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Assessing Patient Satisfaction of a Community Hospital Oncology Rehabilitation Program
Miriam Sleven, RN, MS, OCN and Sheryl Au, MPT, ATC, CLT-LANA, CSCS
Torrance Memorial Medical Center

Purpose
No process exists for evaluating patient satisfaction of the Oncology Rehabilitation program to provide guidance for program improvement and development. The object is to assess patient satisfaction with the Oncology Rehabilitation program and identify areas for improvement.

Background and significance
The literature states cancer rehabilitation contributes to the management of some of the most prevalent and distressing symptoms of cancer care, including lymphedema and fatigue. A priority is placed on successful restoration of optimal function. A comprehensive rehabilitation program offers the best opportunity for optimizing cancer survivor physical and functional status. The Torrance Memorial Medical Center (TMMC) Oncology Rehabilitation program created in 2009 provides services annually to 80-100 patients. The Oncology Rehabilitation program has a wide array of services available to cancer survivors to help them achieve their optimal level of functioning including lymphedema management, swallowing retraining and development of personalized exercise programs to relieve cancer-related fatigue.

Description of methods/procedures
50 patients who completed treatment at TMMC Oncology Rehabilitation participated. Each patient completed pre- and post- treatment evaluation forms provided by their rehabilitation therapist. Of these 30 patients completed a telephone satisfaction survey two months after treatment was concluded conducted by the cancer survivorship coordinator.

Evidence of results/outcomes
90% of respondents reported their expectations of therapy, as stated at the start of therapy, were completely met. 97% who responded to the post-treatment call stated they were completely satisfied with their care. 23% stated they were not able to get their initial appointment in a timely manner. 80% of patients who participated in the project had breast cancer with the majority utilizing lymphedema services.

Conclusions
Overall patients who participated in the TMMC oncology rehabilitation program were satisfied with the care they received. Areas for improvement in patient care quality include timely appointment scheduling, providing services to patients with different types of cancer and expanding utilization of other areas of the oncology rehabilitation program.
Feasibility Pilot to Determine Clinical Performance of a New Clear Silicone Adhesive Dressing with Chlorhexidine and Silver for Central Vascular Access Devices (VADs): Wearability, Comfort and Incidence of Irritant Contact Dermatitis
Nicolann Hedgpeth, DNP, RN, AOCNP; Peggy Kalowes, RN, PhD, CNS, FAHA; And Valerie Messina, RN, CWCN
Long Beach Memorial Medical Center

Purpose
A feasibility pilot to determine performance and tolerability of a novel Clear Silicone Adhesive Dressing with chlorhexidine and silver on PICCs among oncology patients with cutaneous skin changes and previous episodes of ICD.

Background
Vascular access devices (VADs) are essential to the treatment of oncology patients. Cutaneous changes in oncology patients lead to increased incidence of irritant contact dermatitis (ICD) at Peripherally Inserted Central Catheter (PICC) insertion sites. ICD is exacerbated by exposure to adhesives and antiseptics. In response to patients’ complaints in our outpatient infusion center, regarding standard PICC dressing performance and ICD, we sought to trial a new VAD dressing to provide an alternative for this population.

Project
18 adult patients receiving standard PICC dressings were invited to be part of a 30-day trial using the new dressing from June 20 – July 20, 2013.

Results
18 subjects enrolled. 72% (13/18) rated the dressing clinically superior with optimal performance during ADLs; 28% (5/18) rated the dressing acceptable; no patients rated the dressing unacceptable. 100% (18/18) rated the dressing as very comfortable (no pain) on removal. Additionally, 100% of subjects showed absence of irritant contact dermatitis.

Implications
The Clear Silicone Adhesive Dressing with chlorhexidine and silver represents a novel approach with improved performance. A rigorous randomized clinical trial is needed to evaluate effectiveness of the impregnated anti-microbial agents in reducing CLABSI and ICD in acutely ill hospitalized patients.

Conclusions
The Clear Silicone Adhesive Dressing was found to have unique and highly desirable characteristics. It has a polyurethane film coated with an antimicrobial silicone adhesive containing chlorhexidine and silver. The dressing is comfortable and secures VADs to the skin while providing antimicrobial protection with little or no ICD. Based on this evidence-based pilot, this new dressing has been adopted in our outpatient infusion center for high-risk patients.
Decreasing Falls on an Inpatient Oncology Unit

Jenny Mendola, RN, MSN, OCN, NE-BC
Orange Coast Memorial Medical Center

Purpose
The purpose of this project was to decrease falls on the inpatient Oncology Unit.

