers received the go-ahead to attend a Preference-Aligned Communication and Treatment (PACT) skills development conference at Northwestern University Medical Center. An evidence-based statewide collaborative, PACT focuses on advance care planning, coordination of care and honoring patients’ wishes. By better preparing clinicians with the skills and confidence to conduct more meaningful conversations about care preferences, they’re able to establish care plans that truly reflect their patients’ desires.

Throughout the spring and summer, staff members learned how to utilize the program’s screening tool. The PACT team then formed the MacNeal Hospice (Seasons)/Palliative Care Committee to assure alignment with the project, improve end-of-life care and reduce the 31 South mortality rate. Beginning in late 2015, 31 South nurses piloted the PACT Conversation Trigger Tool on patients with specific diagnoses, such as metastatic cancer, heart failure, chronic asthma, and liver and kidney problems. Questions include whether the patient has been readmitted twice in the past three months; if he or she uses oxygen at home; and if there’s been a decline in activities of daily living. If the patient scores greater than three, the screening tool is tagged, and the unit secretary notifies a specially trained conversation “champion” to visit the patient and family.

“Eighty percent of the time, the family is aware the patient is very sick,” adds Diana Mora, RN, BSN, chair of 31 South’s Unit Council. “The conversations have been very well-received by patients and families.” What’s more, mortality on 31 South has fallen. During the last quarter of 2015, five patients went straight to hospice care and died peacefully at home, instead of the hospital. The trend continued in early 2016, with first-quarter results showing a dramatic reduction of 50% in mortality. As a result, the PACT program has recently been expanded to 36 South. “PACT has improved our competence and confidence in having these types of conversations,” Hernandez added. “But most importantly, it helps ensure our patients receive the right care, at the right time, and in the right place.”
Innovation in Action: 45 South Debuts New Nursing Unit

In the dictionary, “innovation” is defined as a new method, idea or product that results in positive change. At MacNeal Hospital, nurses on 45 South have given this concept wings with the development and implementation of a 24-bed “Innovation Unit.” The unit exemplifies evidence-based practices in patient care that will one day transform the delivery of care at MacNeal. It debuted in November 2016 after its forward-thinking nursing staff underwent months of intensive training to pilot and evaluate new practices.

“MacNeal Hospital is dedicated to providing every patient and family with the safest and highest-quality care possible,” explains Marcie Calandra, DNP, MS, RN, CNS, APRN-BC, Executive Director of Professional Services. “With the development of this Innovation Unit, we are committed to raising an already high standard even higher.”

Innovation units are gaining traction at hospitals across the United States and right here at MacNeal; their goal: to ensure that care is safe, effective, timely, efficient, equitable and both patient- and family-centered.

Under the leadership of Nurse Manager Amy Salata, BSN, MacNeal’s Innovation Unit on 45 South has become the testing ground for promising new strategies to improve clinical outcomes and enhance patient, family and staff satisfaction – while reducing costs and length of stay. To do that, the team is focused on improved handoff communication, interprofessional team rounds, better dialogue with patients and families, and improved discharge readiness and education.

“The objective is to create an ideal learning and treatment culture and share it with others,” Calandra added.

Through a series of educational retreats, the nurses of 45 South learned the ins and outs of how to effectively run a patient care unit – from increasing patient satisfaction to lowering infection rates; from setting a budget to counseling a coworker. Since its implementation, things are definitely headed in the right direction. Initial satisfaction scores (patient and staff) are trending up. But that comes as no surprise to Salata.

“Our nurses are energetic, enthusiastic, team-oriented and highly qualified to pilot this new unit,” she adds. “They are true change agents in every sense of the word.”
NEW KNOWLEDGE, INNOVATION & IMPROVEMENTS

Strong leadership, empowered professionals, and exemplary practice are essential building blocks, but they are not the final goals. Hospitals have an ethical and professional responsibility to contribute to patient care, the organization, and the profession in terms of new knowledge, innovations, and improvements. These include new models of care, application of existing evidence, new evidence, and visible contributions to the science of nursing.
Innovation Leads to Healing: Wound Center Nurses Improve Outcomes for Disparate Populations

The human cost of chronic wounds is measured in pain, distress and often-needless suffering. Sadly, more than five million Americans today are living with a non-healing wound that has resisted healing after months or even years of treatment. Then there are the financial costs: without effective treatment, sufferers of chronic wounds may become disabled, unable to work – and unable to pay for their costly wound treatments and supplies.

In their daily practice, MacNeal Wound Center experts Catherine Jackson, MSN, RN, WCC, manager/clinical nurse of the wound center, and Tracy Robinson, MSN, RN, CWOCN, clinical nurse, made a difficult discovery among their patient population: disadvantaged patients – including homeless, low-income, fixed-income and undocumented – with chronic wounds weren’t healing as well as other patients. More concerning, trended data showed the disparate population was growing steadily. Jackson and Robinson immediately committed to finding a solution.

