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AN EPIC ENDEAVOR

Transforming the way we deliver care





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From the Chief Nursing Officer

CINDY DAY, RN, MS, CNAA, BC, VICE PRESIDENT FOR PATIENT CARE, CHIEF NURSING OFFICER



The journey for excellence continues at Stanford Hospital and Clinics. Over the next months, nursing will be involved in one of the most significant initiatives to happen at SHC in years.

The Institute of Medicine (2001) report, *Crossing the Quality Chasm*, addressed the importance of technology in the promotion of evidence-based practice, information and decision support, and reduction of errors. Implementing our new clinical information system will definitely have a great impact on every nurse in the organization. We will all be challenged to learn new ways of doing our work, challenged by the new technology, and a critical source of support for our other colleagues as they learn and become comfortable with the new system.

I was recently reading a book entitled *The Heart of Change*, in which the author discusses how much our feelings impact our ability to adapt to, and accept, change. He also stated “...never underestimate the power of clever people to help others see the possibilities, to help them generate a feeling of faith, and to change behavior.” (Kotter, 2002, pg. 112)

As we enter into the next few months, which will include training, workflow changes, and inevitably heightened anxiety about how the new system will work, let’s all try to remember how important this change is to our ability to provide the best possible patient care and safety, and how we are “clever people” who can help others see the possibilities.

Cindy Day

The Meaning of Magnet

The Continuing Journey to Excellence in Nursing Practice

BY KATHLEEN M. HICKMAN, RN, MSN
ASSISTANT DIRECTOR OF PRACTICE AND EDUCATION

It has been ten months since the exhilarating phone call from the American Nurses Credentialing Center Magnet Program on February 14, 2007 designating Stanford Hospital & Clinics as a Magnet facility. This distinguished award is held by only 256 hospitals, approximately 4.5 percent of hospitals nationwide. Although Magnet status is awarded for four years, there is still much work underway to maintain this prestigious ranking.

Every February for the next three years, we must submit an annual interim report to the Magnet Program Office (MPO) providing information required to maintain our Magnet status. During the fourth year we will start the entire application process again. This includes the submission, in February 2011, of up to 15 inches of documentation demonstrating how we continue to meet the 14 Forces of Magnetism, with a site visit by Magnet appraisers later that year.

A Magnet workgroup is already drafting the first interim report due in February 2008. This report will cover trending, analysis, and improvements in our nurse and patient satisfaction data and a description of trends, interventions, and benchmark comparisons for our nurse-sensitive indicators such as falls, pressure ulcers, and medication errors. Examples of other data required in the interim report include the percent of nursing staff with certifications from a nationally recognized certifying body, the number of associate, bachelor, master and doctorate

prepared nurses, the nursing vacancy and turnover rate, and the average length of employment for nurses (all based on unit demographics). The expectation of the MPO is that these areas will demonstrate growth and improvement every year.

...the journey continues, not just with interim reports, but with our everyday endeavors to provide the very best evidence-based care and elevate the professional practice of nursing.

Additionally, we need to focus our efforts and report on the three areas the Magnet appraisers identified as areas for growth:

- 1) Research,
- 2) Cultural Diversity, and
- 3) National Certification.

We also have a group of 16 enthusiastic Magnet Champions who are working on several projects

that will keep the staff and our patients informed about the Magnet process. One such project is the development of a patient information sheet describing why Stanford is a Magnet hospital. Another project includes a monthly update in the Stanford E-News about Magnet activities and recognition of staff Magnet moments. A number of the Magnet Champions attended the 11th Annual Magnet Conference in Atlanta, where Stanford was recognized as a new Magnet facility. This was an exciting and invigorating conference providing all Magnet facilities the opportunity to share best practices, collaborate, and network.

Although Stanford strove hard to achieve Magnet recognition, and is now recognized with an elite few as delivering excellent nursing care, the journey continues, not just with interim reports, but with our everyday endeavors to provide the very best evidence-based care and elevate the professional practice of nursing. **SN**

The Different Faces of Nursing

BY LEEMA J. PENTA-LOURDUSAMY, RN, CCRN
D1/CCU STAFF NURSE

My journey as a nurse from India to the east coast of the United States to Stanford has shown me so many different faces of nursing. It has made me appreciate what makes Stanford so outstanding; how nurses play a vital role in creating a positive work environment and better patient outcomes. In a complex profession like nursing, we need to be physically, mentally, technically, and intellectually equipped to embrace challenges every day.

Nurses as patient advocates stand up for their patients. *Nurses as role models* demonstrate a “patient first” attitude in their deeds. *Nurses as critical thinkers* identify patient issues by using their judgment. *Nurses as caregivers* approach each patient as an individual with unique needs.