Background
Research has shown that falls result in injuries, co-morbid conditions, increased length of stay and even death. Cancer patients are at high risk for injury related to falls due to their comorbidities such as thrombocytopenia, bony metastasis and pathologic fractures. In addition to the physiologic implications on patients, falls increase hospital’s costs due to reimbursement issues, increased patient length of stay, and diagnosis and treatment of fall-related injuries.

Description of methods/procedures
Based on fall rates that were higher than our hospital’s benchmark, the Oncology Unit began a performance improvement (A3) process in 2011 focused on decreasing the number of patient falls within the unit. Using the Plan Do Study Act (PDSA) process, root causes for our patients’ falls over time were identified and countermeasures were designed and implemented. These countermeasures included improving compliance with bed alarm use, education of patient and family about fall risk and their roles in preventing falls, standard work around offering toileting every time a staff awakens a patient, revisions of the EPIC fall assessment tool, and education about the appropriate use of rental beds.

Results
This project resulted in a decrease in the overall fall rate per 1000 patient days of almost 50% (from 4.15 in 2011 to 2.24 in 2014). As the trends have changed based on countermeasure implementation, there has also been a decrease in unwitnessed falls from 75% in 2011 to 25% in 2014.

Conclusions
The implementation of a formal performance improvement process that continually reviews and acts on the data for trends is effective in decreasing patient falls.
Evaluation of a Professional Practice Model: 
Nurses’ Perceptions of Professional Nursing Practice 
Martha Zepeda, MSN, RN-BC 
Long Beach Memorial Medical Center/ Miller Children’s Hospital 

Purpose 
The study purpose was to evaluate characteristics of professional practice reflected in the organization’s professional practice model through comparison to nurses’ perceptions of empowerment. The relationship between empowerment and the nurse education level and professional certification components of the professional practice model was examined. 

Background 
A professional practice model reflects the professional nursing practice of an organization, and practice components of autonomous practice and a nurse’s control over practice. 

Description of methods/procedures 
A comparative descriptive design was used. A total of 286 clinical nurses completed the Conditions of Work Effectiveness Questionnaire-II. Correlation of six subscales (opportunity, resources, information, support, formal power, and informal power) was examined, and average scores for total structural empowerment examined and compared across factor levels using ANOVA. Stepwise regression determined factors most influential on average total structural empowerment. 

Results 
Access to opportunity to learn and grow was the most empowering structure present. The overall empowerment score of 21.11 demonstrated a moderate level of empowerment (range 6 - 30). Stepwise regression showed that a professional certification increased the average total structural empowerment in nurses whose highest level of nursing education was an Associate Degree or Nursing Diploma (20.52 vs. 17.98, p = .056). Among nurses who obtained certification and/or had a Bachelor Degree or higher education, the average total structural empowerment was 2.90 points higher (95% CI [1.49 – 4.32]) than estimated for nurses who had obtained an Associate Degree or nursing diploma but had not yet received professional certification ( p < .001). 

Implications 
Findings from this study suggested that a professional certification and/or an education level of a Bachelor Degree or higher increased perceptions of total structural empowerment. Organizational strategies that aim to increase opportunity and access to information, resources, and support may help bridge the gap in empowerment especially in Associate Degree nurses.
Excellence in PACU Pain Management: How is our PACU Team Performing?

C.J. Marshak, MN, RN; Terry Bertignoli, BSN, RN;
Elizabeth Mulackal, BSN, RN CCRN; Ellen Reyes, RN, BSN;
Megan Duran, RN, BSN; Loretta Rojo, RN, CCRN; Heide Bradley, RN, BSN;
And Merly Ra quedan, BSMIE
Orange Coast Memorial Medical Center

Purpose
One of the most important goals in post anesthesia care is adequate pain management. Post Anesthesia Care Unit (PACU) pain management outcomes are not required measures for the hospital consumer assessment of healthcare providers and systems (HCAHPS). This project was designed to measure patients’ perception of pain management effectiveness in the PACU.

Description of methods/procedures
In preparation for the study, pain management classes were provided for all staff. Pain champions received additional education related to pain management. Order sets for pain management were reviewed by anesthesia and improved where needed. Team members developed data collection methods and a form. Pain assessment documentation was reviewed for consistency and inter-rater reliability was tested.

