

STANFORD NURSE

VOL. 32, NO. 1

STANFORD HOSPITAL & CLINICS

SPRING 2012



PEERING THROUGH THE
Mask of Pain

STROKE BUSTERS

LIFELIGHT

ENDOSCOPY
ON THE ROAD

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Stanford Nurse is published by the
Division of Patient Care Services.
It is distributed to the Stanford nursing
and medical communities, selected
individuals, schools, organizations,
and professional journals. Address
correspondence to: Editor, Stanford
Nurse, Center for Education and
Professional Development, 300 Pasteur
Drive, MC 5534, Stanford, CA 94305-
5534. Stanford Nurse is indexed in the
Cumulative Index to Nursing & Allied
Health Literature.

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From the Chief Nursing Officer

NANCY J. LEE, MSN, RN, CHIEF NURSING OFFICER, VICE PRESIDENT, PATIENT CARE SERVICES



Someone recently asked me, “After all these years, why are you still a nurse?” Why I became a nurse in the first place is a long story,

but why I am still in the profession is simple: I see it as an incredible opportunity to make positive—and meaningful—change. I could never imagine doing anything else.

As nurses, we are the lifeline for the patients and families who come to Stanford Hospital & Clinics. They come to us in crisis or in pain or needing ongoing care, and we respond with humanity, kindness, and expertise. We show up every day to practice our craft and apply our skill. But we are so much more than caregivers: We are advocates and educators, mentors and leaders.

What other profession can make such an impact?

As nurses, we have an incredible opportunity to take a leadership role in every aspect of the patient experience. Throughout the hospital I see nurses at the forefront of the issues, taking responsibility for solving problems, taking their commitment to the next level. They are eager to learn and to identify realistic changes to improve patient care and outcomes, whether it is at the bedside, in the community, or across international borders. That influence is powerful, with a ripple effect that extends far beyond the walls of the hospital.

The medical community has changed significantly over the years, putting new demands on nurses but also creating new opportunities to make a difference. Our goal at Stanford Hospital is to support nurses to take on new roles and responsibilities, ensuring that the voice of the patient is heard.

We are building a framework for nursing care based on personal ownership and professionalism that enables nurses to grow, learn, and excel. I truly believe that every nurse here has the potential to be a leader and the responsibility to rise to that challenge.

Our renewed Magnet status is a clear recognition of the value nurses add to Stanford Hospital & Clinics in terms of professionalism, leadership, and growth. Thank you for all your dedication and hard work to make this happen.

A handwritten signature in black ink that reads "Nancy J. Lee". The signature is written in a cursive, flowing style.

From the Editor-in-Chief

SUZANNE TAYLOR, MSN, RN

MANAGER, CENTER FOR EDUCATION AND PROFESSIONAL DEVELOPMENT, PATIENT CARE SERVICES



Dear Colleagues,

I am excited to share with you the spring 2012 edition of the *Stanford Nurse* magazine. In these articles, Stanford nurses share their stories of how they personally and collectively contribute to improving health care.

In “Time is Brain,” read how Stanford nurses partnered with stroke coordinators from Bay Area hospitals to educate the public on signs of a stroke. Follow one nurse’s vision to transmit the first live interventional endoscopy procedures class from the endoscopy suite to the classroom in “Endoscopy Goes on the Road.”

The article, “Getting to the Point,” begins with a staff nurse’s desire to find a solution for patients receiving multiple venipunctures, causing pain, anxiety and treatment delays. Don’t miss the unexpected surprise following her poster presentation.

This issue also includes coverage of Nurse Week 2011 at SHC. Each year in early May we host multiple events during the week to pay tribute to our nurses. Enjoy the collage of photos from the traditional brunch, which includes an exhibitor faire and awards ceremony. New this year was the exhibit of uniforms worn by the Stanford University School of Nursing from the 1920s–1950s. Alumnae from the school hosted the exhibit.

It has been a privilege to be the editor-in-chief for the past eight years and I am proud to bring these stories to life, highlighting Stanford nurses’ compassion, dedication, and commitment to patients and colleagues every day. On the following pages, I invite you to meet the nurses who’ve shared their stories for this issue of *Stanford Nurse*.