“Our analysis showed that the target population had poor adherence, prolonged wound-healing times, and, as a result, increased costs based on the need for greater-than-expected supplies,” Jackson explained. “The primary patient barrier was the cost of supplies used in the at-home dressing treatments.” Wound care treatments and supplies, such as gauze pads, gauze wraps, tape and gloves, are expensive, ranging from $15 to $125 per dressing change. When patients couldn’t afford the supplies, they found other ways to dress their wounds. “One patient wrapped a bed sheet around the wound on her leg,” she added. Other patients used whatever they had around the house – from paper towels to baby diapers. When they ran out of makeshift bandages, patients often visited the Emergency Department just to get the supplies they needed. Not surprisingly, compliance with prescribed wound treatments was at an all-time-low of 53.5%, when the two nurses began studying the problem.
Focused on a Solution
Armed with data and a desire to make a difference, Jackson and Robinson began exploring ways to ensure their patients had everything they needed to heal. They reached out to four medical companies that supply wound products to MacNeal. A local company, Byram Healthcare based in Downers Grove, agreed to provide treatment supplies at no cost to the target population – and deliver the supplies to patients’ homes. Two other supply companies committed to providing starter kits to the Wound Center to enhance patient treatment and education. Encouraged by the response, Jackson created a new form to facilitate supply ordering, and both nurses developed a process to identify and match disparate patients with the supplies they needed. They then trained nurses, physicians and non-clinical staff on the new initiative.

The results of their initiative have been nothing short of remarkable! Wound-healing costs plummeted nearly 90% in the first 18 months while patient adherence to wound care treatment almost doubled a year after the program’s rollout, reaching an all-time high of 97%. Best of all, a vulnerable population that once struggled now has what it needs to heal. “Our hope is that they don’t have to go a day without the supplies they need,” Robinson added.

BHS Nurses Create Plan to Eliminate Patient Elopements

Patients who wander or elope from hospitals can harm themselves – and become a danger to others. Patient elopement or wandering is often played out on the evening news; frequently the patient is found unharmed; other times, the outcome is tragic.

In June 2013, a sentinel event elopement occurred at a Chicago-area psychiatric facility with an adverse outcome. “The incident became an impetus for MacNeal Behavioral Health Services (BHS) clinical nurses to assess the safety of the hospital’s five adult locked units,” explains Geri Staehle, RN, Director. It was also very timely as MacNeal’s BHS had experienced two patient elopements between September 2012 and May 2013. Fortunately, both patients made a safe return to the hospital.

Maintaining patient safety became a top priority, and two BHS nurses, Sandra Kalal, BSN, RN, and Sylvia Olson, BSN, RN, BCRN, led an initiative to ensure the BHS nursing practice and care delivery model was safe and effective, as outlined in the MacNeal Professional Practice Model. “We reached a consensus that zero was the goal for patient elopements,” Staehle said.

Following thorough assessment and collaboration with other key stakeholders, the BHS team proposed a double-door “sally port” entry system. Construction of the double-door system began less than a year later; nursing feedback was critical throughout to assure that every conceivable patient and visitor need was considered. “We had to ensure that wheelchairs, crash carts and patient beds could easily move through the secure doors,” she added. “Modifications were made when necessary, based on the nurses’ feedback.”

An electronic door-locking system was installed to provide remote release of the locks, with controls strategically placed on the nursing unit by the windows looking onto the exit hall. That way, BHS nurses have a final review of who’s at the door prior to releasing the lock. The new system was officially completed in June 2014. It’s visually attractive, user-friendly, but most importantly, it provides a more secure environment for BHS patients, especially those at high risk for elopement.
ED ‘Hard-Wires’ Elopement Protocol
Since the Emergency Department is often the first point of entry for behavioral health patients, MacNeal ED nurses have implemented vital protocols to prevent elopements…and save lives. For starters, nurses recommended that all ED patients with symptoms of depression be assigned a “constant observer (CO)” to ensure the patient is never left alone. A privacy screen preserves patient dignity in the restroom.

If the patient is admitted, patient care partners are cross-trained to act as COs on the floors. What’s more, all admitted behavioral health patients are given green scrubs to wear, again at the suggestion of MacNeal nurses. Hospital staff have been trained to sound the Code Gold elopement alert if an individual in green scrubs is walking unattended in the hospital.

Finally, front-line ED nurses recommended the installation of high-security doors at the EMS entrance to prevent elopements. Since the area is a busy, chaotic one with people coming in and out, it would offer an easy opportunity for a patient to elope. But thanks to MacNeal nurses, the doors now can be opened only by authorized personnel, including the ED team leader or hospital security, which also performs hourly rounds in the ED.

An added safety feature – a pendant with call button – was implemented for staff to summon immediate help if a BHS patient should become agitated or violent.
Greetings from the “stethoscope” of the Clinical Nurse President. I have my ears “on” and am ready to listen. I encourage others to vocalize their passion for nursing as well. The past year was an exciting one, especially as it relates to our new shared governance model. The process began about eight months ago; the structure is now in place, and we are easing our way down this new path. We now have two main councils instead of 14: Clinical Practice Council (CPC) and the Professional Nurse Practice Council (PNP). Each meets on the second Thursday of each month. Our goal is to have equal representation from every nursing unit/practice area on each council. Scheduling conflicts aside, I’m optimistic we can achieve this shortly.

This is an amazing time to be a nurse! It’s a time to be heard, to voice your opinions, and to elaborate on policies, clinical decisions, professional growth and development, recruitment, retention and advocacy. I urge you, my peers, to become involved…if not on the main council, then on the board at your individual unit-council.

I would like to conclude by quoting author and EMS thought leader Thom Dick, who so poignantly describes what this amazing profession is really all about. “You’re going to be there when a lot of people are born and when a lot of people die. In most every culture, such moments are regarded as sacred and private, made special by a divine presence. No one on earth would be welcome but you are personally invited…. What an honor that is!” We are most cordially invited. And what an honor I have to represent, rally and practice with the most elite class of nurses!

Sincerely,

Denise Bilotto, BSN, RN, ONC, CMSRN
2016 Nursing Staff President