Results
Using the numeric rating scale (NRS), a sample of 405 surgical inpatients were asked to state their pain goal (their desired maximum/tolerable pain level) prior to surgery. The pain goal was documented at the PACU beside on the data collection form and in the electronic medical record. Immediately prior to transfer from the PACU to the next level of care, patients stated their final PACU pain level. This pain level was documented again and compared to the preoperative pain goal. The data were reviewed and assessed for pain levels less than or equal to the stated pain goal.

Conclusions
The aggregated data during the data collection phase demonstrated that more than 97% of the PACU patients met their stated pain goal. Sampled review of pre-project and post-project medical records confirmed prior and continued pain goal attainment. These results validated the observation that PACU nurses at this facility apply pain management techniques consistently, with resulting patient satisfaction.
HASTE: A Team Approach to Improving Pre-Hospital and ED Delays in Stroke Care

Angela West, MSN, RN, CCRN, CNRN and Melissa Dofredo, BSN, RN, CCRN
Long Beach Memorial Medical Center

Purpose
The purpose of the HASTE (Hyper Acute Stroke Team) is to utilize a case-study approach to uncover pre-hospital and ED delays, and offer performance improvement (PI) ideas to enhance stroke-care delivery systems.

Background
Organizations continue to seek innovative ways to decrease time delays and enhance stroke care delivery systems. After dissecting the case of an acute ischemic stroke (AIS) patient cared for in our facility, areas of improvement were noted from symptom onset until appropriate care.

Description of methods/procedures
The Stroke Program Director and a group of neuro-critical care nurses formed the HASTE to ameliorate delays noted in AIS care. Review of an AIS patient led to a schematic timeline map, which demonstrated minutes lost at each area of delay. Identified areas included lack of community knowledge on stroke, preventative delays in Emergency Medical System (EMS) on-scene time, lack of updated AHA/ASA guideline knowledge at an outside facility ED, inefficient transfer processes to our facility for endovascular intervention, and technical delays in medical record entry. All of these factors contributed to time lost for reperfusion therapy.

Results
Delays contributed to approximately 120 minutes lost. The HASTE initiated projects to address the delays. Community and EMS presentations covering the stroke urgency were created. Connections were made with outside ED educators to offer in-services on AHA/ASA updates. Improved transfer processes were coordinated with local private ambulances. A pre-admitted “John Doe-Stroke” medical record was considered for potential patients coming to our ED.

Conclusions
The HASTE approach is an innovative way to integrate knowledge gleaned from individual case studies to induce coordinated PI projects that affect the community, EMS, and ED. Further case study reviews can reveal other areas that the HASTE can positively affect change in the continuum of stroke care.
How Our Emergency Department Decreased Ambulance Diversion Time
Marlene Vermeer, RN, BAN, CEN and Efren Grospe, RN, BSN, CEN
Orange Coast Memorial Medical Center

Purpose
To develop and implement interventions to address Emergency Department Ambulance Diversion Time (ED-ADT), the consequential safety problems of long waiting room times and patients leaving without being seen (LWBS), and compromised patient satisfaction scores associated with ED overcrowding.

Background
As ED overcrowding spirals out of control nationwide, hospitals close their doors to ambulances, and patients die in waiting rooms or languish on the gurneys of ambulances lined up in hallways. Our ED lost its Paramedic Receiving Licensure (it was granted conditional status) in January 2014 because our ED-ADT time for the previous year had exceeded the maximum six percent (43 hours per month) allowed by OC-Emergency Medical Services. Our high closure times caused lost revenues. Patient safety was compromised as patients became more ill in the waiting room or they left without being seen (LWBS). Meanwhile our AVATARs lingered below benchmark. We were compelled to address our overcrowded conditions.

Description of methods/procedures
- Board Rounds: Care providers meet in real time to discuss patient flow.
- PerfectServe Alerts: ED notifies hospital management of imminent ED-ADT.
- Updated Triage Protocols: Triage Nurses place patients in beds immediately.
- ED/Telemetry Throughput Project: ED expedites patient transfers to telemetry.
- Holding Unit: New unit cares for admitted patients until hospital bed is ready.