A handwritten signature in black ink that reads "Suzanne Taylor".



Time is Brain

STROKE BUSTERS GET THE WORD OUT

CARLINE HOM, BSN, RN-BC

According to the American Stroke Association, about 795,000 Americans each year suffer a new or recurrent stroke, which means a stroke occurs every 40 seconds. For a person in the midst of a stroke, each minute that care is delayed equals an exponential decrease in outcome, thus the expression, “time is brain.” Yet with proper education, stroke can be a preventable disease.

The Santa Clara Stroke Committee meets quarterly to discuss ways to prevent stroke and improve stroke care. The committee, which consists of a medical director and stroke coordinators from different hospitals throughout the Santa Clara County, sponsors community outreach programs focused on educating the public and fellow health care professionals on the signs and symptoms of stroke and its treatments.

High blood pressure is the number one risk factor and a controllable risk factor for stroke (1). On June 6, 2011, the Santa Clara Stroke Committee, along with stroke certified hospitals in Santa Clara County, the Stroke Awareness Foundation and the Peninsula Stroke Association,

sponsored a “Stroke Busters” event at the San Jose Flea Market. JJ Baumann, MS, RN, clinical nurse specialist for the Stanford Stroke Center, gathered a team of medical professionals to help with the event. The Stroke Busters’ mission was to check blood pressures, screen people for stroke risk factors, and educate them about stroke.

Blood pressure stations were set up under a large tent. Although it was a rainy and cold day, many nurse volunteers were eagerly present to work the booth. To better serve the multi-cultural community of Santa Clara County, the volunteer nurses were separated according to languages spoken, including English, Spanish, Vietnamese, Cantonese, Mandarin, and Tagalog. Two nurses were stationed outside the booth to pass out informational flyers. As people walked up to the booth, they were encouraged to sit down and get their blood pressure checked. A surprising number of the people checked were unaware of their high blood pressure. Some of them were taking medications, while others had not seen their doctors for many months or even years. Those who had not seen their physicians were encouraged to do so, and to implement lifestyle changes such as consuming a low sodium diet, to start or continue exercising, to reduce their stress, and to quit smoking.

For more information regarding strokes and for future Stroke Buster events, go to strokeinfo.org. 



Stanford Hospital & Clinics’ Stroke Busters Volunteer Group: C. Hom, RN, A. Fong, K. Nguy, RN, L. Alexandria, RN, A. Moreci, RN, JJ Baumann, RN, CNS

Prabhakaran S, Wright CB, Yoshita M, Delapaz R, Brown T, DeCarli C, Sacco RL. Prevalence and determinants of subclinical brain infarction: the Northern Manhattan Study. *Neurology*. 2008;70(6):425.

Peering Through the Mask of Pain

UNIT-LEVEL SOLUTIONS TO PAIN MANAGEMENT

THERESA MALLICK-SEARLE, MS, RN, ACNP; MARTHA BERRIER, BSN, RN; CHERYL PASSANISI, MS, RN, CCRN; NERISSA B. DEL ROSARIO, MSN, RN, CMSRN; JOAN FORTE, MBA, BSN, RN, CNE-BC; SUZANNE TAYLOR, MSN, RN

Serious, chronic pain affects at least 116 million Americans each year, many of whom are inadequately treated by the healthcare system, according to a 2011 report by the Institute of Medicine (IOM), "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research."



A recent article in the *New England Journal of Medicine* stated: “Major impediments to relief include patients’ limited access to clinicians who are knowledgeable about acute and chronic pain — owing in part to the prevalence of outmoded or unscientific knowledge and attitudes about pain.”(1)

“Pain is an experience that affects virtually every one of our citizens,” says Philip Pizzo, MD, dean of the Stanford School of Medicine, who chaired the committee that wrote the IOM report. “For many patients, chronic pain becomes a disease itself.” In response to a question about how the needed changes will actually take place, Pizzo said it “will ultimately reside in accountability at many levels.”

