BUILDING THE FUTURE OF NURSING

STANFORD HOSPITAL & CLINICS NURSING ANNUAL REPORT

20 13

"Our nurses create a progressive clinical environment via community and teamwork." —MARY RICHARDS, MS, RN, CCRN

Today's health care environment requires nurses with vision, influence, clinical knowledge, and professional expertise.

TABLE OF CONTENTS

"The gardens affect everyone. Their beauty reminds patients that there is more to life than the current crisis, and they create a place of peace. It's inspiring to see a patient roll outside with an IV and sit in these gardens; that is the ultimate statement of nurturing. These flowers offer a sense of life and a powerful message of hope."
—CHAPLAIN, STANFORD HOSPITAL & CLINICS

FROM THE CHIEF NURSING OFFICER

A recent Gallup poll reported that the public regards nurses as the most highly ethical and honest group of professionals. That perception empowers nurses and the nursing profession to play a powerful role in promoting positive change that will ultimately benefit patients.

As primary caregivers and health-care educators, nurses are in the ideal position to improve quality of care and patient safety. Day-to-day interactions with patients give nurses the perfect vantage point to observe and address their physical and emotional well-being. That proximity and personal connection plays a critical role in patient outcomes, both in the hospital and clinics, and after the patient returns home.

At Stanford Hospital & Clinics we are working diligently to create an environment where nurses are supported and encouraged to take part in improving how health care is practiced and delivered. In every unit, clinic, and outpatient setting, we strive to ensure that clear communication, established policies and procedures, and opportunities for education and training are available. This is to ensure that nurses can be motivated, supported, and encouraged to be an integral part of building a foundation for the future.

By holding to the highest standards, guidelines, and principles, and by defining its values and priorities, the

nursing profession will continue to be highly regarded. In turn, nurses can influence how health care is delivered and help develop a framework to objectively evaluate excellence in the field.

More than 140 years ago, Florence Nightingale warned, "The very first requirement in a hospital is that it should do the sick no harm." Today's nurses are the professionals who ensure that those simple but vitally important words remain a guiding mantra, for now and for the future.

Nancy J. Lee, MSN, RN, NEA-BC
Chief Nursing Officer
Vice President, Patient Care Services

FROM THE PRESIDENT & CEO

It has been a year of great progress in patient care at Stanford Hospital & Clinics, much of which connects directly to the efforts of our exemplary nursing professionals. Our "Likelihood to Recommend," inpatient satisfaction scores reached the 92nd percentile in the nation for the period of May through July. This remarkable achievement is the result of the continual streamlining of operations by nurses through our Stanford Operating System lean management efforts, and the outstanding C-I-CARE they demonstrate everyday.

In another notable example, the Marc and Laura Andreessen Emergency Department reached the 80th percentile for "Likelihood to Recommend" for the period of May through July, thanks in part to a new process that places nurses at the entrance of the ED. This redesign has reduced our "door-to-triage" time to only 9 minutes from an average of 27 minutes, and has helped to alleviate patient anxiety during the brief wait to see a physician.

Moreover, the implementation of our hospital-wide follow-up program, where our nurses telephone recently discharged patients, has already led to a significant improvement in patient satisfaction scores and better coordination of care. Our target metric, "Instructions for Care at Home," jumped to the 79th percentile from the 36th percentile at the start of 2013.

Beyond all of the metrics are the letters of praise for our nurses that I receive from patients every week. The skills and compassion of our nursing professionals are second to none and indispensable to delivering the leading edge and coordinated care that truly defines Stanford Hospital & Clinics. Thank you again for an amazing year.

Sincerely,

Amir Dan Rubin
President & CEO

FROM THE ASSOCIATE CHIEF NURSING OFFICER

This has been another outstanding year for nursing at Stanford. I could not be more proud of our achievements and the exemplary care we have given, and continue to give to our patients. I know you will enjoy reading about the innovative programs we have implemented this year and I hope it will inspire you to continue this great work, always striving for excellence and pushing the boundaries of the practice of nursing. Our patients continue to give us feedback that they feel we are keeping them at the core of our practice. This is reflected in our patient satisfaction levels, which have increased to their highest levels ever.
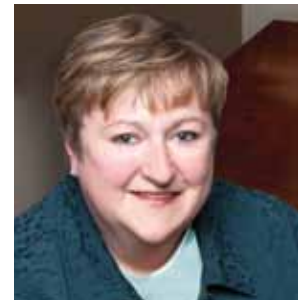
Thank you for your service to our patients this and every year. I look forward to the continued success of nursing at Stanford.

Wendy Foad, MS, RN
Associate Chief Nursing Officer

01 Transformational Leadership

Nurses lead by example to identify new solutions, promote innovation, and motivate others to meet the demands of the future.

Nursing Admission Assessment Redesign:

ADAPTING TECHNOLOGY TO NURSES' WORKFLOW

The nursing admission assessment contains important information to help formulate the patients' individualized plan of care. A nursing team successfully redesigned the admission documentation to improve quality, efficiency and nursing satisfaction.

Multiple themes in the literature support the importance of a complementary fit between the electronic health record (EHR) and nursing practice. This project required collaboration between informatics and nursing to reconfigure the EHR to better support nursing practice and workflow.

The project aims were to:
- Standardize work and reduce data entry redundancy
- Improve documentation related to regulatory and safety requirements
- Increase nurses' satisfaction with the computer workflow

Metrics: Four metrics were measured pre- and post-implementation: the average: time to complete the nursing admission assessment, total number of clicks, clicks per row, and minutes to complete a row.

A multi-phase quality improvement project was developed from a nurse-directed, observational data capture of the admission assessment process.

Phase 1: Nurse observers performed 30 hours of observation related to documentation of direct admissions on fourteen different units over a one-month period.

Phase 2: A quality review of 26 charts revealed incomplete patient records and three areas vulnerable to regulatory requirements. The redesign team focused on these particularly vulnerable areas: allergies, care plans, and patient education.

Phase 3: A survey was sent electronically pre- and post-implementation to 1,100 inpatient nurses to determine how satisfied they were with the admission assessment in the EHR.

Phase 4: Themes were identified using 5S principles, Lean, observational study data, and incorporation of the literature review to prioritize the work. A SWOT analysis was used to summarize the work and identify the strengths and weaknesses of the project. See Table 1.

Phase 5: Cost reduction was determined by the use of existing structures. Shared governance councils reviewed each phase of the project. They also provided feedback and participation to the redesign team, which eliminated additional meeting time required for reviews of the stages.

Phase 6: The shared governance councils disseminated educational information. Use of the councils enabled the team to reduce the costs of training and mentoring.

METRIC OUTCOMES
Time to Complete the Nursing Assessment:
The time to complete the assessment decreased 58%, from 52 minutes to 21 minutes.

Total Number of Clicks: Total number of clicks during the nursing admission assessment decreased 62%, from 141 clicks to 54 clicks.

Clicks Per Row: Clicks per row were reduced by 34%, from 7.5 clicks to 5.2. The reduction of time to complete a row was decreased 75%, from 4 minutes to 1 minute.