Results
For period January 2013 to January 2014:
- ED Ambulance Diversion Time (ED-ADT) decreased 37.6% (down 206 hours)
- Left Without Being Seen (LWBS) unchanged
- Revenue increases commensurate with increased patient census
- Patient Satisfaction Scores (AVATARs) met benchmark and increased 4.5 % (up 4.1 points)

Conclusion
Collaboration and intervention in the ED and hospital wide to decrease Emergency Department Ambulance Diversion Time (ED-ADT) resulted in increased ability to receive ambulance patients, enhanced patient safety, and improved patient satisfaction scores.
Hyper Acute Stroke Nurse Initiative Improves Time to Initiation of Reperfusion Therapy

Melissa Dofredo, BSN, RN, CCRN; Angela West, BSN, MSN, RN, CCRN, CNRN; and Sia-McGee Lety, BSN, RN, CNRN
Long Beach Memorial Medical Center

Purpose
The purpose of the HAS nurse initiative was to improve time to IV tPA and endovascular intervention in stroke care, as well as physician and nurse satisfaction.

Background
Following Primary Stroke Center designation in 2008, several factors contributed to our hospital's influx of stroke patients. In 2010, our county's Emergency Medical System began diverting stroke patients to our hospital. In 2011, we became the only organization capable of providing neuro-endovascular treatments in the region. Our ED experienced increased workloads while attempting to deliver timely stroke. In May 2013, the innovative Hyper Acute Stroke (HAS) nurse was created to meet the time sensitive needs of our expanding stroke population.

Description of methods/procedures
With strong administrative and medical support, the Stroke Program Director and a group of critical care neuroscience nurses formed the HAS team. Orientation included NIHSS certification, training on how to respond to ED Code Strokes and transfers, and formation of stroke care algorithms. Daily rotation ensured 24/7 HAS nurse coverage. IV tPA door to needle (DTN) and door to cerebral angiogram (DTA) times were analyzed. Physician and nursing satisfaction was also surveyed pre- and postHAS nurse involvement.

Results
Data refers to the 12 months pre-HAS compared to data post-HAS nurse. When comparing pre-HAS to post-HAS time periods, DTN decreased from an 82 minute average to 49 minutes, while DTA decreased from 136 to 114 minutes. Physician and nurse satisfaction improved with the institution of the HAS nurse.

Conclusions
When responding to Code Strokes or assisting with transfers requiring emergent endovascular intervention, HAS nurse involvement improved time to intervention, and physician/nurse satisfaction.
Improvement of Pain Management
Nancy Lean, MSN, MHSA, RN, NEA-BC; Yuko Teimatsu, RN, BSN;
And Melissa Gunlund, MSN, RN
Orange Coast Memorial Medical Center

Background
Pain is a ubiquitous problem that continues to be undermanaged nationwide. In May 2012, pain management scores at Orange Coast Memorial Medical Center (OCMMC) were below national average as evidenced by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Inadequate pain management contributes to poor patient outcomes and decreased patient satisfaction. Thus, optimal pain management is of paramount importance.

Purpose
To develop and implement interventions to improve pain management scores at OCMMC.

Assessment of Barriers to Pain Management
In May 2012, the CNO at OCMMC commissioned a multidisciplinary taskforce charged with identifying barriers to appropriate pain management and developing protocols to target those barriers. The goal was to increase pain management scores from the 33rd to the 75th percentile on the HCAHPS survey. The taskforce identified several barriers including lack of knowledge, fear of side effects, attitudes/biases towards patients with addiction, ineffective nurse-physician communication, delays in reporting pain and lack of a well-defined chain of commands.

Interventions to Improve Pain Management
Pain Management Classes: Two in-service activities (a 2-day workshop and a 4-hour class) designed to increase nurses’ knowledge about pain management were initiated. To date, 139 nurses, representing 31% of OCMMC nurses, completed one of these activities.
Pain as 5th Vital Sign: Placed “Pain Assessment” directly following vital signs on EPIC tool bar and on nursing assessment flow sheet. This emphasized importance of pain assessment and facilitated better documentation.
Pain Chain of Command (PCC): Developed a visual/practical tool delineating steps for reporting pain and wait time between steps for physician callbacks. The tool continues to be posted in all medication rooms throughout the hospital.

Conclusion
Increasing knowledge level coupled with the PCC use improved pain management as evidenced by HCAHPS at the 75th percentile for 4th quarter of 2013.
Improving Discharge Medication Safety and the Patient Experience Through Interdisciplinary Partnerships

Paddy Garvin Higgins, MN, RN, CRRN, CNS; Raquel Paige, MSN, RN, CNS, CPN;
Larry Lovett, Pharm D; and Chris Holland, RN, CRRN
Long Beach Memorial Medical Center/Miller Children’s Hospital

Purpose
Improve discharge medication safety and patient/family satisfaction by establishing a direct pharmacy consultation with early delivery of discharge medications.