Stanford Hospital & Clinics’ (SHC) nursing initiatives on pain are focused on a few of the principles underlying the IOM report:

- Effective pain management is a moral imperative, a professional responsibility, and the duty of people in the healing professions.
- Pain results from a combination of biologic, psychological, and social factors and often requires comprehensive approaches to prevention and management.
- Chronic pain has such severe effects on all aspects of a person’s life that every effort should be made to achieve both primary prevention (e.g. surgery) and secondary prevention (the transition from the acute to the chronic state) through early intervention.
- The effectiveness of pain treatments depends greatly on the strength of the clinician-patient relationship. Pain treatment is never about the clinician’s intervention alone, but about collaboration between the clinician, the patient, and the family.

Activities at the forefront of the Stanford nursing pain initiative project are: continuing education to increase nurses’ knowledge about pain and pain management; re-sensitizing nurses to pain management; empowering nurses to take a leadership role in peer-to-peer learning and direct patient education; giving nurses tools to better communicate with patients about their pain experience; and suggesting complementary treatment modalities.

Following are examples of how Stanford nurses are rising to the challenges of pain management reform.

Pain treatment is never about the clinician’s intervention alone, but about collaboration between the clinician, the patient, and the family.

PAIN CHAMPIONS 2012

Recognizing the need to educate nurses about pain management with the goal of improving pain control for hospitalized patients, Stanford Hospital & Clinics created a task force to appoint unit Pain Champions as bedside experts and partners in pain management. These Pain Champions attended the 4th Annual Innovations in Pain seminar and are the information resources

for their peers. Dr. Einar Ottestad, director of the SHC Acute Pain Service, is the physician Pain Champion of this initiative and has offered to participate in some of the didactic exercises.

All nurses will also be given the opportunity to attend seminars throughout the year addressing a number of topics including pain assessment, types of pain, barriers to pain management, and complementary and pharmacological interventions. The seminars will utilize a problem-based learning approach to foster a dynamic and interactive exchange for the participants.

B2 PAIN PROJECT

The B2 Unit chose to use the pain accordion view, which displays a graph of the patient's pain over 24 hours, medications received for pain, and vital signs. This quick reference highlights a patient's pain and response to pain medication, providing a dramatic visual cue and conveying a lot of information quickly.

With the help of an informaticist, the "Pain Scale" heading, which can be inserted into the patient list, was created. The Pain Scale shows the last recorded pain level to be displayed on the patient list, allowing the resource nurse or the float nurse to quickly look at the unit census and be alerted to the patients who are struggling with pain issues and then assist the primary nurse in treating the patient's pain.

As nurse educator for B2, Cheryl Passanisi, MS, RN, CCRN, provided education and awareness to the staff about the importance of pain management. The unit discussed common misconceptions regarding pain and how to adequately assess and treat pain. B2 then reviewed the California Board of Registered Nursing documents regarding the nurse's responsibility in pain management, the necessity to work in collaboration with the doctor, and how to involve the patient in the pain management process.

B3/C3 UNITS PAIN PROJECT

Since each individual experiences pain differently, pain control is complex and addressing uncontrolled pain can be very challenging for nurses. Nurses are frequently caught between a chronic pain patient and a doctor who will not order any more pain medication, which can lead to patients believing that nurses are not adequately controlling their pain. One of B3/C3's units goals are to provide nurses with tools and resources to help them manage such situations. Two nurse pain management champions have been identified to lead the unit through this journey, Robin Martin, RN, and Jenna Palomares, RN. The unit's plan includes crafting unit-specific scripts for acute and chronic pain patient interaction, promoting proactive management by anticipating pain relief needs, establishing pain goals through discussion about expectations and perceptions of acceptable pain level or pain relief, and offering non-pharmacologic pain relieving strategies to patients. The ultimate goal is to improve pain control outcomes by educating the nursing staff and providing them with tools and resources they need in order to provide the best possible care to this patient population.

AUGMENTATIVE PAIN THERAPIES TEAM

The Augmentative Pain Therapies Team acts on the premise that a strong partnership between patient and nurse will lead to good pain management. The team, which consists of both nurses and patients, identified each group's barriers to effective pain management. Nurses expressed frustration when patients had pain but it was too soon for medication to be administered, or when the medication was ineffective. Patients expressed a desire to be more involved in managing their own pain.