For example, on the D1 unit, it is critical that nurses are sensitive to patients’ individual needs and support them both

In a complex profession like nursing, we need to be physically, mentally, technically, and intellectually equipped to embrace challenges every day.

emotionally and psychologically, especially those waiting for heart transplants. It can be heartbreaking to see young patients on the transplant list for first or even second transplants or to watch a patient die while awaiting a heart and lung transplant. It can be hard to say good-bye when it is time. As nurses, however, we offer comfort until the last moments, and at the end of the day, we take home the lesson of how valuable every life is.

Nurses as leaders focus on the quality of patient care, and contribute their knowledge and skills by making recommendations to improve nursing practice. *Nurses as teachers* at the patient’s bedside explain complex physiology and pharmacology. *Nurses as team players* participate in a multidisciplinary team approach to solve patient problems. When we feel like



Leema J. Penta-Lourdusamy, RN, CCRN

we need multiple hands and multiple brains to handle a situation, we can always count on other nurses to help us.

Nurses as managers understand other nurses and provide support during crisis situations, including personal crises, and make us feel like we are part of a family at Stanford. *Nurses as preceptors* support and guide new graduate nurses and new hires by providing a positive learning environment. *Nurses as learners* charge their brains with effective education through the Center for Education and Professional Development, which helps to update and strengthen our knowledge to meet the demands of our fast-growing profession. *Nurses as educators* are committed to creating new initiatives that improve clinical excellence.

Stanford nurses are called to make a difference in someone’s life everyday. **SN**

The Ties That Bind

The Many Gifts of Organ Donation

MARGUERITE BROWN, RN, MSN
ADMINISTRATIVE DIRECTOR, TRANSPLANT SERVICES

On December 22, 1986, when a four-month old baby named Michael McCann lost his life, his parents, Steve and Karen, determined in the midst of their grief to give the gift of life to another infant by donating their son's heart.

It took the North Dakota Air National Guard and a dedicated transplant team to deliver the heart from Fargo, North Dakota to California. Stanford transplant nurse Marguerite Brown, RN, MSN, was on the team that recovered the heart for 5-month-old Andrew De La Pena. Below, she reflects on a recent reunion that brought Steve and Karen together with Andrew and the original flight team.

The reunion was a very emotional event for me on several levels. First it reminded me of how much time had really passed relative to an event that in my mind still seemed to have happened a short time ago. I only had to see this handsome and impressive young man, Andrew, to recognize that over 20 years had gone by since that harrowing night in Fargo when I went with our team to recover the infant heart that now was beating in this young man's

chest – a young man who was now a college student.

I was particularly struck by meeting the parents of the infant whose heart had been donated as a result of Sudden Infant Death Syndrome. As a donor coordinator, it was always so difficult to see the tragic circumstances that surrounded the death of infants. These parents were quite remarkable to have the courage to donate the organs at a time when donation was not as



Col. Robert J Becklund, Andrew De La Pena, Marguerite Brown, RN, MSN

accepted a practice as it is today. It was so touching to see the bond that quickly formed between these two families, and I was so thankful to have taken the opportunity to witness the meeting and take part in the reunion.

I was very proud to represent the many individuals on the Stanford Heart Transplant team at the event with regard to the care provided by OR nurses, ICU nurses, step-down unit nurses, and transplant nurse coordinators, all of whom played a major role in getting Andrew through his transplant and through the subsequent 20 years of his life.

For nurses in our Surgical ICU and in the OR who play a role in organ donation at Stanford, this can often be a very difficult and stressful experience. I hope that they recognize that they are also critical members of the transplant team. They are rarely able to see where their contributions lead; this story is just one example of a young man who would not be alive today without the assistance of the nurses who took part in the donation case in Fargo. All of us involved with the transplant programs at Stanford sincerely thank them for their efforts each and every time they assist with the critical organ donation process. **SN**



Medication Pass Time Out

It's Time to Eliminate Medication Errors!

BY ELISA NGUYEN, RN, CMSRN, PATIENT CARE MANAGER F3

Background

Up to 98,000 Americans die each year from medical errors. Of these, 7,000 patients die as a consequence of medication error (Kohn et al., 1999), 700 patients in the state of California alone (Mayo & Duncan, 2004). Medication error is the eighth leading cause of death in the United States with an estimated annual cost of \$17 to \$29 billion (Banning, 2006). In addition, a patient's hospital length of stay associated with medication error is increased by 4.6 days with an increased cost of \$4500 per patient (Mayo & Duncan, 2004).

As a result, medication error, particularly those caused by medication administration, has become a major concern in acute care settings, with both direct and indirect impact on patients and nurses. Direct impact includes harm to patients as well as increased healthcare costs, while indirect impact includes harm to nurses in terms of their professional and personal status (Mayo & Duncan, 2004).