Background
Discharge is a critical juncture for transitioning patients to home. Incomplete processes can lead to readmissions and negative patient experiences. Understanding prescribed medications is essential. Patients follow prescribed medication regimens about half of the time, leading to 125,000 deaths annually in the U.S.1 For patients facing chronic disease management, this leads to negative consequences.

Description of methods/procedures
A project team was formed (nursing, medicine, pharmacy) and using Lean methodology, we analyzed the existing discharge process and identified areas for improvement.

Implementation
Process design incorporated assessment of patient preparedness for discharge, medication reconciliation and a direct 1:1 pharmacy consultation with delivery of medications to patients in two specialized areas, a general pediatric unit serving children with diabetes and an adult inpatient rehabilitation facility (IRF). IRF revenue/cost savings along with length of stay (LOS), hospital readmission and patient/family satisfaction rates were studied for both areas.

Results
Actual prescriptions filled onsite for IRF (June 2010-September 2010) yielded $32,000 income. Annual projection in IRF 2012 is $120,000-$150,000.
January-December 2012: LOS IRF 15.4, now 14.0; Pediatric Unit 3.4, now 2.9.
Satisfaction data related to discharge instructions: IRF 90.80, now 94.16; Pediatrics 91.30, now 92.86.

Implications
Nursing plays a critical role in facilitating Interdisciplinary discharge medication education. This leads to a decrease in readmissions and improvement of the overall patient care experience.

Behavioral Objectives
To develop a discharge medication process that yields improved patient care and fiscal outcomes.
To illustrate the role of the RN in process improvement in patient/family centered care.
References


Norman, G. “It takes more than Wireless to Unbind Healthcare.” Presentation at Healthcare Unbound 2007 Conference.
IMPROVING OUTCOMES IN OUT-OF HOSPITAL CARDIAC ARREST
Heather Wyma, MSN, RN, CNS, CEN; Annette Austin, BSN, RN, CEN; and Christopher Walker, MSN, RN, CNS, CEN
Sharp Healthcare

Background/Problem
Challenges exist among hospital staff in performing high quality cardio pulmonary resuscitation (CPR) according to the 2010 international guidelines. Effective and uninterrupted chest compressions improve patient outcomes. The literature recommends that education and training specific to teamwork and leadership be provided to healthcare providers caring for patients requiring resuscitation.

Aim
The overall aim of this study was to evaluate patient survival and neurological outcomes using a nurse team leader approach that was initiated in June 2012 for the management of out of hospital cardiac arrest in the emergency department.

Methods
The practice change occurred in five phases beginning in February 2012 through June 2012 at a large medical center in Southern California to include resuscitation team training and nurse leadership training. A retrospective data analysis design was used and data was collected during a six month period pre and post-practice change.

Conclusion
The results demonstrated no significant differences ($\chi^2$ test, $p = .058$) in patients achieving return of spontaneous circulation in the pre group (7/20) compared to the post group (2/20). There were no significant differences in survival to discharge with two in the pre-group and none in the post group. Neurologic outcome was not analyzed due to the lack of survival in the post group.

Implications for Practice and Further Study
The results suggest that future research should include a large group of subjects to fully evaluate the effect through patient outcome analysis. The implementation of an evidence based nurse led resuscitation team training program in the emergency department can promote teamwork and empowerment among staff. Training specific to leadership skills to empower nurse timing of events, introduce team skills such as pre-brief and de-brief and cross monitoring team adherence to resuscitation treatment guidelines.
Improving Patient Quality in Pediatric Diabetes Care Using Lean Methodology through Care Coordination across the Continuum

Carole Colln, RN, MSN; Suzie Reinsvold, MSN, RN; and Joyce Volsch, RN, PhDc
Miller Children’s Hospital Long Beach

Background
Quality of care in the newly diagnosed, pediatric, diabetic patient goes beyond the walls of the hospital. A team of inpatient/outpatient nurses, physicians, and ancillary staff, used Lean methodologies to formulate new processes to improve communication, reduce patient wait time, and enhance education.

Purpose
The purpose of this project was to address the continuum of care and provide a seamless transition from inpatient to outpatient, resulting in competent self-management and stability. Poor diabetes control can result from a lack of education, poor communication, or extended wait times.