REGULATORY AND EDUCATION OUTCOMES

The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) mandate an admission assessment for all patients. Audits performed on 26 charts revealed that 69% of the admission assessments were complete; that 92% of care plans were initiated, 85% of allergies were verified and 62% of education assessments were completed. Six weeks after the redesign implementation, overall regulatory and quality compliance increased from 69% to 99%. The percentage of completed patient learning assessments increased by 34%. Initiation of a care plan increased by 4% and allergy verification increased by 2%. See Table 2.

NURSING WORKFLOW OUTCOME

Nurses had requested a standard charting process, screens matching workflow and standard access to all provider documentation screens. The results of the email survey revealed that the redesigned admission assessment more closely matched nurses' workflow.

Application and redesign of documentation workflows saved an estimated 25,000 hours of additional nursing documentation time based on 60,000 admissions per year. Regulatory compliance has been achieved and is now monitored by the automated admission assessment in real time.

Redesign of the nursing admission assessment improved efficiency, documentation quality, and nursing satisfaction.

TABLE 1: PRE- AND POST- IMPLEMENTATION METRICS

METRICS	PRE-IMPLEMENTATION	POST-IMPLEMENTATION	RESULTS
Time to complete admissions assessment (average)	52m 11s	21m 41s	↓58%
Total number of clicks (average)	141 clicks	54 clicks	↓62%
Clicks per row (average)	7.5 clicks	5.2 clicks	↓34%
Minutes to complete a row (average)	4 minutes	< 1 minute	↓75%

n=27

TABLE 2: REGULATORY AND EDUCATION OUTCOMES

METRICS	PRE-IMPLEMENTATION	POST-IMPLEMENTATION	RESULTS
Overall completion rate (average)	69%	99%	↑30%
% of care plans initiated	92%	96%	↑ 4%
% of allergies verified	85%	87%	↑ 2%
% of learning assessments/education completed	62%	96%	↑34%

n=26

IDENTIFYING BEST PRACTICES

CLINICAL PATHWAY FOR SURGICAL VALVE PATIENTS

To maintain financial viability in a competitive market—and with low returns on reimbursements—it is imperative that health-care organizations continuously seek methods to contain costs and improve the efficiency of patient care without compromising quality. One tool to decrease waste and reduce variation is a care path or a clinical pathway.

Zevola, Raffa, and Brown reported results from various studies that consistently showed a decrease in the mean length of stay, fewer complications, and decreased cost for patients who were in the clinical pathway programs compared to patients who were not in the clinical pathway programs.

The Stanford Cardiovascular Health Clinical Effectiveness Council identified a cohort of surgical valve patients as good candidates for an initial care path. The council selected this cohort because it experienced a relatively high average total length of stay (TLOS) in fiscal year 2012 (13.4 days) and because variation in the timing and delivery of care appeared to be a contributing factor to the high TLOS. In addition, cardiothoracic surgical leadership expected to see similar progress after surgery.

The council set standardized goals to decrease variability in care, maintain quality outcomes, reduce the TLOS by 18 percent, and reduce direct cost per case by 2.5 percent.

METHODS

The surgical valve patient population includes patients who need repair or replacement of the aortic valve, mitral valve, tricuspid valve or pulmonary valve. A multidisciplinary team was created as the initial step of the improvement process. The Surgical Valve Team was comprised of surgeons, nurses, physician assistants, hospitalists, physical therapists, respiratory therapists, dietitians, case managers, pharmacists, and quality/patient safety consultants.

The group members met weekly to identify barriers such as variability in care, process, equipment, and environmental factors that delayed patients' progression and contributed to the increased length of stay. The team also discussed ideas and strategies to improve the current state for the surgical valve patient cohort. Various care paths from other institutions were evaluated to provide guidance and ideas for the development of the Stanford Hospital & Clinics care path. Using existing Stanford cardiac surgery order sets as a starting point, the team incorporated best practices, guidelines, core measures, and protocols to create the first draft of the surgical valve care path. Iterations of the care path were reviewed with stakeholders, including the cardiothoracic-intensive care unit (CT-ICU) task force and cardiothoracic surgery faculty, prior to the release of the final draft.

RESULTS

A care path was created for the surgical valve patients to provide a tool for all staff members involved in patient care. The care path is initiated on the day of surgery and continues until discharge. Additional parameters for the day before discharge and the day of discharge have been added to decrease delays in the process by ensuring that all necessary goals of care are met.

The care path encompasses the goal of care, communication, activity, and pain management that directly impact patient progression, quality care, as well as length of stay after surgery. The care path is not a replacement for sound clinical judgment nor is it a replacement for physician orders; rather it serves as a guide for staff to provide safe, consistent, and therapeutic quality care.

Implementation of the care path was a two-phase process and measures were taken to communicate expectations for each phase. Changes in the order sets in the electronic medical record system are required for implementation; however revisions require time and the team did not want to slow implementation of the care path.

To minimize delay, the council team designed a checklist that included essential steps in the care path for the surgical valve patient, such as out of bed to chair activity, ambulation, and pain management. The checklist also includes the estimated date of discharge, which allows all team members to work toward a common goal for date of discharge. The checklist is placed at the end of each patient's bed and tracked by everyone who interacts with the patient, including family members. The goal of the checklist is to facilitate participation, communication, and engagement among all patient care participants. The checklist is monitored to determine whether patients are meeting the charter goal.

DISCUSSION

Although the empirical success of the path has yet to be determined, it will be measured by changes in TLOS and direct cost. Improved quality of care, which includes the patient experience post-operatively, will be measured as well as overall patient satisfaction.

A true multidisciplinary team effort was required to develop the care path for the surgical valve patients.

THE CORE TEAM MEMBERS:

1 cardiac rehabilitation staff nurse

1 case manager

1 nurse practitioner

1 respiratory therapist

1 surgeon

1 clinical & business analytics data architect

1 performance excellence consultant

1 quality, patient safety & effectiveness consultant

2 dieticians

2 hospitalists

2 nurse coordinators

2 patient care nurse managers

2 physical therapists

2 staff nurses

4 physician assistants

5 pharmacists

The creation and the development of the care path helped to establish an environment for the exchange of ideas, knowledge, and experiences. The process has led to better communication and working relationships among all staff involved in the project. In addition, the project allowed the group members to be creative while instilling confidence in their ability to transform and apply the style and techniques for future care path projects. Team members expressed a sense of real accomplishment as they transformed the care path from initial stage to implementation.

The development of a care path for surgical valve patients was a catalyst for positive change because it created a culture that promotes improvement in quality care, challenged members to find strategies for more efficient patient care delivery, and encouraged professional growth among all members involved.