Medication errors occur in different stages of the medication process. Leap et al. (1995) reported that most medication errors occur during physician ordering (39%) and medica-

tion administration (38%), followed by transcribing (12%) and processing (11%). Seventy percent of physician-ordering errors are intercepted by pharmacists and nurses prior to administration (Leap et al., 1995); however, there is no human safety net for nurses during administration of medications. As a result, Pape, as cited by Carlton and Blegen (2006), reported that medication administration errors are

third on the list of sentinel events leading to a patient's loss of function or death. Carlton and Blegen's (2006) literature reviews also found that the highest scoring subcategories of medication administration errors are caused by distractions (50%) and interruptions (47%) followed by inadequate staffing and nurse-to-patient ratios.

Yet their direct patient care activities, as the final step in the system of checks and balances for the medication administration process, give nurses the opportunity to play a very important role in the prevention of medication administration errors (Mcbride-Henry

& Foureur, 2006). To tackle this issue, a medication safety initiative, Medication Pass Time Out, was implemented at Stanford Hospital and Clinics as part of a larger, multi-hospital initiative designed to improve patient outcomes throughout Bay Area hospitals. Through this initiative, frontline

Their direct patient care activities . . . give nurses the opportunity to play a very important role in the prevention of medication administration errors.

*Standing, from left to right,
Karen Jazmin, Maureen
Prasad, Van Bellew, Mariel
Matthews, Eugenie Marek, Ana
Chamagua, Brandi Ward, Erma
Williams, Vanessa Malbog
Sitting: Elisa Nguyen*

*Team Leads: Elisa Nguyen,
Susan McKay
Members: Sharon Butler,
Ninette Pierce, Eva Mendez,
Laura Morris, Maria Cheung,
Van Bellew, Davinder Bhatia,
Joyce Montemayor*

*INLP Team not in picture:
Susan McKay, Sharon Butler,
Nan Pierce, Eva Mendez,
Laura Morris, Maria Cheung,
Davinder Bhatia, Joyce
Montemayor*



nurses have a chance to demonstrate that they are capable of driving significant change at the bedside.

The Program

This initiative stemmed from a broader program – the Integrated Nurse Leadership Program (INLP) Cohort 2 – designed to measurably improve the quality of nursing-related patient outcomes in seven acute care hospitals in the Bay Area. The INLP was created as part of the Betty Irene Moore Nursing Initiative in the Bay Area, which was funded by the Gordon and Betty Moore Foundation. Its mission is to create a replicable model for improving nursing-related patient outcomes through a regional system that expands the nursing workforce and implements hospital best practices. The INLP Cohort 2 focused specifically on addressing existing systems that do not consistently safeguard against dangerous and avoidable medical errors such as medication errors. Its purpose is to transform the hospital work environment and improve nurse-related patient outcomes through developing nurses’ professionalism while enhancing their capacity to create and lead sustainable change. Stanford Hospital and Clinics became one of the hospitals that joined the journey to improve the quality of nursing-related patient outcomes.

The Team

The Stanford INLP put together an Implementation Team (IT) that consists of 10 members from both inpatient and outpatient units throughout the hospital. The IT is led by two team leaders and supported by three senior executives: the chief nursing officer, the associate director of nursing operations, and the director of patient care services. The team leads are responsible for coordinating team meetings and ensuring that team activities are completed on time.

Vision, goals, and objectives

To align with the vision of the hospital, Stanford’s INLP IT vision is to set the standard for safe medication administration, and the team’s goal is to promote zero tolerance for medication errors. The team set forth two objectives to accomplish this goal. The first is to determine failure modes for medication administration, reviewing the administration process and identifying which parts of the process are potential causes of medication administration error. This could be due to failure to perform the following tasks: 1) double checking the medication with the order when pulling the medication out of the Pyxis, 2) labeling the medication from preparation to administration time, or 3) checking at least two patient identifiers. The second objective is to understand the cognitive and environmental factors that affect medica-

tion administration. Understanding the cognitive factors means identifying knowledge-base errors such as medication calculations or familiarity with the common medications used for specific patient populations. Understanding the environmental factors means identifying those elements that might cause medication administration error; for example, the sicker the patients, the more vulnerable the nurses are to making medication errors. Another example of a common environmental factor is the likelihood of distraction or interruption with regard to medication administration.

Methodology

In the pilot unit in which this initiative was implemented, a Plan-Do-Check-Act (PDCA) cycle was instrumental in evaluating the process and monitoring the interventions. The PDCA cycle guided the process of implementation in designing, performing, and revising the intervention as necessary.

