Cone Health Nurse Executives

Theresa Brodrick, RN, PhD, CNS, CNA
Executive Vice President & Chief Nursing Officer

Anna Brown, RN, MSN, PCCN
Director, Nursing/Patient Services
Wesley Long Hospital

Dennis Campbell, RN, MS, BSN
Executive Director, Quality Excellence

LaVern Delany, RN, MSN, MHA/MSA
Director, Nursing/Patient Services, ICU Service, Moses Cone Hospital

Debbie Grant, RN, MSN, CEN
VP Nursing/Patient Services, Women’s Hospital

Debbie Green, RN, DNP, CENP
VP Nursing/Patient Services, Moses Cone Hospital

Debbie Green, RN, DNP, CENP
VP Nursing/Patient Services, Annie Pern Hospital

Interim VP Nursing/Patient Services, Behavioral Health Hospital

Cheryl Hausner, RN, MSN, MSED
Director, Nursing Practice and Education

Karlin Henderson, RN, MSN, CENP
Executive Director, Organizational Integration

Joan LoPresti, RN, MS, BSN
Interim Director, Nursing/Patient Services, MedSurg Service, Moses Cone Hospital

Sue Pedaline, RNC, DNP, MS
VP Nursing/Patient Services, Women’s Hospital

Annette Smith, RN, MSN
VP Nursing/Patient Services, Wesley Long Hospital

Cheryl Somers, RN, MSN, NEA-BC
Executive Director, Emergency Services

Youland Williams, RN, MSN, NEA-BC
Executive Director, Nursing, Oncology Services
Message from the CNO: Shadowing

We serve our communities by preventing illness, restoring health and providing comfort, through exceptional people delivering exceptional care.

Since my arrival at Cone Health almost two years ago I have been shadowing nurses in different departments across the network. Many of our senior leaders also shadow nurses; they do this to gain a better understanding of what occurs in various departments and to experience what staff do each day to provide for our patients. Over the past couple of months I have shadowed nurses in departments 3700 at Moses Cone Hospital, Carelink, the Moses Cone OR and the Cancer Center Infusion Center at Wesley Long Hospital.

I enjoy my shadowing experiences for a number of reasons. I get to know you better. I get to know your names, your faces and to see what you do every day. I also appreciate that you allow me to hang over your shoulders and learn the pure joy of being close to our patients. This is a real pull for me; it reminds me of why I went into nursing. Each day I shadow in an area, I can’t wait to share with my secretary Michelle (who is amazing) and my family (they’re amazing too) what an incredible day I had.

I LOVE my job as CNO at Cone Health, and I never want to forget why I am a nurse and why I love the profession of nursing. Shadowing with you keeps me close to you and to our patients and grounded in my love nursing.

Respectfully,
Theresa Brodrick, RN, PhD, CNS, CNA

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From the Editor

Keys in the bathroom...

Since my last editorial I have moved to the Magnet Program coordinator (trainee) role. That meant taking up residence in the Northwood building (the “black box”). The first day I went to the bathroom and left my keys, including my car and house keys, on top of the toilet paper dispenser. Since I had not locked my office door and did not need them to get back in (so why did I take them in the first place?), it was hours before I discovered what I had done. You know that feeling – a thousand thoughts and fears cross your mind in an instant.

Sherese Bell, Administrative Assistant for Dennis Campbell, Executive Director of Quality Excellence, found the keys, enlisted her co-workers’ help to find out which car in the parking lot belonged to them, and then posted signs at the elevators and in the hallways. When I got my keys back and could ditch the plans for calling a locksmith for my car and home, an amazing feeling of support washed over me.

Being a novice is no fun, no matter how much life or professional experience you have. But as I started my new position, my co-workers had my back. Being a patient is no fun either. Being out of control, in pain, fearful and in a foreign environment, not to mention the disruption that illness and injury causes in the family rhythms, throws all sense of order out the window. Who is the patient’s anchor in the health care system? We are. Nurses have patients’ backs. We keep them free from infection, keep their skin from breaking down and keep them from falling. We keep them from feeling trapped by restraints with our creative solutions to the threats to their safety. There are some key things good nursing can prevent. That’s why NDNQI calls them “nurse sensitive” indicators.