References

Wheelwright, S. C. & Weber, J. (March, 2004). Massachusetts General Hospital: CABG Surgery (A). (Harvard Business School Case 696-015). Retrieved from *Harvard Business Review* http://hbr.org/search/696015-PDF-ENG

Zevola, D., Raffa, M. , & Brown, K (2002, February). Using clinical pathway in patients undergoing cardiac valve surgery. *E-Journal of Critical Care Nurse*, 22, 1, 31-50. Retrieved from http://ccn.aacnjournals.org/content/22/1/31.full.pdf+html

A care path is "an optimal sequencing and timing of interventions by physicians, nurses, and other staff for a particular diagnosis or procedure, designed to minimize delays and resource utilization, and at the same time maximize the quality of care." —WHEELWRIGHT AND WEBER (1995)

02 Structural Empowerment

Strong relationships and partnerships provide an environment where professional practice flourishes and where nurses are empowered to find the best way to accomplish organizational goals and achieve desired outcomes.

PRACTICE MAKES PERFECT

THE USE OF SIMULATION-BASED EDUCATION TO ADVANCE EMERGENCY NURSING PRACTICE

The emergency department (ED) nurse performs in a high-pressure environment where the time window for treatment continues to tighten as technologies advance to improve patient outcomes. The moment a major trauma, myocardial infarction, or stroke patient enters the ED, the stopwatch starts ticking.

A nurse is often an ED patient's first contact. The ED nurse must have the knowledge to assess and recognize a spectrum of clinical presentations in both pediatric and adult populations and immediately initiate the required protocols. The ED nurse must also continuously assess the patient and effectively respond to any changes or needs throughout his or her stay.

IMPROVED TRAINING SESSIONS
Stanford's ED provides continuing education and training to enhance the staff's ability to meet these daily demands. In the past, all ED nurses attended an annual skills review, which consisted of an all-day session reviewing patient care procedures and equipment in the form of lectures and skill stations. Over time, this method of teaching proved to be ineffective in closing performance gaps and in maintaining the staff's interest throughout the entire session.

In 2011, Denise Robinson, MS, RN, CNS, the ED clinical nurse specialist, and Edward Shradar, MSN, RN, CNS, CEN, the department's nurse educator, felt that a change in teaching methods were warranted. They wanted to foster a safe learning environment where the staff could reflect on their clinical practice while closing performance gaps.

Studies have shown that students have up to 90 percent retention of information when the learning activity is presented in a simulation format, so simulation-based learning became a viable option to increase staff clinical knowledge, skills, and involvement.

They set out with a one-year test run using simulation-based education in the Goodman Surgical Simulation Center, located on the third floor of Stanford Hospital & Clinics. Participant course evaluations were positive, and the program outgrew the space and resources of the simulation center so it was moved to the School of Medicine's Immersive Learning Center in the Li Ka Shing Center for Learning and Knowledge in 2013.

DEVELOPING THE SIMULATIONS
Scripts to guide the simulation scenarios were written using a cognitive, behavioral, and technical objectives approach. The objectives were embedded within each simulation along with cues such as changes in vital signs, physical assessment findings, and laboratory results. Current ED performance gaps were also embedded into each scenario. Once the objectives were met, the scenario was stopped and a debriefing session was held.

Each education day includes at least five simulations lasting 60 to 90 minutes, depending on the complexity. One to four nurses per team are selected at random to participate in any given simulation. More nurses are required for a major trauma; fewer for a less acute situation.

Scripts were drawn from actual cases and represented all age groups, from infant to geriatric. The scripts

were downloaded into the simulation labs' audiovisual system, and related props, such as 12-lead ECGs. Laboratory reports, and X-ray/CT images were projected on screens during the simulations.

The simulation room was set up to look like a resuscitation room in the ED and stocked with equipment commonly used by the staff. Standardized patient actors, high-fidelity mannequins, and coworkers were utilized to create a realistic sense of working in the ED.

The patient actors were briefed prior to the simulation with their presenting symptoms and communication style, and were informed of expected activities as the

scenario progressed. They used an earpiece so the control room could communicate with them throughout the entire simulation.

The high-fidelity mannequins can be controlled to blink, talk, breathe, cough, and respond to interventions as the ED staff performed procedures such as intubations, needle chest decompressions, and line insertions. Coworkers posing as respiratory therapists, physicians, and pharmacists entered the simulation at different intervals to provide essential information that helped each case progress.

A typical scenario would be a patient arriving via ambulance to the ED with the paramedics giving a hand-off report to the ED nurse. From there the nurse would use assessment skills to discover critical signs and symptoms, initiate approved ED protocols, and alert other members of the team. In a scenario with a patient presenting with stroke symptoms, the expectation would be for the nurse to call a stroke code and work with other members of the team to carry out time-crucial interventions and respond to changes in the patient's condition.

POST-SIMULATION DEBRIEFING SESSIONS

Debriefing is an essential part of the training program, where participants pull together the entire experience. Staff can be emotionally involved with the simulation they have just completed and some are uneasy about being observed by the faculty behind the mirror and being videotaped in general. To address these concerns, instructors were required to complete a debriefing training course that taught skills and communication strategies to foster active participation.

PEOPLE GENERALLY REMEMBER

90%

OF WHAT THEY DO,

20%

OF WHAT THEY HEAR.

THE IMPACT ON ED

The 120 ED nurses who attended the simulations in the winter and spring of 2013 were asked to complete an anonymous survey. More than 90 percent of the responders agreed that their simulation experience exposed them to opportunities to improve their clinical practice. Audits show that compliance has improved with documentation and the adherence to patient care guidelines and protocols since the program was implemented.

More data needs to be accrued before a focused assessment of the impact of simulations on ED patient outcomes can begin. The goals for the fourth year of ED simulations, which began in October, 2013, are to have more interdisciplinary team involvement with each simulation and to continue to provide a highly interactive educational program.

NURSING INFORMATICS

A COMBINATION OF CLINICAL AND TECHNICAL EXPERTISE

Nursing informatics is a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, knowledge, and wisdom in nursing practice.

—AMERICAN NURSING ASSOCIATION (ANA)

The role of the nurse informaticist originated in the mid-1980s as acute care facilities began to implement hospital information systems. It became clear that design must consider not only technical aspects but caregiver workflows in order to foster system adoption by clinicians. The ANA recognized nursing informatics as a specialty in 1992, and a scope of practice was developed in 1994.

Nursing informatics focuses on finding ways to improve information management and communications to improve efficiency, reduce costs, and enhance the quality of patient care. These professionals aspire to develop systems that are both effective and user friendly, while integrating seamlessly into existing hospital systems and routine nursing process workflow.

They speak two languages: clinical and technical. They are responsible for translating the needs of patients and staff into computer programs.

Nurse informaticists have strong clinical backgrounds, are technically curious, and are willing to try new

THERE ARE

900

CERTIFIED INFORMATICS

NURSES IN THE

UNITED STATES

things that they think would benefit patients, staff, and the health-care organization. Although no formalized training is currently required for nurse informaticists, more health-care organizations are looking to hire people who have graduated from informatics education programs and have been certified by the American Nurses Credentialing Center (ANCC).

In 2007, 177 nurses (0.8 percent of all 22,159 certified nurses) received nursing informatics credentials In 2010, this number grew to 779. As of 2012, there were approximately 900 certified informatics nurses in the United States.