The implementation team conducted an analysis of the pilot unit's reported medication error data from an electronic incident reporting system called Patient Safety Net. The data showed that the unit ranged from two to ten medication administration errors a month. The IT partnered with the California Nursing Outcomes Coalition (CalNOC) to build and sustain a valid and reliable outcome database for accurate medication administration process. The IT also conducted a 100 dose naïve observation in the pilot unit using a CalNOC Observation Codesheet, which included six indicators for the medication administration process: 1) comparing medications to the MAR; 2) no interruptions or distractions during medication administration; 3) labeling the medication from preparation to administration time; 4) checking two patient identifiers; 5) explaining the medication to the patient, and 6) charting the medication immediately after administration. The results showed that 20% of interruptions or distractions happened in the unit during the medication administration process, indicating significant room for improvement. The rest of the indicators scored at a positive 85%-98%. The IT brought the data to the pilot unit council in hopes of getting some feedback from them in terms of how to improve the process of medication administration by reducing distractions and interruptions.

The initiative

The pilot unit council was very receptive to the data and welcomed the chance to participate in the transformation. After much collaboration, both sides agreed to implement the Medication Pass Time Out Initiative. The implementa-

tion team gave the nurses the responsibility of drafting the policy, which was then ratified by the unit council. The initiative was also designed according to Stanford Hospital guidelines and protocols, and meets the Joint Commission's National Patient Safety Goal #3 – to improve the safety of using medications. It builds in a protected hour with no interruptions early in a shift for a nurse to exclusively focus on reconciling medication orders, administering medications, checking medication labels, and charting the administration of medications. Except for emergencies, all patient inquiries, phone calls, pages, physician visits or inquiries, and other daily intrusions are delayed for that period of time.

The implementation

The Medication Pass Time Out Initiative was implemented a week after the policy was ratified, and implemented on a 25-bed pilot unit, F3, on the day shift between 7:30 a.m. and 8:30 a.m. Before the implementation, the initiative was communicated to the patients, physicians, and other staff in the unit. The unit manager worked closely with the day shift staff to make sure everyone in the unit was aware of the plan, and flyers, which informed everyone not to interrupt nurses during the protected time period, were posted all over the unit. The staff let patients know of the "Time Out" period during nursing rounds, and the unit manager developed scripts for unit clerks to guide them on what to



Maria Perez and Karen Jazmin

say when individuals requested to talk to a nurse during this period. Resource nurses and nursing assistants were briefed on their role in keeping distractions away for that one hour. Two days after the implementation, the timeframe for the Time Out was changed to 8 a.m. to 9 a.m. due to multiple procedure calls during the earlier period. The procedures were revised four more times as well to reflect realities on the unit, including changes in the roles of the resource nurses, nursing assistants, and unit clerks, and changes in break coverage.

Analysis and evaluation

The implementation team and the unit manager teamed up to evaluate the process two weeks after implementation. The CalNOC Observation Codesheet was used to collect data, then sent to CalNOC where staff combined the data with the data from the other six hospitals, and benchmarked the scores based on the six CalNOC indicators. The CalNOC staff analyzed the data and sent the report to the team leads, who reviewed the data with the unit manager and staff.

In addition, PDCA cycles were used to plan, implement, and evaluate the process, allowing changes as needed throughout the pilot.

Six months after implementation of the Medication Pass Time Out initiative, the implementation team conducted another 100 naïve observation to see whether the initiative had reduced interruptions and distractions during medication administration, and whether it had made an impact on medication administration errors in the pilot unit. The results showed a significant decrease in the incidents of interruptions or distractions during administration time: the pilot unit had zero interruptions for five out of six months compared to 20% interruptions before implementation. Medication administration errors also decreased significantly: the pilot unit experienced 2-10 medication administration errors prior to implementation; six months following implementation, the pilot unit experienced only 0-3 medication administration errors per month over a six-month period.

Spread units and future plans

The initiative is now implemented on B3, Neurosurgery and Vascular Unit, with the same methodology used but slight differences in practice; the Neurosurgery Close Observation Room (NCOR) is not part of the implementation. D3, a telemetry unit, has also implemented the initiative with the same methodology. With the initial success of the initiative,

the plan is to implement it on three units by the end of 2007 and on five additional units by the end of 2008.

The initiative also has been communicated to the hospital's Quality Council, Clinical Nurse Specialist Group, Nurse Manager's meeting, and Quality Improvement and Patient Safety Committee (QIPSC). The implementation team conducted an on-site training workshop designed to give assistant managers, educators, and resource nurses the tools to implement the initiative. The workshop generated a lot of interest in the initiative which the implementation team plans to capitalize on, spreading the initiative throughout the hospital to improve the medication administration process. **SN**

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An Epic Endeavor

Transforming the way we deliver care

CONNIE TAYLOR, RN, MPA
DIRECTOR OF NURSING INFORMATICS

If Thomas Edison had simply tried to make longer burning candles, we might have waited much longer for electricity. If Henry Ford had dreamed of creating a better wagon wheel, the automobile might have come much later. True innovators don't just improve current products or processes, they aim higher, thinking beyond the boundaries of **what is to what could be**.