The support I felt at the end of the “keys in the bathroom” incident helped me get over a mini crisis and move forward. The best nursing care helps our patients get over major crises and move forward, and keeps them safe while doing so. Nurse sensitive means nurse critical, nurse impact, nurse domain. What we do matters – every day, every hour, every minute.

Please don’t underestimate what you do every moment you practice good nursing care.

Sarah Lackey, RN, MSN, CCNS, Editor-in-Chief
Magnet Program Coordinator, Trainee
Rapid Response Team, Relief
sarah.lackey@conehealth.com

“Nurses have patients’ backs.”

“Nurse sensitive” means nurse critical, nurse impact, nurse domain.”

Read Nursing Beat online. Go to the intranet home page and click on the Nursing Beat logo.
The Obstetric Rapid Response Nurse
Brings Expertise to the Patient’s Bedside

By Beth Smith, RN, MSN, NE-BC

“The goal of the OBRRN is to bring expert obstetrical care to the patient’s bedside wherever she is, and to assist with maternal and fetal monitoring and care.”

- Amy Skrinjar, RN, MSN, Birthing Suites Department Director.

The birth of a baby is the fulfillment of hopes and dreams for many of the patients we serve. If you are expecting, chances are you go to all the classes, eat all the right foods, lay out tiny new baby clothes and decorate a nursery. But what if suddenly your life changes when your car is involved in a motor vehicle accident? You are transported as a trauma patient to the Emergency Department (ED) at The Moses H. Cone Memorial Hospital, and all you can think about is your baby. You arrive at Moses Cone Hospital where you are evaluated for injuries, but there is no one immediately available with obstetrical expertise to evaluate your baby. Prior to April 8, 2012, this would be the scenario for a pregnant trauma patient in the Cone Health system. But now, thanks to a special team, support for pregnant women involved in trauma is available 24 hours a day.

Spearheaded by Theresa Brodrick, RN, PhD, CNO, CNA, an interdisciplinary group developed and implemented the role of an Obstetrics Rapid Response Nurse (OBRRN). This nurse is charged with responding to potential or ongoing obstetric emergent conditions at Moses Cone Hospital, Wesley Long Hospital and Women’s Hospital. According to Amy Skrinjar, RN, MSN, Birthing Suites Department Director, “The goal of the OBRRN is to bring expert obstetrical care to the patient’s bedside wherever she is, and to assist with maternal and fetal monitoring and care.”

The interdisciplinary committee was comprised of representatives from Trauma, Neonatal Intensive Care, Emergency Department, Pediatric Emergency Department and Birthing Suites. Members convened in December 2011 to evaluate care of obstetrical patients treated at the emergency departments on campuses other than Women’s Hospital. This team evaluated how frequently prenatal patients greater than 20 weeks gestation were seen in ED settings. Historically, care provided through collaboration between obstetrical providers and the ED physicians involved pregnant women who experienced motor vehicle accidents, trauma, atrial fibrillation, shortness of breath, pneumonia, possible labor, suicidal attempts, and pre- and post-op monitoring. They also reviewed calls for fetal assessment and assessment of pregnant patients who were admitted as inpatients to Moses Cone Hospital, Wesley Long Hospital and Women’s Hospital.

Since its creation, the OBRRN team has been called to the Moses Cone Hospital and Wesley Long Hospital campuses to evaluate an average of 30 pregnant patients each month. The OBRRNs have been well received in those campus Emergency Departments. ED staff report that the collaboration has improved patient care in many ways and has fostered mutual respect and admiration for each nursing practice specialty. The OBRRN, in addition to responding to other campuses, also assists at Women’s Hospital with triage, emergencies, STAT cesarean-section births, deliveries with shoulder dystocia, vacuum-assisted deliveries, multiple births, rapid admits for labor and postpartum hemorrhages. The results? Better outcomes for our patients.