To become certified one must have a BSN and RN degree, have worked as a nurse for two years, and practiced at least 2,000 hours over the past three years in nursing informatics. After passing the initial exam, certification must be renewed every five years.

To assist Stanford nurses in preparing for the exam, the Center for Education and Professional Development has hosted several nursing informatics boot camps over the past five years. These intensive two-day courses focus on current informatics trends and issues in health care, and emphasize how vital the nurse informaticist role is in incorporating technology into health care. Classes are taught by instructors who are deeply involved in the field. Review courses are invaluable to any nurse who is preparing to take the exam.

THE STANDARD FOR STROKE

STANFORD DESIGNATED AS COUNTRY'S FIRST STROKE COMPREHENSIVE CENTER

In October, 2012, Stanford Hospital & Clinics was the first hospital to be awarded The Joint Commission's Disease Specific Care Comprehensive Stroke Center Certification.

The certification recognizes centers which provide important resources in the form of staff and training that enable treatment of complex stroke patients. This certification reflects that the center has met or exceeded requirements in the following areas: 24/7 availability of neuro-critical care along with dedicated neuro-intensive care beds for complex stroke patients, advanced imaging and treatment capabilities, participation in stroke research, and specialized coordination of care for stroke patients. Stanford was commended on its multidisciplinary approach to treating patients. The Stanford Stroke Center's interdisciplinary team meets and collaborates monthly to discuss essential issues in the care of stroke patients and how to improve outcomes. The 30 to 40 member interdisciplinary team includes physicians, nurses, social workers, case managers, pharmacists, rehabilitation therapists, clinical nutritionists, radiology and lab technicians.

 "We've always worked cohesively," said JJ Baumann, MS, RN, CNS, Clinical Nurse Specialist for Stroke Neurology, "and we've been early adopters who strive for continued improvement as a multidisciplinary team."

800,000
AMERICANS HAVE A NEW OR RECURRENT STROKE EACH YEAR.

As an essential role in caring for the complex stroke patient, nurses provide expert and complex care, including evaluation, monitoring of treatment plans, and education. The Stroke Center promotes an integrated stroke education program which includes educating nurses, patients, and the community. Members of the nursing Comprehensive Stroke Center Leadership Team include JJ Baumann, CNS, Teresa Bell Stephens, RN, Stephanie Casal, CNS, Alison Kerr, RN, Mary Marcellus, RN and Joli Vavao, NP.

The Stanford Stroke Center, initiated as a multidisciplinary team in 1992, now cares for more than 2,000 ischemic and hemorrhagic stroke patients a year. Stanford's comprehensive care includes multiple specialties, including neurology, neurosurgery, neuroradiology, neurocritical care and emergency medicine. Stanford continues to be one of the forerunners in new advances in the treatment and prevention of stroke. The Stanford Stroke Team works collaboratively with an interdisciplinary team to assist patients and their families from the first signs of stroke, through hospitalization, rehabilitation and ongoing follow-up appointments. They champion the hospital's mission to heal humanity through science and compassion, one patient at a time.

The Stanford Stroke Center, one of the first comprehensive centers of its kind, was established in 1992. The Stroke Center was ranked No. 1 in the US for stroke management by the University Health Consortium, and its members have made the largest number of research contributions to the American Heart Association's International Stroke Conference for the past several years.

Exemplary Professional Practice

Commitment to the highest standards of professionalism sustains a culture of safety, compassion, and quality in the delivery of patient care.

PALLIATIVE CARE COUNCIL

COORDINATING AN INTERDISCIPLINARY APPROACH IN INTENSIVE CARE

The council's overall goal is to change the culture of the ICU so that palliative care can be better integrated into the care of critically ill patients.

Nurses working on E2 ICU care daily for patients who are facing serious illnesses. Nurses often witness doctors recommending and/or families requesting invasive treatments that will likely be more of a burden than a benefit to the patient. Often times, these patients would gain more from palliative care, an interdisciplinary care which focuses on preventing and relieving suffering, thereby supporting the quality of life for the patient.

The E2 ICU Palliative Care Council was formed in June, 2012 to train and empower bedside nurses to initiate discussions with family members. The purpose is to elicit the patient's values and wishes, and to help align the goals of care in the ICU with these values and wishes.

Currently 22 nurses participate in bi-monthly, two-hour education and communication sessions led by Judy Passaglia, RN, CNS, palliative care program manager, and Stephanie Harman, MD, palliative care medical director. In addition, 75 percent of council members have completed the American Association of Critical Care Nurses continuing education program, Promoting Excellence in Palliative and End-of-life Care, and five have attended the two-day End-of-Life Nursing Education Consortium's Train-the-Trainer course administered by the American Association of Colleges of Nursing.

The council created the E2 ICU Palliative Care Nurse role, and a council member is assigned to this role every shift. Responsibilities include being a resource for the staff, educating nurses and physicians on palliative care issues, and caring for patients transitioning to comfort care.

In June, 2013 the council presented Palliative Care Essentials, a four-hour class attended by nurses, respiratory therapists, and nurse practitioners who work in critical care. The course covered topics ranging from palliative care as an emerging medical specialty, symptom management at end of life, moral distress, and communication with patients and their families.

Projects for this year include implementing a process to coordinate meetings of the interdisciplinary team, including the bedside nurse and family members, to discuss plans for patients who may require palliative and/or end-of-life care. After the meeting the nurse writes a Goals of Care note in the patient's electronic medical record about what was discussed at the meeting.

Every attempt is made to assign an E2 ICU Palliative Care Nurse to the critically ill patients requiring end-of-life care. The assigned nurse can prepare the family for the meeting and elicit questions that need to be answered, attend the meeting, and reinforce the decisions made at the meeting. Another goal is to teach E2 ICU nurses and doctors the difference between palliative care and end-of-life care. The Palliative Care Council continues to make multiple strides toward these goals.

HEART FAILURE DISEASE MANAGEMENT

MULTIDISCIPLINARY EFFORT TO REDUCE AVOIDABLE ADMISSIONS

With renewed national focus on controlling healthcare costs and resources, heart failure disease management and care processes are under close scrutiny across the country. Reducing readmissions has become paramount.

DRIVING CHANGE

At Stanford, these factors have prompted re-evaluation of our care delivery processes for heart failure, particularly those that impact patient transitions across care settings. Under a triad leadership model, (physician champion, administrator, and nurse leader), Stanford has undertaken a multidisciplinary effort to assess and reshape a number of processes to improve patients' ability to succeed in their health management post-discharge. More significantly, a reduction in avoidable readmissions can positively impact quality of life for patients.

Stanford Hospital & Clinics is fortunate to be supported by a two-year Betty Irene Moore Foundation grant that allowed the hiring of key team members, including a heart failure registered nurse coordinator, a data analyst, and a pharmacy technician to support project planning, workgroups, and implementation of small tests of change that will benefit patient care processes throughout the hospital and clinics.