At Stanford Hospital and Clinics, the Epic Design Parameters team set out to do just that. "They did something that had never been done before, so they did it without a roadmap," says Director of Nursing Informatics Connie Taylor, RN, MPA.

The goal? An improved experience for patients at Stanford Hospital and Clinics, at every step in the process.

The challenge? To solve the problem that, despite the care they rate as excellent, patients report significant frustration getting into and through the system at Stanford.

The solution: To create an efficient new hospital-wide clinical information system, one that incorporates a comprehensive electronic medical record, registration system, and billing/insurance/revenue system.

"Typically," Connie notes, "hospitals seeking a technical solution to a problem plunge in at the implementation stage. As a result, they end up simply automating the processes already in place, regardless of whether they're working or not. This very often leads to automating flawed systems."

Four teams, five months, one groundbreaking initiative

Stanford took a different approach. Guided by CEO Martha Marsh's challenge to dream big, to come up with a "pie in the



sky" design that puts the patient at the center of the process, a cross-functional team of approximately 40 end-users and subject-matter experts was assembled for a five-month process intended to transform the way care is delivered at Stanford.

The worldwide management consulting firm Accenture helped the Stanford team evaluate vendors and eventually select a clinical information system from Epic Systems Corporation. Accenture participated on the teams, provided the methodology, and helped tailor tools to fit Stanford's needs.

Mysti Smith-Bentley, RN, OCN, Program Manager for Process Excellence who participated early in the process by attending demonstration sessions by different vendors before ultimately casting her vote for Epic, was excited to be included in the initiative. "Because I feel so strongly about including clinicians, I was thrilled when I was asked to participate in the Epic Design Parameters project," she says. "I believe involving operational people was crucial for success, to make sure we didn't build our broken processes into our new robust system."



Jody Leeds, RN, Team Leader, Clinical Documentation Team

Identifying what is

For five months, the team worked to understand in detail current state workflows throughout Stanford Hospital and Clinics, from scheduling, ordering, and documenting, to how patient care is managed across the continuum of care.

By conducting over 100 interviews, the team was able to identify more than 370 “pain points” they would seek to

eliminate. A review of the discharge process, for example, revealed wasted effort due to the multiple forms physicians must fill out, all of which duplicate information, as well as the bottleneck that typically occurs in pharmacy where patients often have lengthy waits until the pharmacist has documented that the required counseling has been provided.

Imagining what could be

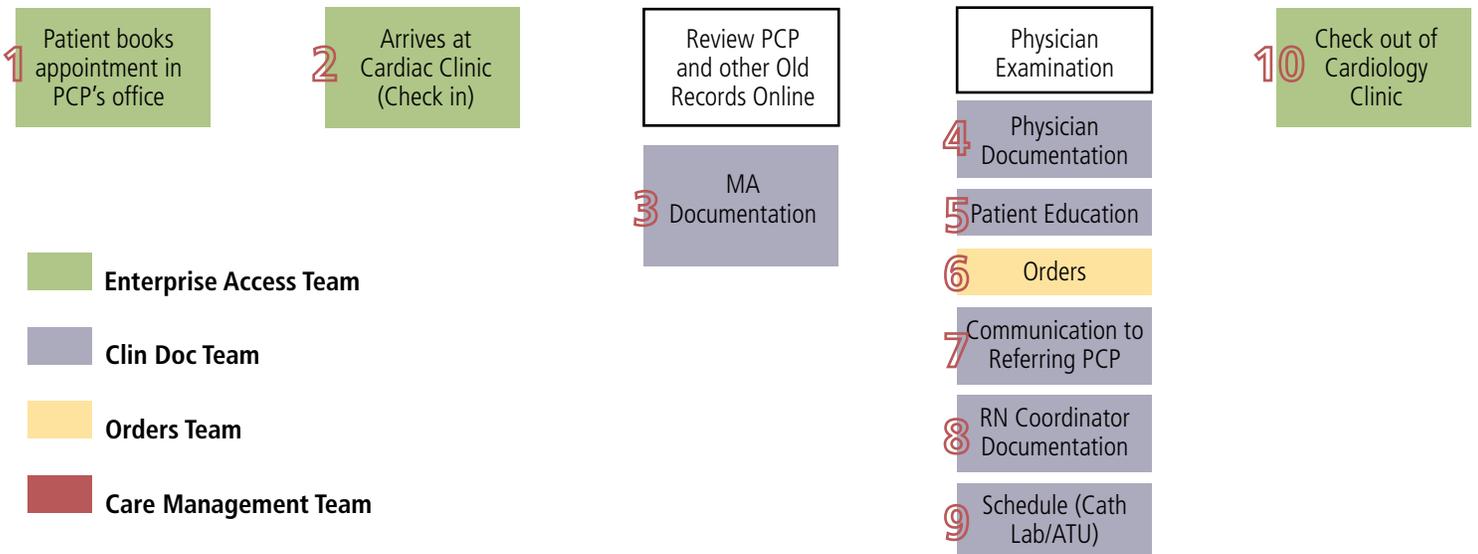
Jody Leeds, RN, team leader for the Clinical Documentation team, explains that the team was then tasked with designing what they called “future state” workflows. “We challenged ourselves to answer the question: ‘How can we transform the way we deliver care at Stanford?’” From this overarching query came hundreds of specific questions, like “What if patients could schedule all of their required appointments in a single interaction?” and “What if physician documentation could be done online, with the results immediately available to the entire care team?”