The Obstetric Rapid Response Nurse is available to care for obstetrical patients at Women’s Hospital, and on the Moses Cone and Wesley Long campuses.

DermaTherapy Academy Celebrates Cone Health’s Achievements

Annette Smith spearheads the DermaTherapy project.

DermaTherapy linens significantly reduce hospital-acquired pressure ulcers (an NDNQI nurse-sensitive indicator) and decrease hospital lengths of stay. Cone Health is the first health care organization in the world to study and implement DermaTherapy linens.

“...the DermaTherapy Academy was held March 1...”

“The purpose of the academy was to share results from Cone Health’s evidence-based research. After three clinical trials between August 2008 and June 2011, results showed that DermaTherapy linens significantly reduce hospital-acquired pressure ulcers (an NDNQI nurse-sensitive indicator) and decrease hospital lengths of stay. Cone Health is the first health care organization in the world to study and implement DermaTherapy linens.”

Barbara Deskins is the Cone Health education champion for DermaTherapy and helped coordinate the event.

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Ventilator-Associated Pneumonia in the Trauma Patient: An Accident Prevented by Thinking Outside of the Bundle

By Sarah Clark, RN, MSN, CCRN, and Sue Ashcraft, RN, MSN, ACNS-BC

Ventilator-associated pneumonia (VAP) is a preventable health care-associated infection that affects 8 to 28 percent of critical care patients and increases a patient’s stay in the Intensive Care Unit by four to six days (www.haiwatch.com). The nurses on Moses H. Cone Memorial Hospital’s Department 3100—Neurologic Intensive Care Unit (Neuro-ICU)—took action to “zap VAP” for their patients. Here’s how they did it.

Step One: Identifying triggers and formulating a burning question
Although existing VAP prevention strategies in the Neuro-ICU yielded 98 percent compliance, rates plateaued for two consecutive years. The monthly VAP infection rate also showed great variation, ranging from zero incidents some months, to as many as 34 other times. Department 3100 nurses recognized the need for rethinking existing strategies to decrease VAP rates in trauma patients. These factors served as an impetus for the burning question: will implementing multidisciplinary trauma rounds decrease the incidence of ventilator-associated pneumonia?

Step Two: Forming a team
Neuro-ICU nurses and Trauma Services recognized the importance of adopting an interdisciplinary approach. Additional stakeholders were added to the team, including a dietician, pharmacist, and respiratory and physical therapists. Leadership from nursing and respiratory therapy also weighed in. Team members included Heather Klenk, RN, BSN; Devon Lofters, RN, BSN; Megan Powell, RN, BSN; Debbie Underwood, RD; Teri Hicks, RRT; Denise Verga, RN, MSN; Shawn Rayburn, PA-C; Burke Thompson, MD; Heather Pitts, RD; and Sue Ashcraft, RN, MSN, ACNS-BC.

Growing in Practice

Adult-Gerontology Acute Care Nurse Practitioner
Jessica Karam RN, MSN, AGNP-C, Piedmont Senior Care
Kimberly Burkhart, RN, MSN, NP-C, SW/EE General Surgery/Orthopedics, Wesley Long Hospital
Certified Critical Care Acute Care Nurse Practitioner
Margaret Gilschist, RN, MSN, CCRN, CCA, 2100-Medical-Surgical Intensive Care, Moses Cone Hospital
Certified Geriatrics Nurse Practitioner
Julie Eastwood RN, BSN, CGN, Emergency Department, Ainni Penn Hospital
Nursing Professional Development Certification
Kristin McLamb, RN-BC, MSN, Staff Education

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When Current Practice Is Not Best Practice: Using the Iowa Model to Change Practice

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By Sarah Clark, RN, MSN, CCRN, and Sue Ashcraft, RN, MSN, ACNS-BC