Using this feedback, the team created the Comfort Care Toolkit, which focuses on augmentative therapies when pain relief medication is not indicated or is refused by the patient. The Comfort Care Toolkit has three components:

- Comfort Carts, which hold comfort items such as aromatherapy treatment, eye masks, puzzles, and a list of available complementary therapies, such as reiki.
- A patient brochure, which is designed to increase patient engagement. Also available is a Joint Commission on Accreditation of Healthcare Organizations brochure on pain management in Spanish and English.
- A Guide for Staff on patient pain management. The guide includes dialogue using the C-I-CARE (connect, introduce, communicate, ask, respond, exit) template. The guide also encourages nurses to use each patient's dry erase board to write pain relief goals and the time at which the next medication may be administered.

By empowering patients to manage various aspects of their care, we hope to increase patient comfort and satisfaction and reduce the amount of pain medication patients require. **SN**

Pizzo, P., & Clark, N. (2012). Alleviating Suffering 101—Pain Relief in the United States. *New England Journal of Medicine*. 366 (3), 197-199.

A Patient's Prescription for Pain Management

Scott, a former patient at SHC, can tell you all about pain. Scott was flown by air ambulance to Stanford in 1985. At the time, he was given a five-year survival rate of 50 percent. After surviving multiple organ transplants, surgery and treatment for cancers, and a bout of acute pancreatitis requiring emergency gall bladder removal, he has become an expert on pain. How Scott copes with chronic pain: mindfulness. He visualizes a beautiful, peaceful location.

Scott explains, "My journey started in 1985 when I was in the Coronary Care ICU. My mother reminded me of a family trip we took to the beach a few years earlier." He visualized himself on the sandy beach with the warmth of the sun and found momentary pain relief.

Twenty-seven years later, Scott still uses this technique, is an SHC volunteer, and an active member of the Patient Advisory Council.

Scott offers this advice for nurses caring for patients with pain:

- Be an advocate for your patients.
- Remember the 4 C's: Compassion, Caring, Communication, and Center. Be compassionate and caring, and keep the patient in the communication loop and at the center of the team.
- Nursing management can be supportive with an open door policy to patients and their families.
- Empathize: What if this were your family member?
- Engage patient before surgery by explaining delays and offering anti-anxiety medication.
- Be available in an emotional crisis.

Scott's advice for making a patient feel cared-for:

- Observe the atmosphere in the patient's room. Is there a sense of calm, anxiety, or tension? Remember that patients lose much of their personal identifiers when admitted: clothing, valuables, and aspects of individual identity, which can provoke anxiety.
- Use principles of C-I-CARE as the starting point for active listening.
- Confirm your observations by asking questions.
- Anticipate situations that could result in stress and try to defuse them.
- Focus attention first on the patient, and secondly upon any family members present.



Vital Improvement

QUALITY CARE IN THE EMERGENCY DEPARTMENT

CHERYL BUCSIT, RN

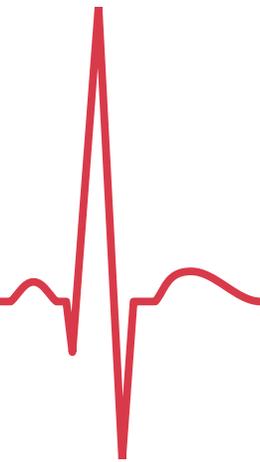
In the midst of the Emergency Department's (ED) high pace activity, quality care remains a top priority and the ED is committed to continuous improvement. In January 2011, the Emergency Department undertook a set of initiatives to improve patient care and satisfaction. Led by Maria Cheung, RN, assistant patient care manager of the ED, we launched the program, "Quality in ED." The ED Quality Council (QC) began this initiative by focusing on three factors: one core measure, one nurse sensitive indicator, and infection control.