Walking a mile in the patient’s shoes

The initial research and information-gathering process included talking with staff at other hospitals in order to learn from their experiences. From these interactions came “the germ of an idea,” recalls Connie, to structure the design process around five patient journeys as well as a “day in the life” of a physician. The five patient journeys were set in these high-volume service lines:

Project Deliverables: Integrated Design Story Board Example

Scene 1 – Mrs. Ramos is seen by Dr. Hart in the SHC Cardiology Clinic. The exam confirms the need for a Cardiac Catheterization.



- Cardiac Services
- Medical Oncology
- Orthopedic Surgery
- Surgical Oncology
- Neurological Services

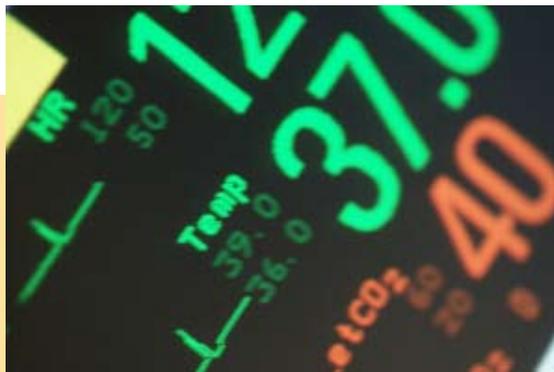
The teams then went to work in integrated design sessions to create storyboards illustrating an ideal patient journey through each of these services, including any touch points outside the service and tracking the patient's every move and every interaction. Their goal was to create perfect "future state" paths without any limitations (including Epic's specific functionality). Then they developed narratives based on each of these journeys, identifying 187 new "future state" ideas and dividing the ideas into six specific categories: Ideas that benefit patients, ideas that benefit physicians, ideas that benefit staff, ideas that Epic facilitates, ideas determined to be current best practice, and ideas they identified as Stanford-created "leading-edge" ideas.

More than 200 stakeholders (including physicians, nurses, technologists, and other staff) participated in a series of review and feedback sessions. From these original journeys came 541 new workflows that resolved the original pain points. Finally, the journeys were edited to identify those ideas that could be enabled by Epic and those that were out of the current scope.

In all, 120 of the future state ideas were considered to be in scope, while 48 were deemed out of the current scope, 19 were put on hold to be revisited at a later date. Even ideas that are not within the scope of the current implementation project – such as kiosks at which patients can do a wide variety of tasks like register, update their personal information, and receive an itinerary of their scheduled appointments – have not been discarded but simply put on hold for the present.

And both Epic and Accenture are using this project to market to other hospitals and healthcare organizations as an example of what is possible when *anything* is deemed possible.

With the handoff to the CIS team, the implementation process is now well underway. Jody, who has joined the implementation team in order to contribute to the next phase, reflects: "The Epic Design Parameters project was a truly inspired project, one that I was honored to have worked on. It was a dream come true. I believe that information systems can really improve the patient experience. But even more than that, I think they can save our healthcare system." 



The Epic Design Parameters Teams

Orders

Julie Krieger, RN, *Team Leader*
 Nanci Fleck, RN
 Karen Pendley, RN
 Christopher Sharp, MD
 Andrew Shelton, MD
 Geri Tolentino, RN
Team Sponsor: Connie Taylor, RN

Clinical Documentation

Jody Leeds, RN, *Team Leader*
 Nancee Braddock, RN
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Enterprise Access

Michelle Relloma, *Team Leader*
 Judy Bruzus
 Kim Desilva
 Chas Dibble
 Michele Thomas
 Christopher Sharp, MD
 Andrew Shelton, MD
Team Sponsors: Chet Jones, RT, CRT,
 Sandy Rozmarin, RN, Buffie Stark

Care Management

Elizabeth Polek, LCSW, *Team Leader*
 Peg Albrets, RN
 Christopher Sharp, MD
 Andrew Shelton, MD
Team Sponsors: Design Advisory Group