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Setting the Pace

Dawn Whitmire, RN-BC, MSN, CNOR, Staff Education
Certified Emergency Nurse
Paula Ozment, RN, BSN, CEN, Cone Health CareLink
Hazel Reich, RN, CEN, Cone Health CareLink
Certified Flight Registered Nurse
Jeff Carr, RN, CCRN, Cone Health CareLink
Critical Care Registered Nurse Electronic
Elizabeth Suits, RN, CCRN, eLink Critical Care
Critical Care Registered Nurse
Rita Brown, RN, BSN, CCRN, Department 2900, Moses Cone Hospital
Holistic Baccalaureate Nurse
Margaret Ann Martin, RN, HNB-BC, BS, Intermediate Care/Urology, Wesley Long Hospital
Nurse Executive Advanced Certification
Lisa Boland, RN, MSN, NEA-BC, Nursing Administration
Dennis Campbell, RN, MSN, NEA-BC, Quality and Patient Safety

Advancing in Education

MSN
Mildred Brooks, RN, BSN, MSN, Emergency Department, Wesley Long Hospital, Western Governors University
Kimberly Burkhart, RN, MSN, MSN, Department 6E-Orthopedics, Wesley Long Hospital, University of North Carolina at Greensboro, December 2012
Benjamin Harrison, RN, BSN, MSN, Department 6E-Orthopedics, Wesley Long Hospital, University of North Carolina at Greensboro, December 2012
Kimberly Lynn, RN, MSN-Ed, BSN, CCM, Triad HealthCare Network University of Phoenix, December 2012

Associate Degree in Nursing

Katie Silk, RN, Department 6E-Orthopedics, Wesley Long Hospital, Guilford Technical Community College, December 2012
Susan Walton, RN, Department 6E-Orthopedics, Wesley Long Hospital, Guilford Technical Community College, December 2012
Joanna Warren, RN, BSN, Department 3300, Moses Cone Hospital, Winston-Salem State University, December 2012
Karloyn Bajos, RN, CEN, Critical Care, Wesley Long Hospital, Guilford Technical Community College, December 2012

Paramedic

Sharon Hayes, NS/NT, Maternity Admission Unit, Women’s Hospital
Rockingham Community College, March 2013

CONE HEALTH
Step Three: Reviewing the evidence

A literature review revealed that team rounding using an interdisciplinary tool had a beneficial effect on VAP rates. This rounding technique had not ever been tried as a part of the Cone Health VAP bundle. The team took the opportunity to incorporate this new knowledge and seek innovative improvements in practice.

Step Four: Changing practice

Each discipline was responsible for confirming specific evidence-based practices that prevent VAP. The strategies were then merged into a check-off tool to be used during rounding for the specific purpose of VAP prevention. The tool was frequently modified in the beginning to improve team communication.

The interdisciplinary team rounded twice a week. Nurses recognized and valued the impact rounding made on patient outcomes and began daily rounding on all ventilated patients using the tool, as well as intervening promptly.

Step Five: Evaluate the practice change

Daily nursing rounds and biweekly interdisciplinary rounds had an amazing impact on patient outcomes. Trauma Service patients have experienced a VAP rate of zero for six consecutive months. The nurses expanded the process to include every ventilated patient in the unit, resulting in the overall VAP rate decreasing from 3.0 to 1.54. Leadership strongly supports rounding and prompt intervention to continue to deliver excellent care to this patient population.

Step Six: Dissemination

The findings from this project will be shared through a poster presentation in May at the National Teaching Institute and Critical Care Exhibition hosted by the American Association of Critical-Care Nurses.

How’s that for zapping VAP?

References:
Cone Health Introduces LVAD Program

By Ali Cosgrove, RN, MSN, APRN, AGNP-C and Ashley Jarrell, RN, BSN, BA

Imagine caring for a patient who has no palpable blood pressure but functions well enough to carry on a conversation. Imagine not initiating CPR when that same patient’s heart goes into ventricular tachycardia or ventricular fibrillation. Imagine that patient’s cardiac function relying on an external battery. If you can imagine these things, you can imagine a patient with a Left Ventricular Assist Device, or LVAD. Moses Cone Hospital is debuting its LVAD program this spring, to improve outcomes for patients with advanced heart failure.