Description of methods/procedure
Our Length of Stay (LOS) was 2.5 days longer than the national average. Wait between discharge and first follow-up visit was unsatisfactory (23-56 days). The outpatient setting reported unsatisfactory HgbA1C results indicating poor self-management. Bedside rounds addressed patient status, daily goals, and educational needs. A new schedule increased the number of teaching sessions from one to up to three/day by the outpatient Certified Diabetic Educator (CDE), rather than by the bedside nurse. Delivery of equipment and supplies to the bedside occurs within 24 hours of admission. New level-loaded schedule template was created for the outpatient setting.

Results
Our LOS reduced from 4.26 to 2.43 days. The outpatient CDE providing education to the hospitalized patient increased continuity of information. A 30% improvement in HgbA1C levels at subsequent follow-up visits indicated patient compliance and self-management. Early delivery of home supplies allows patient/family time to become competent with their own equipment throughout their hospitalization instead of in the hours just before discharge. The discharged patient is seen in the outpatient setting within 7-14 days.

Conclusions
Improved inpatient/outpatient interdisciplinary collaboration and communication reduced fragmentation in care. Education by one content expert caregiver provides uniformity of information delivered, eliminating inconsistency. A timelier follow-up visit to the outpatient setting allows the team to address issues before they become problematic.
Infection Burden Measure in NICU
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Purpose
To assess antibiotic use as a part of the infection burden measure and identify strategies to
decrease antibiotic days in the NICU.

Background
Baseline data indicated there was 10-fold antibiotic days per 1000 patient days to treat clinical
sepsis versus central-line associated bloodstream infection, and the total antibiotic days were
approximately 30% of total patient days.

Description of methods/procedures
A quality improvement project based on the Aim-PDSA model was initiated in 2008. Data on
antibiotic days was collected over a 6-month period every 2 years from 2008 to 2012. Total
broad spectrum cephalosporin days in the NICU in relation to Extended-Spectrum Beta-
 lactamase (ESBL) producing organisms were also evaluated and compared during this period.
Several small tests of change were conducted which included discussion and determination of
antibiotic days during daily patient rounds; monitoring patient clinical data/labs for signs of
infection; and specifying an end-date for antibiotic treatment by the ordering provider.

Results/Outcomes
Total antibiotic days were reduced from 31.4% in 2008 to 22.3% and 24.9% in 2010 and 2012
respectively, while cephalosporin days remained similar. The duration of antibiotic days with
treatment days of equal or less than 2 days significantly increased from 6.7% in 2008 to 13.9%
and 39.7% in 2010 and 2012 respectively. Concurrently, antibiotic duration of 4 to 6 days
decreased from 22.9% in 2008 to 4.4% in 2012. As a result, cost savings were estimated at
$64,725 in 2010, with further savings estimated at $39,686 in 2012.

Conclusions
Decrease in antibiotic days did not result in an increase of clinical sepsis in the NICU. Current
strategies of limiting antibiotic duration for neonates with rule-out sepsis, neonatologists
communicating antibiotic orders with defined end date and time to nurses, and pharmacists
monitoring antibiotic duration with neonatologists follow-through during patient rounds will
continue.
Joint Replacement Program
(Sailing Through Joint Replacement Surgery)
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Purpose
To evaluate the effects of an evidence-based patient-family centered program for patients with total joint replacement on patient satisfaction and selected patient outcomes: rate of blood transfusion; length of stay; disposition to home, and incidence of complications.

Background
Lack of a standardized protocol for management of patients with total joint replacement was associated with poor patient outcomes, including increased need for blood transfusion, length of stay, and incidence of complications. In 2012, Orange Coast Memorial partnered with Marshall Steele & Associates to develop and implement a program of care designed to improve clinical outcomes in patients with total joint replacement.

Program Description
The Destination Center of Superior Performance program was built around patients with total joint replacement and their key need along the continuum of care. This comprehensive program included: extensive pre-op education; trained healthcare team that follows standardized protocols; group physical therapy; involvement of family; daily newsletters on activities for the day; and an inclusive discharge class in preparation for transition home.

Program Implementation
Seven physicians agreed on a standard of care which aimed at eliminating factors that contributed to delayed physical therapy. These included discontinuing use of patient controlled analgesia, eliminating the use of foley catheters, using clear criteria for blood transfusions, instituting group physical therapy and ambulating patient on day 0.

Results
Implementation of the program was associated with a reduction in blood transfusion rate from 11.8% to 5%, a decrease in the length of stay from 2.88 days to 2.16 days, an increase in disposition to home vs. skilled nursing facility from 55% to 86%, and a decrease in complications rate from 6.5% to 0.8%.