STRUCTURE AND FUNCTION

A monthly nurse-led Heart Failure Operations Committee was initiated in April, 2012 that includes staff members from several disciplines as well as community partners representing local post-acute care facilities and home care agencies. A Palo Alto Medical Foundation cardiologist also attends, representing the foundation's commitment to partner with Stanford in reducing readmissions. Two patient volunteers provide valuable input and insight, such as giving feedback on new education tools.

5.8
MILLION PEOPLE WERE DIAGNOSED WITH HEART FAILURE IN 2012. THAT NUMBER IS PROJECTED TO BE

8.5
MILLION IN 2030

Weekly Cardiovascular Clinical Effectiveness Council meetings, under the leadership of the Director of Cardiovascular Operations, bring together clinicians and experts in quality, finance, coding, performance improvement, clinical business analytics, and clinical informatics to develop and track the collaborative work. The work produced is uploaded to an intranet Sharepoint site for team member access. A number of workgroups have met at least bi-weekly over the past year; comprised of frontline staff and led by a clinical leader and performance excellence coach. They partner with Clinical Effectiveness and Informatics personnel to tackle key issues and test freshly crafted interventions.

PROJECT GOALS AND INTERVENTIONS

Stanford's goal is to reduce 30-day readmissions for primary heart failure patients by 30 percent and 90-day readmissions by 15 percent. In addition, the project strives for a 5 percent improvement in the Hospital Consumer Assessment of Healthcare Providers and Systems questions to capture the subjective patients' experiences that relate to discharge (e.g., how well patients felt they were prepared to self-manage after discharge).

Because the greatest concentration of primary heart failure inpatients is on B2, B3, and D1, interventions will be focused on these units. However, once tested and validated, the interventions and performance improvements will ultimately touch all departments.

The project goals are to streamline and improve the following patient care processes to ensure improved transitions through the following key interventions:

▪ **Early assessment for readmission risk:** Evaluate patients during admission for risk of readmission within 30 days and flag those at high risk in the hospital's electronic medical record, Epic, with a flag and profile screen banner. A high-risk status drives more expeditious follow-up phone calls and clinic visits within seven days of discharge.

▪ **Medication safety:** Improve medication reconciliation at admission and at discharge, to ensure a clear, accurate, and understandable medication list on the After Visit Summary (AVS); provide a computer printout to patients at discharge.

▪ **Patient education/teach-back:** Redesign patient education materials across inpatient/outpatient settings using multimodal delivery systems. Written and audiovisual (Skylight videos, online modules, and the hospital internet) empower patients to take action based on self-monitoring signs and symptoms. Patient learning will be enhanced by training nursing staff on "teach-back," an evidence-based method for engaging learners, assessing patient understanding, and tailoring education to the target learner for optimal effectiveness.

▪ **Improve post-acute care follow-up:** Notify the primary care provider/cardiologist at patient admission,

HEART FAILURE IS A CHRONIC CARDIOVASCULAR SYNDROME THAT CONTINUES TO GROW IN PREVALENCE, DUE IN PART TO EFFECTIVE THERAPIES THAT PROLONG LIFE AS WELL AS SIGNIFICANT GROWTH IN OUR ELDER POPULATION. (HEIDENREICH, 2013).

give a timely transmission of the discharge summary, and provide the patient with a follow up appointment at discharge (indicated on the AVS).

▪ **Post-discharge follow up phone calls:** Phone calls are made within 48 hours of discharge for high-risk patients and within 96 hours for all others. High-risk patients receive an additional call at two weeks post-discharge. A telephone template built into Epic documents call information and may be mined to identify problems and trends for rapid improvement.

▪ **Improved communication to next level of care:** Enhanced communication tools with community partners, as well as an RN-to-RN handoff for patients discharging to post-acute care facilities, is in development.

Designing and implementing these interventions are a cross-functional team effort and span the continuum of care, resulting in Epic enhancements that will facilitate effective patient care throughout Stanford Hospital & Clinics. An HF Dashboard has been designed to review process and outcomes metrics that are pulled from the newly created Cardiovascular Health Enterprise Data Warehouse virtually in real time. The data can be filtered in multiple ways, such as by time increment, by care unit, or by medical care team.

Heart failure patient outcomes to date have been positive and promising. The program design and experience is helping to mold the hospital-wide enterprise, with innovative and improved care coordination for patients with chronic disease conditions.

04 New Knowledge, Innovation, and Improvement

Nurses contribute to patient care, to Stanford Hospital & Clinics, and to the profession by identifying new models of care, improving existing protocols, assessing new evidence, and developing more effective practices.

NURSING GRAND ROUNDS

FORUM PROMOTES EXCELLENCE AND QUALITY IN CLINICAL CARE

Nursing Grand Rounds provides a forum for nurses at Stanford Hospital & Clinics to share clinical expertise, nursing best practices, and other topics of interest that help improve patient outcomes and enhance patient experiences.

Stanford has offered Nursing Grand Rounds (NGR) as an educational forum since 2006. At the time, the Clinical Nurse Specialist group organized two to four NGR presentations per year, with a range of 15 to 41 attendees per presentation. In September, 2011, the Magnet Champion Council established a goal of enhancing the quantity, consistency, and quality of NGR offered at Stanford Hospital & Clinics, and as a result, in December, 2011 a NGR workgroup was formed.

The initial workgroup included several direct care nurse Magnet Champions, managers, clinical nurse specialists, and members of the nursing leadership team. The team first assessed the current inconsistent state of NGR quality and attendance. The team determined the need to expand the workgroup to include representatives from other areas of practice, such as the operating room and outpatient areas. After reviewing relevant literature and exploring other organizations' NGR internet sites, the workgroup defined NGR goals and developed standard work to provide consistency and rigor to the process.

The workgroup met twice a month for eight months and continues to meet once a month. Since the workgroup was initiated, the following goals were achieved:

• Consistent, monthly presentations with increased attendance
• An NGR intranet site which launched in July, 2012
• Tracking and trending NGR evaluations, attendance by job title, and attendance by work area to increase bedside nurse attendance

The 2012 NGR calendar included presenters from all levels of nursing, most of them clinical bedside nurses. Topics included Diversity in Health Care, Pain and Pain Management, Taking Action to Improve Patient Outcomes, and The Future of Nursing Practice. In December, 2012 the workgroup invited nationally known nursing leader Patricia Benner, PhD, RN, FAAN, who presented Distinctions Between Competent, Proficient, and Expert Practice.

Since the implementation of the new NGR processes, there has been a marked increase in attendance. Evaluations of the programs showed that on a scale of one to four (with four being excellent), approximately 98 percent scored threes and fours on the program's overall teaching effectiveness.

Although the present process for NGR is successful, the workgroup continues to find ways to increase nurse engagement and attendance. Future plans include exploring the use of WebEx for live streaming to allow distance attendance and video recording presentations to load onto the NGR website.

NGR provides a valuable educational opportunity for Stanford nurses and promotes excellence in nursing. It is an essential venue for sharing knowledge and experience, and will continue to evolve to meet the needs of the nursing community.