6-HOUR WINDOW RULE

The ED has struggled to reach 100% compliance with the pneumonia core measure, *Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital*. The QC team collaborated with Donald Schreiber, MD, director of quality improvement of the ED, and Denise Greci, MS, RN, ED unit educator, to implement current best practices for patients with pneumonia. As a result, the ED now draws blood cultures within 6 hours of arrival at the ED and prior to giving antibiotics. By monitoring a patient's length of stay through EPIC, the hospital's electronic medical record, a nurse will know to advocate for a patient who has symptoms of pneumonia and who is approaching the 6-hour window. The ED improved from 83% compliance in December 2010 to 100% compliance as of November 2011, as reported in Stanford Hospital & Clinics' Quality Alert Biweekly Report.

HAND HYGIENE CAMPAIGN

One hundred percent hand hygiene compliance is a special challenge in the ED. In order to instill better habits and raise awareness, the QC created the campaign, "Quality Care Comes with Clean Hands." Debra Johnson, RN, from Infection Control provided the council with guidelines on how to audit hand hygiene compliance of nurses and doctors. As part of the campaign, the council proposed involving patients in encouraging staff to comply. Hand gel dispensers were added in areas where patients can see nurses gel their hands between patient care. A bottle of hand gel sanitizer was given to each patient in the ED. Patients are thus encouraged to ask staff if they washed their hands and can offer hand sanitizer if needed. A sticker on each gel bottle states: "*Quality Care comes with Clean Hands. The Stanford Emergency Department is partnering with you to create a clean and healthy environment. Everyone is encouraged to gel before and after patient contact. QM - Quality Matters*" The ED continues to promote this campaign as it works toward 100% compliance.



PAIN ASSESSMENT/DOCUMENTATION SELF-AUDIT

	pain documented at triage, or your first contact?	pain documented when roomed?	reassessed within one hour?	reassessed within one hour?	reassessed within one hour until pain score is "0"?*	reassessed and addressed at discharge?
Severity (S) Location (L) Orientation (O) Description (D) Aggravation (A) Relieving (R)	Y N Y N Y N Y N Y N Y N	Document ONSET of pain in triage note. S, L, O, D, A, R also need to be documented at triage, at your initial contact with pt (change of caregiver/change of shift), or with any changes in those pain factors. <i>If all factors are documented at those times, only pain level and intervention need to be documented with subsequent reassessments.</i>				
Pain level	Score:	Y N	Y N	Y N	Y N	Y N
Intervention	Y N	Y N	Y N	Y N	Y N	Y N

*If pain level is "0" reassess pain at routine vital sign intervals appropriate for patient's acuity.