Conclusions
Implementation of a standardized evidence-based program for total joint replacement patients improved patient outcomes, increased volume of total joint replacement patients, and increased physician, patient, and employee satisfaction.
Measuring the Evidence: Quantifying Blood Loss at Birth Saves Lives
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Focus of Abstract
Evidence Based Practice
Purpose
The goal of this training is to increase the performance and documentation of quantitative blood loss (QBL) at delivery and at the end of the postpartum recovery period. By increasing performance and documentation of QBL we increase the staff’s ability to recognize significant blood loss and implement quicker interventions in the management of PPH.

Background/Significance
Postpartum hemorrhage (PPH) is an obstetrical emergency and is estimated to cause 25% of all maternal deaths in the US. It is estimated that worldwide, 140,000 women die of PPH each year. The accepted practice of estimating blood loss (EBL) has been demonstrated to be grossly inaccurate. Evidence demonstrates, that QBL is an accurate assessment method to use in guiding the clinical management of PPH. Incorporating QBL into clinical management helps to ensure that women receive appropriate care and thus prevent maternal mortality.

Description of methods/procedures
Nursing staff participated in a clinical skills workshop providing experiences in the performance and documentation of QBL. Practical experience comparing the efficacy of EBL and QBL was provided. Charting techniques were reviewed. Targeted audits of delivery records were performed for individual nurses that participated in the workshop. Chart audits included three charts prior to the workshop and three charts after the workshop.

Results
Nurses EBL’s varied significantly from actual QBL (range -1062ml to +1597ml). Efficacy performing QBL was established (100%). However, preliminary results revealed a decrease (85.7% vs. 80.6%) in documentation after participating in workshop.

Conclusions
Participating in QBL workshop significantly improved the accuracy and ability to determine blood loss (100%). However, this accuracy does not translate into accuracy of documentation with review of these skills. Therefore, the workshop has been modified to include practical application of documentation skills. Data will continue to be collected until July 2014, and will be compared to current results at final presentation.
References


Nurse Identified Barriers and Facilitators to Palliative Care Consultation Initiation
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Purpose
Palliative Care Services (PCS) are beneficial to patients who require end-of-life (EOL) planning or those suffering from a terminal illness. PCS is intended to address the needs of patients and their families using a holistic supportive approach. Unfortunately, studies have shown that up to 30% of patients feel communication with the dying patient is greatly lacking (Calbots, 2012).

Background
The role of the primary nurse in initiating and assessing patients and caregivers for PCS is crucial. Thus, it is important to understand the attitudes and feelings of nurses related to consultation initiation. Addressing the barriers to consulting the Palliative Care Team will also assist in issues related to financial strain. It is estimated that a quarter of Medicare’s $550 billion annual budget pays for treatment in the last years of patients’ lives, which involves time spent in an ICU where the cost of futile care can reach well over $300,000 in one week (Mcgrath, Foote, Frith, & Hall, 2013). Using a four-point Likert-scale and open-ended questions, registered nurses in five hospital units were surveyed about their experience with initiating palliative care consultations at a 334-bed acute care facility. Forty-four RNs volunteered and returned the survey to designated locked boxes.

Results
Results showed that limited education and comfort with discussing EOL planning was a barrier to initiating palliative care consultation. However, nurses also reported that the physician was the biggest barrier due to the referral process at the facility of study. Nurses believed that PCS referral facilitators would include continued education for both nursing and primary physicians as well as increased nurse autonomy. Data support that insufficient knowledge and comfort inhibit referrals for adjunctive PCS in the acute care setting. As a result, there is an underutilization of Palliative Care Services and a need for review of the referral process as well as clarification of nursing roles in EOL care and planning.

Conclusions
Recommendations for future studies include additional physician survey with additional questions regarding nurse-physician communication and its impact on PCS referral.
Nurse-led Heart Failure Patient Education Clinic
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Purpose
The purpose of this project are a) reduce 30 day all-cause readmission rates for inpatients with heart failure (HF) diagnosis by 20%, and b) prevent Centers for Medicare and Medicaid Service (CMS) readmission penalties.

Background
In 2010, approximately 6.6 million Americans were living with HF (American Heart Association, 2012). CMS established the Hospital Readmissions Reduction Program effective for HF patient discharges beginning October 1, 2012 which requires CMS to reduce payments to hospitals with excess 30-day readmissions. A diagnosis of HF requires significant involvement of the patient in his/her own care for successful quality of life. As a result, patient education on the disease is considered a vital aspect of treatment (Jackson & Emery, 2011).