IT'S A NURSE'S CALL

IMPROVING THE PATIENT EXPERIENCE: FOLLOW-UP WITH DISCHARGED PATIENTS

During a stay at Stanford Hospital & Clinics, patients and family members work directly with the healthcare team to address questions and concerns. However, the transition out of the hospital can be difficult, and there are often questions about follow-up care after a patient has been discharged and back at home.

Wendy Foad, MS, RN, Associate Chief Nursing Officer, determined that implementing a standardized follow-up process would improve the patient experience. Said Foad, "We could see that this was a best practice at other organizations, and we knew it would assist patients and their families as they transitioned from the hospital to home."

She asked two of the hospital's busiest units, D2 and G2S, to pilot a discharge phone call program in which patients are called within 72 hours after discharge from the hospital. Evidence suggests that these types of programs are linked to lower readmission rates as well as improved patient satisfaction. To design and implement the program, Melissa Aurelio, RN, and Hirut Truneh, RN, used their experiences from other hospitals as a framework for building a model for Stanford.

The discharge calling nurse makes between three and five calls per day with each call lasting approximately five minutes. Each call is documented in the electronic medical record as a telephone encounter. Patients are asked about how they are feeling, if they have any questions regarding follow-up care, and how they felt about their hospital stay.

The purpose of the calls is to obtain a patient's subjective perspective and to answer any questions they may have—not to provide medical advice. If patients have clinical questions, or are experiencing a medical problem, the nurse refers them back to their physician or care provider as appropriate. The nurse also will notify the physician team if there was a finding from the call.

One of the hallmarks of the program is that it is being done internally, with nurses making the phone calls. Some hospitals hire an outside vendor to make the calls, but Aurelio stated that Stanford nurses and the interdisciplinary team "see this program as an extension of personalized patient care."

Although the units piloting the program initially found it challenging to balance workloads in order to make the calls within 72 hours, the nurses saw how meaningful the calls were to patients and quickly made adjustments. "There was one call I will never forget," said Truneh, Patient Care Manager of D2/G2S. She spoke to a patient who told her, "I never knew nursing could be this good."

"It's rewarding to hear about your unit, your colleagues' work, and how it's reflected in the patient experience," Truneh added.

IMMEDIATE RESULTS

"One of the most exciting things about this program was the immediate improvement in the patient experience once it was implemented," said Marlena Kane, MPH, MSW, Director of Strategic Operations, Patient Care Services.

All inpatient units recognized a significant increase in the Press Ganey patient satisfaction survey score (see figure 1) for the question related to Instructions for Care

at Home. "The response to this question is directly correlated to a patient's likelihood to recommend a hospital, which is an important measure of patient satisfaction," Kane said. The two pilot hospital units started with a 36th percentile ranking in January, 2013 and jumped to 90th percentile in Apri,l 2013.

Nancy Lee, MSN, RN, NEA-BC, Chief Nursing Officer and Vice President of Patient Care Services, said, "Our work in this important area is continuing. We

are developing ways to automate the process in Epic to maximize the time nurses spend in conversation with patients versus finding and inputting information. We also want to share what we learn through these invaluable calls to keep improving our care and communication with patients."

Results of the pilot were so successful that the program was implemented hospital-wide in March and April, 2013.

FIGURE 1. PRESS GANEY INSTRUCTIONS FOR CARE AT HOME

mean 88.0
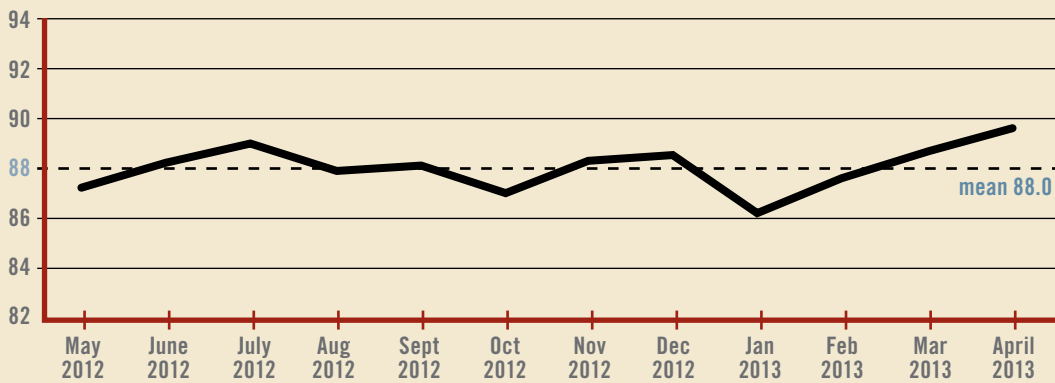
05 Empirical Outcomes

Nurses create solutions and contribute to best practices by demonstrating measureable outcomes based on quantitative and qualitative data.

UNIT EXPERTS

DIABETES RESOURCE NURSES IMPROVE INSULIN INFUSION MANAGEMENT

Many nurses who work on E2 Intensive Care Unit (ICU) receive additional education to support specialized care, improve patient outcomes, and to act as a resource for their peers while also working at the bedside.

The unit created an E2 Diabetes Resource Council in March, 2012 to address challenges with the continuous intravenous insulin infusion protocol. The Diabetes Resource Nurse role was developed as a result.

From daily audits to hypoglycemia reviews, teaching new nurses and resident physicians, consulting at the bedside, collaborating at interdisciplinary meetings, conducting unit skills labs, and presenting at national conferences, the Diabetes Resource (DR) Nurse plays a vital role to E2 ICU staff and their patients.

DR Nurses do not have to be diabetes experts but must be willing to increase their clinical knowledge and want to provide direct consultation to their nurse and physician colleagues. To prepare, nurses take a formal diabetes overview class and receive intensive education on blood glucose and insulin management in the ICU.

There are currently 20 nurses who share this role during their regular 12-hour shift in the ICU. A DR is pre-scheduled every shift, every day. At each shift the nurses announce to their peers that they are the DR for that shift so that everyone knows whom to seek out for diabetes-related questions.

THERE ARE

20

DIABETES RESOURCE NURSES ON E2

A key responsibility of the DR is a daily electronic medical record audit to track adherence to the insulin infusion protocol. There are typically one to four patients on this protocol each day on the unit. DR Nurses provide real-time feedback about adherence and educate peers about patient safety issues. At the bimonthly E2 Diabetes Resource Council meetings the council examines the audit data and look for areas of improvement. These improvement opportunities are transformed into short teaching topics for change-of-shift huddles.

The DR Nurses retrospectively examine all episodes of hypoglycemia—particularly severe hypoglycemia—in E2 ICU. They examine the electronic medical record charting and speak with the bedside nurse to identify the cause. As a result, in the last three-months E2 ICU learned that not all hypoglycemic episodes have the same root cause and that most are due to organ failure with patients not on insulin. A Stanford Alerts For Events (SAFE) report is submitted for all hypoglycemic events, which is the event reporting system at Stanford Hospital & Clinics.