A Balance of Work and Play



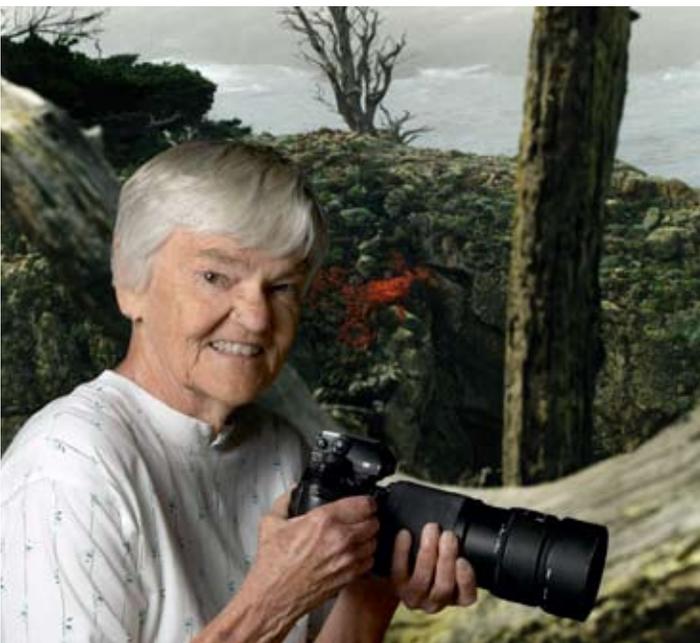
KATIE CHAN is a staff nurse on North ICU who started painting in 1997. She says her paintings are about her passion for life and a vision of a perfect world and that her encounters of tragedy and struggle at work are her inspiration. She recently has had her work exhibited at a Palo Alto art gallery.



ELNURA KULDAEVA is a new staff nurse on D1 who immigrated to the USA from the Kyrgyz Republic five years ago. She speaks 4 languages; Russian, Kyrgyz, French, and English. Her hobby is reading classic literature in its original language by authors such as Leo Tolstoy, Chingiz Aitmatov, Honore De Balzac, and Charles Dickens.



CRAIG SEPPALA, an Assistant Patient Care Manager on B2, recently originated a bowling face off between **B2 AND E2** in September 2007. Craig designed the clever bowling shirts. The B2 Killer Bees resoundingly defeated the E2 Night Fockers and fun was had by all. The rivalry, says Craig, has just begun! The photograph was taken by Luke Girard, husband of E2 bowler Anita Girard.



LIZA TAFT actually retired in 2002 but has been working as a relief Case Manager since. Photography has been her hobby since she was a teenager. She creates note cards for friends and has been the "Official Photographer" of the F Ground Christmas Card for years. She says she continues to work to support her hobby.

In Recognition of...

CONFERENCE PRESENTATIONS

Judy Barnes, RN, BSN, MPA: "Managing the Challenges of the Complex Patient" Panelist, American Case Management Association Northern California Chapter Conference, Fairfield, CA, June 13, 2007.

Pat Emmons, RN, MSN, CNS, CWOCN: "Diaper Free Zone: Innovative Approach by a Step-Down Unit to Reduce Nosocomial Pressure Ulcers" Poster Presentation, Symposium for Advanced Wound Care, Tampa Bay, FL, May 2007.

Anne Klevay, RN, MSN, APRN, BC: "Early Recognition and Intervention Options for Delirium", 22nd Annual National Psychiatric Nursing Conference, San Francisco, CA, May 19, 2007.

Jody Leeds, RN, BA, HNC: "Transforming Your Organization: The First Steps to a CIS Implementation", Epic User Group Meeting, Madison, WI, September 2007.

Jody Leeds, RN, BA, HNC and Connie Taylor, RN, MPA: "Evidence-based Care Plans: Epic and ZynxCare Integrated Approach", Epic Nursing Advisory, Madison, WI, September 2007.

Julie Morris, RN, BSN: "Home INR Monitoring", 23rd Annual National Marfan Foundation Conference, Stanford, CA July 14, 2007.

Michael Sheehan, BSN, RN, MSN, FNP: "The Aortopathy of Bicuspid Aortic Valves", Western Thoracic Surgical Association Conference, Santa Ana Pueblo, NM, June 2007

Connie Taylor, RN, MPA: "ZynxCare Implementation Roundtable – The Stanford Hospital and Clinics Experience", Zynx Health Conference, St. Pete Beach, FL, May 10, 2007.

Jane Wang, RN, MSN, RNP: "Nasal and Sinus Anatomy with Flexible and Rigid Nasal Endoscopy", Society of Otorhinolaryngology and Head-Neck Nurses, Washington DC, September 14, 2007.