Description of methods/procedures
OCMMC established the nurse-led Heart Failure Education Clinic in April 2013. The HF Education Clinic team is led by two Acute Care Nurse Practitioners, one Clinical Coordinator RN and the support of the telemetry unit RNs. The HF Education Clinic provides both inpatient and outpatient education to recently hospitalized HF patients and their family. Education topics include the disease process, medication purpose, use and side effects, dietary and fluid guidelines, self-monitoring including weight and blood pressure monitoring, symptom recognition, lifestyle guidelines and reasons to contact your health care provider.

Results
HF readmission rates were reduced from 21.74% in FY 2011 to 14.85% in FY 2014 year to date. In comparison, the national average of 30-day readmissions for HF patients is 23.0%.

Conclusions
A diagnosis of heart failure creates the need for patient self-care to preserve heart function, avoid hospital admissions, and maintain quality of life. The implementation of the nurse-led HF Education Clinic resulted in a significant decrease in heart failure readmissions and prevention of CMS penalties.
References


READY-BED: ED to Telemetry Throughput
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Purpose
To eliminate or significantly reduce the patient hold time after the MD order to admit to Telemetry to increase ED capacity and decrease diversion hours.

Background
The Emergency Department was holding patients prior to being placed in an inpatient bed resulting in patient complaints, decreased patient safety due to patients waiting to be seen, a significant increase in diversion hours and lost revenue.

Program Description
A multidisciplinary team including nurses from ED and Telemetry, physicians, Administrative House Officers, Case manager, EVS, and IS developed the READY-BED concept defined as a bed that is clean, equipped and staffed to receive a patient, to always be available. The telemetry unit was selected as the pilot as 45% of all ED admissions go to telemetry.

Program Implementation
The READY-BED program developed processes for the receiving unit “pulls” the patient by calling the ED for report within 15 minutes of the bed assignment. Discharge planning begins on admission with Anticipated Discharge Date (ADD) assigned to patient within 24 hours of admission. This redistributed patient discharges to be level loaded and earlier in day with discharge by appointment.

Results
The process changes that were implemented resulted in a decrease in time from “bed assigned” to “wheels out of ED” from a mean of 57 minutes to 37 minutes, decreasing the gap of HCAPS score on Telemetry to benchmark on questions related to discharge: #19 Help needed after discharge 9.99 to 2.88, #20 Written discharge instructions 9.57 to 1.57, #21 Rate the hospital stay 8.87 to exceeding benchmark, #23 Preferences discharge needs 11.74 to 3.74. ED diversion hours decreased from a high of 212 to 7 for the same month in the next year.

Conclusion
Joint effort between departments resulted in decreased diversion time, increased throughput and patient satisfaction.
Staff Perceived Barriers and Self-Efficacy in Fall Prevention at a Community Hospital

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Purpose
The aims of this study included: determining if staff member self-efficacy impacts fall reduction and ascertaining what barriers existed with fall prevention program compliance by discipline in a community hospital.

Background
Patient falls remain one of the leading causes of injury among older adults\(^1\), both causing adults to seek medical care\(^2\), as well as being a common adverse event in acute care\(^3\). Little research has focused on staff self-efficacy or perceived barriers to fall program compliance.

Methods
A descriptive, correlational study was conducted via an electronic survey administered over a 4 month period in 2012 to a convenience sample of RN and Unlicensed Assistant personnel (UAP) at the main campus of a community hospital. 194 total participants responded including 129 RN’s and 65 UAPs.

Results
Staff member self-efficacy was found to be statistically significant in fall prevention protocol compliance (p=.000) as well as registered nurses’ level of education (p=.004) and years of experience (p=.003). This finding is consistent with existing research that states that RNs possessing higher education and certification are associated with less medical errors\(^4\). There


was no correlation among UAP staff levels of education, experience, or self-efficacy in relation to patient falls. The top two barriers to adherence with fall prevention protocols for both groups were lack of sufficient staff (RN: n = 95 or 73.7% and PCA: n = 41 or 58.5%) and lack of equipment (RN: n = 95 or 73.6% and PCA: n = 36 or 51.4%).

Conclusions
This study determined that there are universal barriers despite discipline of employment and there are some discipline-specific barriers that could be addressed to aid in fall prevention program adherence at a community hospital.