Monthly blood glucose data collected by the Diabetes Clinical Nurse Specialist showed that only 75 percent of E2 ICU point-of-care blood glucose values fall within the target blood glucose range of 70 to 180 mg/dL (Stanford's goal is at greater than 85 percent). The present initiative is focused on working with physicians to initiate a glycemic control intervention when there are two consecutive blood glucose values over 180 mg/dL. DR Nurses are educating their peers at change of shift huddles and coach nurses and doctors at the bedside.

Every month one of the DR Nurses teaches a 20-minute class to the new ICU residents and fellows, sharing expertise and promoting communication about blood glucose management at the bedside. Transition from intravenous to subcutaneous insulin requires careful calculations of insulin doses to meet each patient's metabolic needs. To prevent errant insulin doses that may lead to hypoglycemia, the DR Nurse is often consulted to review orders.

Each month the Diabetes Resource Council writes a short update about blood glucose management for the E2 newsletter. Topics have included diabetic keto acidosis (DKA). The council member presented a poster about the work of the E2 ICU Diabetes Resource Nurses at the Magnet conference in Orlando, Florida, in October, 2013.

SUPPLY ROOM REDESIGN

5S WORKSHOPS SOLVE ORGANIZATIONAL COMPLICATIONS

Nurses and other staff members floating from one floor to another often find themselves spending extended amounts of time looking for needed items in the unit supply centers. Nurses would notice that supply room items that were in one location one month were sometimes moved to another location the next month. These complications—along with changing demands of the hospital—make it challenging for nurses and staff to readily find what they needed.

To solve this problem, Patient Care Services, which comprises nursing, respiratory care services, and rehabilitation services, worked with Infection Prevention and Materials Management to improve supply center organization by applying the 5S method.

5S comes from Lean methodology, which is widely used throughout Stanford Hospital & Clinics to improve process efficiency and continuous improvement.

Beginning in February, 2013, 5S workshops were conducted in all six hospital supply centers to organize the inventory in a way that makes it as easy as possible for nurses and staff to find supplies. Each supply center is shared by several units, and staff members from many departments access them each day, sometimes numerous times in one day. To create a successful set-up for each center, it was important to identify supply priorities and requirements for each group of users.

"One of the most exciting aspects of this project was the teamwork among Materials Management and Patient Care Services. This collaborative effort enabled us to hear and respond to a broad range of perspectives, including specific needs and 'wish list' of items, all of which factored into the decisions made during the 5S workshops," says Marlena Kane, MPH, MSW, Director of Strategic Operations, Patient Care Services. She spearheaded the initiative with Laura Hill, Director of Procurement, Lori Avila, Assistant Director of Operations, Materials Management, and Rex Fieck, administrative director of Materials Management.

Kane also worked with Materials Management to organize a field trip to the hospital's medical supplies distributor, Owens & Minor, where 5S workshop leaders gained insight into the operations of the supply chain giant. The onsite visit helped to provide an understanding of the complexities of hospital materials management and clarified how the 5S theory applied in the context of a world-wide materials distribution center.

THE 5S WORKSHOP

Each workshop group was composed of six to eight team members representing their unit or area of focus and included a clinical nurse and an assistant patient care manager from each unit.

Participants attended a preparatory meeting where the 5S workshop scope was defined and the details of the process were explained. Goals and a timeline for the day of the workshop were also set during this meeting.

On the day of each workshop, team members:
• Reviewed all inventory and determined whether they would keep the item or not

- Removed supplies the team agreed they did not want to keep
- Reduced inventory on infrequently-used supplies
- Implemented visual signals and categorized all supplies for improved visibility and access

Further classification included looking at supplies in other locations on the unit as well as items that needed to be requested from the supply distribution department.

SUPPLY CENTER MAINTENANCE

Unit staff were briefed on the set-up of the newly organized supply centers and how they are to be maintained. Feedback and questions are encouraged as people become accustomed to the new layouts.

The "standardize and self-discipline" components of 5S include a daily audit tool called the 5-minute 5S checklist. The checklist includes tasks that can be accomplished in less than five minutes to maintain order in the supply rooms. Nurses from each unit are trained on the update process, and a nurse or team member is assigned to complete the checklist on a daily basis.

So far, feedback has been positive, with reports that the supply centers are much easier to navigate. The 5S program is allowing nurses and staff to spend less time

THE

5S:

SORT

SIMPLIFY

SWEEP

STANDARDIZE

SELF-DISCIPLINE

searching for supplies and more time caring for their patients. After using the reorganized supply room on C1, Terry Yan, RN, excitedly commented to a colleague, "Look! I found what I was looking for. This really works!"

Wendy Foad, MS, RN, Associate Chief Nursing Officer, credits the enthusiasm and commitment of the workshop groups with the initiative's success.

"Everyone involved was really excited about the project and understood how an organized supply room would improve their jobs and enable them to spend more time at the patient's bedside," she says.

The next stage of the initiative, which began in June, is to complete 5S workshops on all 60 inpatient nursing unit supply carts. It was also decided that the color-coded categorization system would be implemented in all areas that contain supplies across the inpatient units.

"The 5S workshop is just the first step in maintaining functional supply centers," says Kane. "The success of 5S lies in personal accountability to the standards that each group agrees to as part of the workshop and shares with their unit. It is an ongoing process to sustain and continuously improve the centers."

AWARDS AND CERTIFICATIONS

Accredited Case Manager (ACM)
Tatiana Norman-Brivet, March, 2013, Infusion Treatment Area

Acute Care Nurse Practioner (ACNP-BC)
Aimee Lee, December, 2012, Cardiology

Advanced Oncology Certified Nursing Practioner (AOCNP)
Lindsay Stringer, December, 2012, Nursing Education & Practice

Advanced Oncology Certified Clinical Nurse Specialist (AOCNS)
Shanwell Saad, December, 2012, Infusion Treatment Area

Certified Ambulatory PeriAnesthesia Nurse (CAPA)
Van Nguyen, May, 2012, Ambulatory Surgery Center

Certified Clinical Transplant Coordinator (CCTC)
Laura Denton, January, 2013, Liver Transplant
Kulwant Gill, November, 2012, Liver Transplant
Jane Waskerwitz, July, 2012, Kidney Transplant

Certified Emergency Nurse (CEN)
Kay Lee, July, 2012, Emergency Services
Lucas Marciniak, April, 2013, Emergency Services
Crystal Miles-Threatt, August, 2012, Emergency Services
Ijeoma Okonkwo-Pope, June, 2013, Emergency Services
Elena Sokolova, May, 2012, Emergency Services

Certified Heart Failure Nurse (CHFN)
Anne Mullin, July, 2012, Cardiology
Christine Thompson, July, 2012, Cardiology

Certified Medical Surgical Registered Nurse (CMSRN)
Margaret Agtual, December, 2012, C3
Deborah Bone, October, 2012, C1
Melanie Chang, February, 2013, F3
Angeli Danao, May, 2012, E3

Marisa Gonzalez, August, 2012, E3
Denise Martin, March, 2013, C1
Janine Santa Maria, January, 2013, C2
Jemima Santos, February, 2013, C3
Susan Turley, August, 2012, B1