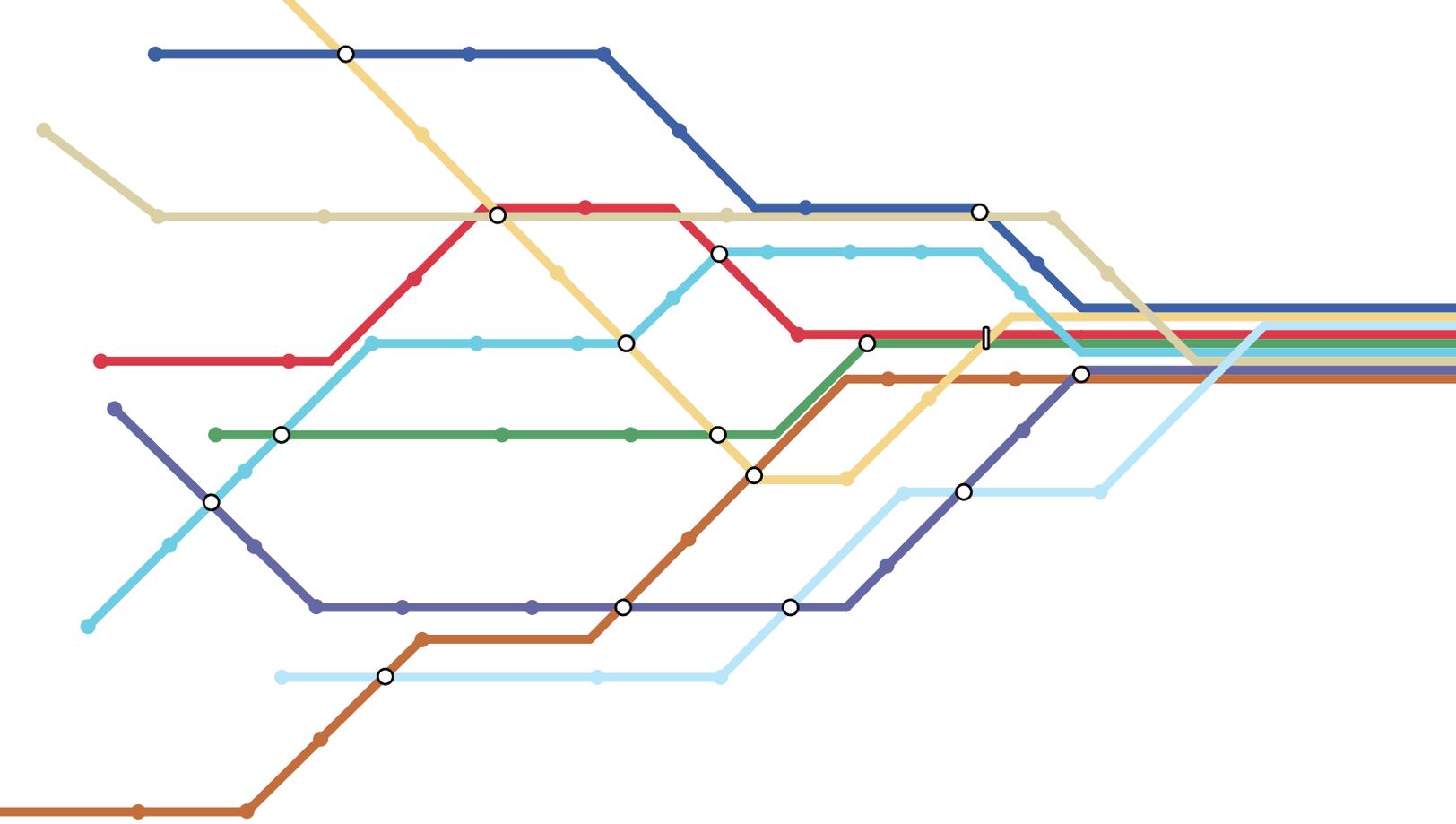
RESPECT FOR PAIN CAMPAIGN

Pain is the most common complaint reported by patients upon arrival in the ED. The "Respect for Pain" campaign was launched to increase staff understanding of assessment, treatment, and reassessment of pain in patients. An audit tool – first paper and then electronic – was developed by Pam Pilotin, MSN, RN, CPHQ, nursing quality management coordinator of patient care services. As the paper audit evolved, so did the campaign. A pain documentation flow chart was designed to clarify how to assess pain, when to initiate assessment, when to intervene, and how often to intervene based on how often pain should be reassessed from triage to discharge.

In February 2011, a Pain Assessment/Documentation Self-Audit Tool was developed to incorporate six key factors: Severity, Location, Orientation, Description, Aggravation,

and Relieving. The QC circulated this audit tool and trained staff how to document pain in EPIC. Each staff member was required to audit one chart per shift using the audit tool as a guideline. Eighty-five percent compliance was achieved. Data was gathered from the collected audit tracer tool and posted on the QC board in the ED break room, providing a "real-time" pain audit; that is, as the patient is being cared for. As a result of the campaign, a Quality Audit (QA) nurse is assigned to complete a pain audit for each patient with pain documentation in real-time, and follows up with the primary nurse to complete pain documentation in EPIC.

The aim of the ED is to provide excellent patient care as defined by our commitment to quality. While it continues to be a work in progress, these initiatives are important steps in the right direction. **SN**



Navigating the PNDP Application

ONE NURSE'S JOURNEY

LING CHEN, MSN, RN, CNOR, CN IV

Resume, degree certification, membership of professional nursing organizations, copies of continuing education certificates, references, verification of meetings and committee participation, Assessment of Clinical Expertise (ACE), and the daunting exemplars. Here is one nurse's experience with the Professional Nurse Development application process.