POSTER PRESENTATIONS

Annual Meeting of the American Association of Neuroscience Nurses, Orlando FL, Apr-May, 2007: "Implementation of an Evidence-based Project for Craniotomy Incision Care": Joy Ryan, BSN, RN, CNRN; Julie Tisnado, MSN, RN, CNRN; Teresa Bell-Stephens, RN, CNRN

Professional Certification – One Neurosurgical Unit's Systematic Approach": Julie Tisnado, MSN, RN, CNRN; Teresa Bell-Stephens, RN, CNRN; Joy Ryan, BSN, RN, CNRN; Bree Yaeger, BSN, RN, CNRN

"Moyamoya Disease: Neuroscience Nurses Must Lead the Way to Educate Patients": Teresa E. Bell-Stephens, RN, CNRN; Julie Tisnado, MSN, RN, CNRN, Bree Yaeger, BSN, RN, CNRN

"Extracranial-Intracranial Bypass: What We Learned Along the Way": Bree Yaeger, BSN, RN, CNRN; Teresa Bell-Stephens, RN, CNRN; Julie Tisnado, MSN, RN, CNRN

APPOINTMENTS

Mary E. Lough, RN, MS, CNS, CCRN, CNRN: Awarded a two-month fellowship, National Institutes of Health, Bethesda, MD, sponsored by the National Institute of Nursing Research, June-July 2007.

Albert Medina, RN: Elected Program Chair, San Francisco Chapter of the Oncology Nursing Society, August 2007 – September 2008.

Elisa Nguyen, RN, CMSRN: Appointed to the Bay Area Regional Nurse Network Advisory Council, July 2007

Julie A. Shinn, RN, MA, CCRN, FAAN: Representative for the Counsel on Cardiovascular Nursing of the American Heart Association, National Writing Committee, sponsored by the American College of Cardiology and the American Heart Association.

Jacquette Ward, RN CCRN: Elected President of the South Bay Chapter of American Association of Critical Care Nurses, July 2007 – June 2008.

CERTIFICATES

American Association of Critical Care Nurses Certification Exam

Kiana Bayani, RN, BSN, CCRN, July 2007
Marie Canoy, RN, CCRN, July 2007
Jason Collins, RN, ARCT, BMus, BSN, CCRN, December 2006
Juliet Javier, RN, BSN, CCRN, July 2007
Dennis Manzanades, RN, BSN, CCRN, June 2007

American Association of Critical Care Nurses Cardiac Surgery Certification Exam, July 2007

Myrna Gutierrez, RN, BSN, CCRN, CSC

American Case Management Association Certification Exam

Connie Doherty, RN, BSN, ACM, July 2007
Carolyn Hronik, RN, BSN, ACM, August 2007
Paula Kaur, RN, BSN, ACM, August 2007

American Nurses Credentialing Center Certification Exam, Ambulatory Care Nursing

Nancy Masunaga, RN, MS, BC, March 2007

Academy of Medical/Surgical Nurses Certification Exam, May 2007

Claudia Duran-Otero, RN, BSN, CMSRN
Jill Egerbrecht, RN, BSN, CMSRN
Kerry Farthing, RN, BSN, CMSRN
Laura Gleason, RN, BSN, CMSRN
Brian Lee, RN, BSN, CMSRN
Mary Lucitt, RN, BSN, CMSRN
Qun Ma, RN, BSN, CMSRN
Marsha May, RN, BSN, CMSRN
Ian Stewart, RN, BSN, CMSRN

American Association of Neuroscience Nurses Certification Exam

Cynthia Hernandez, BSN, RN, CNRN, May 2007
Bree Yaeger, BSN, RN, CNRN, May 2007

National Certification Board for Diabetes Educators Certification Exam

Aileen McAllister, RN, MS, CNS, CDE, June 2007

California Board of Nursing Clinical Nurse Specialist

Aileen McAllister, RN, MS, CNS, CDE, March 2007

Oncology Nursing Society Certification Exam

Eileen Tejano, RN, OCN, August 2007

DEGREES

Masters of Science in Nursing San Francisco State University/Stanford Cohort Group, Summer 2007

Laurie Bacastow, RN, MSN, CNRN
Sabrena Chapman, RN, MSN
Stephanie David, RN, MSN
Aimee Cortez, RN, MSN
Susan M. Cox, RN, MSN, OCN
Ann Mitchell Ellsworth, RN, BSN, MSN-CNS
Maria I. Faulve-Montojo, RN, BSN, MSN
Donna Healy, RN, BSN, PCM, MSN
Rosa Magana, RN, BSN, NP
Sandip Suprai, RN, MSN
Faith Vander Linden, RN, BSN, MS, ANP

Myrna Filman, RN, MS, NP : Masters Degree in Nursing, University of California San Francisco, June 2007

Cathy Rizzo, RN, BSN, MPA: Masters in Public Administration, Notre Dame De Namur University, May 2007

Michael Sheehan, BSN, RN, MSN, FNP: Masters of Science in Nursing/ Family Nurse Practitioner Program, Duquesne University, May 2007.



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