Heart failure is a disease in which the heart loses its ability to pump enough blood to meet the body’s needs. It is a chronic and progressive disease, affecting over five million people in the United States alone. Heart failure is classified into four categories based on symptoms experienced during activities of daily living. With Stage IV disease, a patient is eligible for treatments beyond medication therapy alone, such as a heart transplant or LVAD placement.

Up until now, patients that qualify for this device would have to travel across the state for evaluation, surgical implantation, and ongoing treatment and follow-up. But beginning this spring, the device, known as the Heartmate II, will be offered to select individuals, and surgically implanted at Moses Cone Hospital by Dr. Peter Van Trigt. Surgical implantation is a complex procedure requiring an inpatient stay. Outpatient follow-up will take place at the Cone Health Heart Failure Clinic, operated by Dr. Daniel Bensimron.

Simply stated, the LVAD device performs the pumping that would typically be performed by the left ventricle, and allows a patient’s sick heart to rest. The Heartmate II LVAD is a pump attached to a patient’s own heart with a driveline that exits the body near the abdomen. The line is then connected to an external controller device that dictates the LVAD pumping rate, and monitors for complications. The device must have access to electrical power at all times, either by batteries or by conventional electrical power.

LVAD’s will be used in both temporary and in longer-term scenarios. For heart transplant candidates who cannot manage the wait until a donor heart becomes available, an LVAD can be implanted temporarily. Other patients with advanced heart failure who fall short of qualifying for heart transplants may qualify for LVAD “destination therapy,” or long-term mechanical circulatory support.

Ali Cosgrove, RN, MSN, APRN, AGNP-C, has been named the LVAD Coordinator for this new program. Cosgrove explains, “In the past when patients were considered to be in Stage IV heart failure, they did not have many options left for treatment. The goal with this treatment is to increase the patient’s length of life, but also to offer them quality of life.” Cosgrove and her multidisciplinary team will work to educate patients, and to facilitate their medical care both prior to and after surgical placement.

When asked about the most exciting aspect of this job, Cosgrove answers, “These patients and I will develop a therapeutic relationship that will last not only from the time of their workup and surgery, but for as long as they have their device. My team and I will be charged with teaching these patients how to adjust to living with this pump. We will need to bear in mind that we are not just treating the patients medically, but holistically, so we will need to address their psychosocial needs, too.”

The onset of a sickle cell crisis, which can be triggered by something as small as a change in temperature, can mean a painful hospital stay. This spring, sickle cell patients will have a new option – the Cone Health Sickle Cell Medical Center. Opening in a renovated wing of Wesley Long Hospital, the Center will allow sickle cell patients to receive both primary and acute care needs in one location, according to Carol Washington, RN, MS, NEA-BC, Assistant Director, Cone Health Sickle Cell Medical Center.

“Nurses were empowered to provide input in the early planning stages for the new clinic,” says Kenny Miller, RN IV, BSN, OCN, Wesley Long Hospital Inpatient Oncology. A patient-centered, holistic approach will ensure that every patient has physical and psychosocial needs addressed at the clinic and after discharge. A nurse practitioner, a team of nurses, and admission service associates (positions somewhat similar to nurse techs) will join social workers and case managers to follow patients from admission to post-discharge. Dedicated staffing and post-discharge follow-up will provide consistent relationships between patients and staff to create an effective caring and healing environment.

Initially, sickle cell disease patients who present to the ED for pain control will be evaluated and treated there. The ED physician will determine the next course of action, including follow-up care at the Center. The Center has five beds and one treatment room with three recliners. Patients can receive blood transfusions and pain management. After 23 hours they will be assessed for the most appropriate plan of care. The Center will operate 24 hours a day, seven days a week.