In the beginning, I was a bit nervous about the Professional Nurse Development Program (PNDP) points system. However, one night as I was reading *The Magic School Bus* by Joanna Cole with my child, I came across a quote from the science teacher to her students: "Take chances, make mistakes, and get messy!" These words clicked with me. The next day I printed the PNDP application, boarded the PNDP "bus", and headed down this bumpy road.

Although I encountered a few obstacles along the road, I was able to successfully maneuver my way through the PNDP process. One roadblock was my discovery

that the letter of intent is not simply a brief cover letter; rather the letter must include a detailed narrative of the applicant's nursing experience and qualifications for the clinical nurse level applied for. Another roadblock emerged when I overlooked the requirement for signatures from the committee chairs on the verification of committee participation form. Fortunately, I was able to obtain the signatures from two committee chairs on very short notice. Writing the exemplars was my biggest obstacle. My modesty made me uneasy using words such as "intuitive, excellent, expert, professional, and advocate" to describe myself. I initially wrote about several memorable clinical events, only

to realize many of them seemed frustrating and emotional rather than “glorious and shining.” I needed help.

I am grateful to my coaches, Sue Hoopes, BSN, RN, CPAN, patient care manager of the ambulatory surgery center, and Carole Kulik, MSN, RN, ACNP, director of practice and education, who coached me through the exemplar writing process. They helped me effectively describe my professional nursing expertise. One of the exemplars involved my description of having my patient unexpectedly remain “aware” during surgery. Another was about an emergent procedure in an unusual and chaotic setting. My coaches wisely pointed out the potential behind those experiences. The writing exercise provoked honest evaluation and reflection of my current practice. I continue to benchmark myself at the expert clinical nurse level. Since then, I have maintained a heightened sense of integrity, role modeling, and a professional conscience.

The bumps along the PNDP application road allowed me to grow from the experience. Although it was overwhelming at first, through perseverance and positive coaching I was able to step up and onto the Clinical Nurse (CN) ladder. The experience was more rewarding than I expected; the



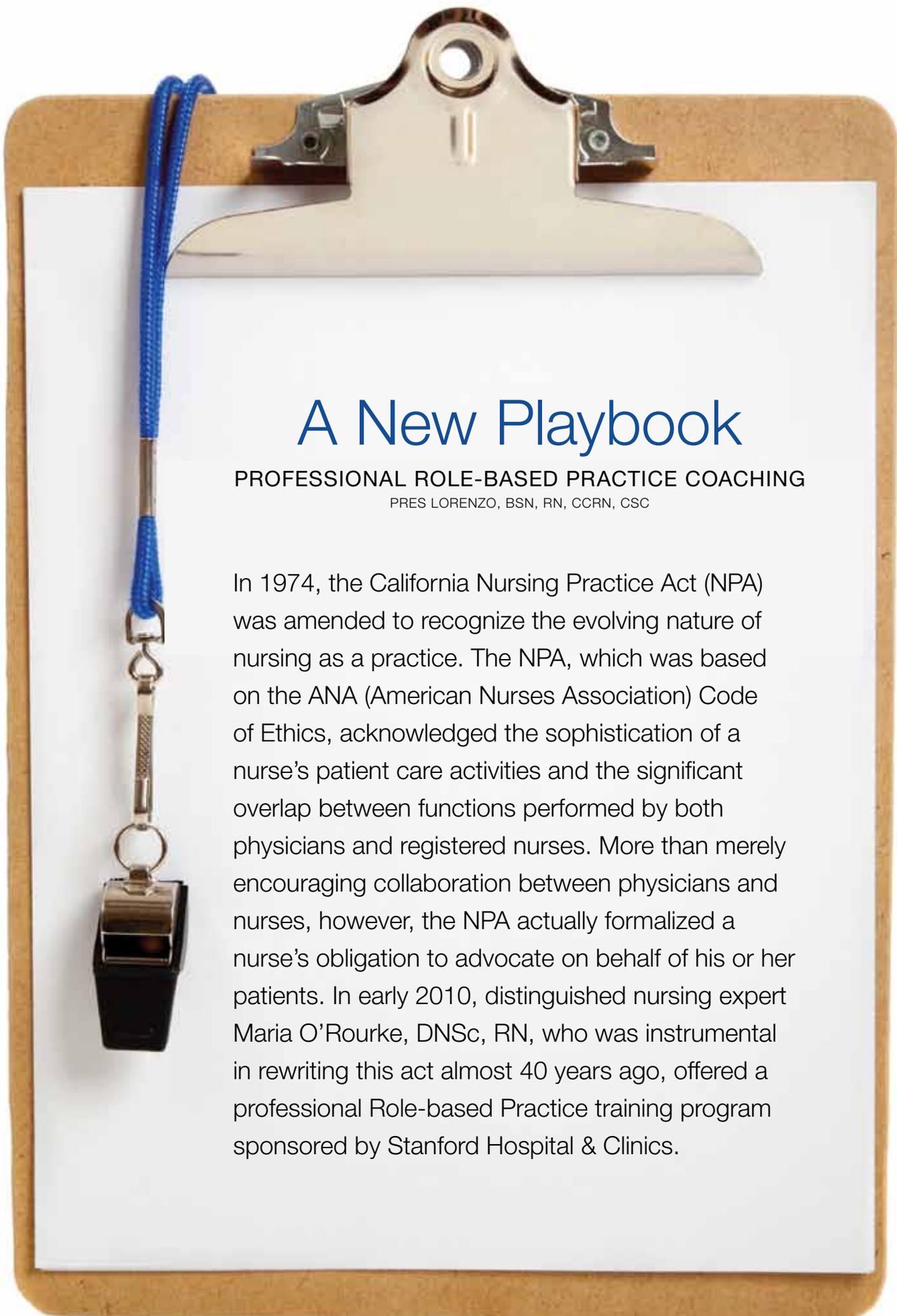
Promoted Clinical Nurses, October 2011: T. Koep, CN III, J. Montejo, CN IV, R. Avelino, CN IV, J. Lober, CN III, E. Wohlers, CN IV