Certified Nephrology Nurse (CNN)
Hongqing Zhang, October, 2012, Dialysis

Certified Neuroscience Registered Nurse (CNRN)
Maggie Buckley, October, 2012, E2
David Caballero, October, 2012, Critical Care Float
Irene Chang, July, 2012, G1
Denise Paulo-Colaci, October, 2012, E2

Certified Nurse Operating Room (CNOR)
Joan Kline, January, 2013, Operating Room
Hyacinth McIver, May, 2012, Operating Room

Certified Pediatric Emergency Nurse (CPEN)
Bibiana Olalia, September, 2012, Emergency Services

Certified Post Anesthesia Nurse (CPAN)
Cynthia Berglund, May, 2012, Surgery Admission Unit
Dana Freedman, September, 2012, Life Flight
Elisabeth Guglielmelli, October, 2012, Post Anesthesia Care Unit
Laurie Jackson, May, 2012, Post Anesthesia Care Unit
Van Nguyen, May, 2012, Ambulatory Surgery Center
Rosemary Raymond, May, 2013, Post Anesthesia Care Unit
Carol Silliman, October, 2012, Surgery Admission Unit

Certified Professional Healthcare Quality (CPHQ)
Anita Girard, July, 2013, Nursing Education & Practice

Certified Wound and Ostomy Care Nurse (CWOCN)
Maria Josephina Gomez, July, 2012, Digestive Health Center

Clinical Nurse Leader (CNL)

Jana Barkman, August, 2012, E2
Angela Bingham, December, 2012, Cardiology
Shannon Fenstemaker, December, 2012, B1
Anita Girard, December, 2012, Nursing Education &
    Practice
Kathryn Grimley-Baker, July, 2012, G2P
Shelby Taranto, May, 2012, E2/ICU

Critical Care Registered Nurse (CCRN)

Azenith Dela Cruz, October, 2012, B2
Kristeen Derrick, September, 2012, NICU
Diane Dobbins, August, 2012, D3
Farshad Keyghobadi, July, 2012, D1
Cherrie Lozada, August, 2012, D1
Roy Lundquist, June, 2013, E2/ ICU
Deanna Malberg, August, 2012, North ICU
Mario Nolasco, January, 2013, North ICU
Margaret Odamo, October, 2012, Cath-Angio
Marlow Phillips, December, 2012, D2/G2
Anna Quelendrino, June, 2012, North ICU
Sandra Reiter, February, 2013, D1
Andrew Veitch, June, 2012, Life Flight

Critical Care Registered Nurse with Cardiac Surgery Certification (CCRN-CSC)

Darvin Antonio, September, 2012, North ICU
Robin Clearly, November, 2012, North ICU
Isobel Fox, July, 2012, North ICU

Family Psychiatric and Mental Health Nurse Practioner- Board Certified (PMHNP-BC)

Ali Abolfazli, September, 2012, G2P

Oncology Certified Nurse (OCN)

Kendra Bartlow, September, 2012, E1
Linda Glatt, October, 2012, Radiation Therapy
Catherine Krum, August, 2012, Infusion Treatment Area
Jemima Santos, May, 2012, C3
Lillian Villanueva, July, 2012, F Grd

Orthopedic Nurse Certified (ONC)

Pamela Schreiber, August, 2012, Nursing Education &
    Practice

Progressive Care Certified Nurse (PCCN)

Charlotte Hanna-Ahr, April, 2013, D2/G2
Azenith Dela Cruz, September, 2012, B2
Monica Dryden, November, 2012, B3
Brandy Emanuel, June, 2013, D1
Meghan Farro, June, 2012, D2/G2
Mary Joseph, August, 2012, D3
Christina Kalemkeris, July, 2012, B2
Ferdinand Rosales, May, 2013, B2
Erica Scott, August, 2012, D3
Heather Searles, March, 2013, B2

Registered Cardiovascular Invasive Specialist (RCIS)

Dympna Doherty, June, 2013, Cath-Angio
Steven Wilson, May, 2012, Cath-Angio

Registered Nurse-Board Certified (RN-BC)

Jan Leslie Dequina, March, 2013, Nursing Float

Master/Graduate Degree

Darren Batara, MS in Nursing Health Systems &
    Leadership, UCSF, June, 2013
Angela Bingham, MSN, University of San Francisco,
    December, 2012
Monica Cfarku, MSN, San Francisco State University,
    August, 2012
Elham Jafroodi, MSN/FNP, San Francisco State
    University, December, 2012
Amida Kakar, MSN, San Francisco State University,
    August, 2013
Joanne L. Meneses, MSN, San Francisco State
    University, August, 2013
Betina Pelesic, MSN-NP, Holy Names University,
    December, 2012
Kerry Porto, MSN, UCSF, June, 2013
Armine Tayag, MSN/FNP, Holy Names University,
    September, 2012
Donna Terry, MSN, San Francisco State University,
    August, 2012

Bachelor/University Degree

Amy McNabb, BSN, Chamberlain College of Nursing,
    June, 2013
Maritess Salgado, BSN, Chamberlain College of Nursing,
    September, 2013
Amanda Simmons, BSN, Holy Names University, May,
2012
Christina Wing, BSN, Chamberlain College of Nursing,
    July, 2013

DAISY AWARDS

HONOR FOR NURSES WITH HEART

Nurses who receive a DAISY award demonstrate a Caring H.E.A.R.T.

CARE AND COMPASSION show kindness and caring for everyone

HONESTY show truthfulness and sincerity in all aspects of patient care

EXCELLENCE AND EDUCATION commit to doing the best of all times

ADVOCACY speak for or defend the patient's right to make choices about their care

RESPECT show consideration and appreciation of others and sensitivity for individual differences, needs and concern

TEAMWORK collaborate with team members to assure excellence in patient care

JJ Baumann
May, 2013 Daisy Award Recipient

RECIPIENTS OF THE DAISY AWARD FOR 2012–2013

JJ Baumann, RN, Stroke Center
"JJ has empowered bedside nurse to have open discussions with patients, families, and physicians about the patient's condition and outcomes looking at a holistic approach."

Teresa Bell-Stephens, RN, Stroke Center
"Because of her caring and compassion, many keep in touch with her for years after their treatment."

Hyeunsook Chon, RN, D1
"She has endless empathy, practicing kindness with all patients and authentically listening to their unique stories."

Yanli Jiang, RN, B1
"Her extensive background in nursing and medicine makes her an excellent teacher."

Eric McClain, RN, F ground
"Eric uses his humor on a daily basis to brighten people's days and his compassion to help patients and their families as they deal with very serious illnesses."

Laura Zitella, ACNP-BC, Inpatient Hematology and Oncology
"I think of Laura as the person who took charge of my care and helped me through every aspect of my battle with cancer. I am forever grateful for her dedication and compassion."

STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

MAGNET
RECOGNIZED
AMERICAN NURSES
CREDENTIALING CENTER

Center for Education &
Professional Development
300 Pasteur Drive, MC 5534
Stanford, CA 94305-5534