Dr. Eric Dean, the Center’s Medical Director, says offering treatment at the early onset of symptoms can help patients avoid full-blown sickle cell crisis events, emergency department visits and prolonged hospital stays. The Center offers a winning solution for a painful and life-disrupting disease.
Six Years and Counting: Maintaining a Ventilator-Acquired Pneumonia-Free Intensive Care Unit

By Celine Gore Harris, RN, BSN, CCRN

In the United States, forty-six percent of hospitalized patients diagnosed with ventilator-associated pneumonia (VAP) die. Practicing evidence-based preventative strategies means that one of the most frequent nosocomial infections (HAI) is ventilator-associated pneumonia (VAP). In some intensive care units (ICUs), VAP surveillance has been initiated. This article discusses the ways Annie Penn Hospital embraces the Cone Health VAP Prevention Bundle, including daily sedation holiday, spontaneous breathing trial, oral care with twice-daily chlorhexidine mouth rinse, peptic ulcer prophylaxis, and DVT prophylaxis.

In October of 2011, Cone Health adopted the PCR (polymerase chain reaction) test to diagnose CDI. This test is rapid, accurate and very sensitive. Only one stool sample is necessary, and Infection Prevention does not recommend repeat testing during an inpatient stay. In the United States, one fifth of hospitalized patients with Clostridium difficile (C. diff) infections are hospitalized with C. diff outbreaks, and many patients diagnosed with C. diff die. Practicing evidence-based preventative strategies means that one of the most frequent nosocomial infections is C. diff. In some intensive care units, C. diff surveillance has been initiated. This article discusses the ways Annie Penn Hospital embraces the Cone Health CDI Prevention Bundle, including bi-level ventilation, bi-level ventilation with the goal of extubation, and bi-level ventilation with the goal of extubation.

The Scoop on C. diff

Clostridium difficile (C. diff) is a widespread bacterium found in many places, including the gut of healthy individuals. Its sudden overgrowth or spread to individuals with compromised immunity causes C. diff infection (CDI) and C. diff-associated disease (CDAD). Not only can CDI present as life-threatening, it also accounts for increased lengths of stay and added hospital costs.

When treating patients with CDI, keep in mind these four things: When a patient tests positive by PCR test, the nurse should go ahead and order the “C. diff protocol.” It is easy to order treatments using the order set in Cone HealthLink. Keep hands with soap and water when exiting the room of a C. diff-infected patient. CDI is resistant to alcohol hand gel, and removing C. diff spores requires the physical scrubbing of soap and water. CDI spores can live outside the human body for a long time, and remain on surfaces in the environment including bed rails, bathroom fixtures and medical equipment. Use the orange-topped bleach wipes when cleaning equipment that has been in a C. diff room. Let the item dry for 4 minutes prior to rinsing or wiping off bleach. Evaluate patients’ need for antibiotics. The CDC reports that 50 percent of all antibiotic use is not actually necessary for treatment of the average patient, increasing their risk for CDI (www.cdc.gov). Stopping unnecessary antibiotics helps the normal bacteria of our gut control CDI. To prevent further CDI infections, Cone Health’s Infection Prevention Department has formed a multidisciplinary group that will look at CDI rates system-wide and develop protocols on how to best prevent, identify and treat CDI. This working group will be facilitated by Dr. Cynthia Snider (Infectious Disease), Kim Helsabeck (Infection Prevention Manager), Jeremy Frans (PharmD), and Melissa Morgan (Infection Prevention Data Analyst).

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Why Magnet?

In an informal survey, Cone Health nurses who have worked in non-Magnet hospitals were asked to describe the difference between those facilities and Magnet facilities. Here are some of their answers:

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<tr>
<th>Non-Magnet Hospitals</th>
<th>Magnet Hospitals</th>
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<tr>
<td>“Non-Magnet hospitals are unable to meet goals because there is not a lot of teamwork, and they are not goal-oriented.”</td>
<td>“Magnet is more precise, more goal-objective. There is more consistency, and the goal is always to be at the ‘most’ level.” -Anna Maria Magbitang, RN, BSN, CCRN MCH 4700</td>
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<td>“Non-Magnet hospitals do not push so much for employee satisfaction.”</td>
<td>“With Magnet, there are more staff on committees.” -Jody Crisp, RN, BSN Flexible Resources</td>
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<td>“Non-Magnet hospitals don’t pay for your exams or support you to go to conferences – you are on your own. Also, nursing practice was not evidence-based.”</td>
<td>“At Magnet hospitals, everything is geared for the nurse, encouraging continued education, certifications. There is support for certification through reimbursement. Our thoughts, ideas and opinions are valued highly. We are encouraged to give input.” -Pauline Colquhoun, RN-BC MCH 3300</td>
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<td>“In a non-Magnet hospital, decisions are made and you are told to follow. Opinions don’t matter and are not considered valuable.”</td>
<td>“With Magnet, staff have active input into multiple decisions, processes and policies. Opinions are valued and often sought after before any changes are made.” -Joan LoPresti, RN, BSN, MS, NEA-BC Interim Director, Nursing Patient Services</td>
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<td>“In non-Magnet hospitals, budgets are not nurse-driven; there is not a lot of nursing input into resources, and patients are more in the background.”</td>
<td>“With Magnet, the patient focus is multidisciplinary and nursing drives that focus. We are the integrators of care.” -Joanne Thomson-Waters, RN, MSN, CMSRN Department Director, MCH 4500/Palliative Care</td>
</tr>
<tr>
<td>“In a non-Magnet hospital, nursing is just a job.”</td>
<td>“With Magnet, I see people striving for quality, for exemplary practice with our exceptional care theme – that is what we strive for. People grow in a Magnet facility.” -Nancy Marzof, RN, BSN, RNC Flexible Resources/Admission Nurse</td>
</tr>
<tr>
<td>“Non-Magnet hospitals are not as focused on the professional growth of nurses and autonomy. There is an ‘old school’ mentality and less collaboration for patient care.”</td>
<td>“With Magnet, there is more celebration of, and recognition for, the strength of nursing; more leaders are open and encourage staff to develop. It better defined who we were, and we get involved in showcasing our accomplishments.” -Gretta Fiorenza, RN, BSN, MBA/MHA Interim Director, Clinical Support Services</td>
</tr>
<tr>
<td>“The difference between the two is the collaboration and willingness to work together as a team for the benefit of the patient.”</td>
<td>“With Magnet, there is more more of a professional growth of nurses and autonomy. There is an ‘old school’ mentality and less collaboration for patient care.” -Debbie Malick, RN, BSN, MBA Department Director, MCH 3300</td>
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Magnet Update

Cone Health’s Magnet application is now in progress of being written and will be the third submitted by Cone Health. Our first designation was achieved in 2005; the system was re-designated in 2009. The Magnet Application writing deadline is June 1, 2013. The Magnet Application submission deadline is Aug. 1, 2013. Only 6 percent of hospitals in the United States are Magnet designated.

Following submission of the application, it takes up to four months to hear whether we qualify for a site visit. In order to merit a site visit, we need to present strong evidence in the application for everything we say about nursing at Cone Health. Also we must firmly demonstrate the development, dissemination and enculturation of nursing initiatives, and changes to practice.

After the document is written, we will concentrate on education and learning; we will use the application to inform all nurses and nursing departments about where they are represented in the document. We hope to have a mini manual available as a synopsis of the 2,000-page application.

Champion Update

2013 Magnet Champion Meetings will start in May. Magnet Champions are important for getting all areas ready for Magnet surveyors’ visits. Each department has one to two Magnet champions who take information back to their departments. These individuals develop creative ways to help educate about the Magnet components and how these components are expressed in their individual departments. Meeting days and locations for Magnet Champion meetings are listed on the Magnet home page. Click on the icon on the right-hand side of the Cone Health home page or go to https://sharepoint.conehealth.com/magnet/default and then click on Champions.

A “Constructing Magnet Outcomes” (CMO) certificate was given to the Vascular Access Team for its innovation that merited inclusion in the Magnet document. Section TL7 of the Magnet document reads: “Describe and demonstrate how nurse leaders value, encourage, recognize/reward and implement innovation.” The Vascular Access Team implemented the use of EKG leads for peripherally inserted central catheter (PICC) line placement, enabling PICCs to be used before an X-ray is performed. This innovation greatly expedites treatment in urgent and emergent situations, and the practice change has enjoyed system-wide dispersion.