LING'S TOP TIPS FOR NAVIGATING THE PNDP PROCESS

1. Be confident and spirited – it's not as hard as it seems.
2. Start early and be prepared to discuss with your manager where you fit in the ACE. This will help you to know if you should apply for CN III (proficient) or CN IV (expert).
3. Be thorough in organizing your portfolio – a binder helped me. Add your documents as you go and make a copy or electronic file of everything before you turn in the portfolio. The portfolio will assist you greatly during your panel interview.
4. Be open-minded with the topics of your exemplars, and don't hesitate to brag about your skills. Speak from your heart. Also, seek a coach who will help bring out the best in your clinical expertise.

after experience was sweet, and I am still savoring it. Besides receiving congratulations, I was approached by many nurses for advice on the PNDP application. I am enthusiastic about mentoring and supporting my colleagues through the PNDP program because I know what it is like to travel this road.

You decide your destination. Take chances, make mistakes, and get messy because you never know how successful you can become until you take the first steps of the journey. When you arrive at your destination, there are numerous unexpected rewards awaiting you. **SN**



A New Playbook

PROFESSIONAL ROLE-BASED PRACTICE COACHING

PRES LORENZO, BSN, RN, CCRN, CSC

In 1974, the California Nursing Practice Act (NPA) was amended to recognize the evolving nature of nursing as a practice. The NPA, which was based on the ANA (American Nurses Association) Code of Ethics, acknowledged the sophistication of a nurse's patient care activities and the significant overlap between functions performed by both physicians and registered nurses. More than merely encouraging collaboration between physicians and nurses, however, the NPA actually formalized a nurse's obligation to advocate on behalf of his or her patients. In early 2010, distinguished nursing expert Maria O'Rourke, DNSc, RN, who was instrumental in rewriting this act almost 40 years ago, offered a professional Role-based Practice training program sponsored by Stanford Hospital & Clinics.

A few months later, together with Dr. O'Rourke, several facilitators and a group of coaches led a series of two-day training programs for cohort groups from the critical care nursing units in the hospital. The program included the principles behind the Role-based Practice philosophy and provided an opportunity for nurses from various experience levels to engage in interactive discussions about the professional role of registered nurses and the expectations thereof. The exchange of ideas between the coaches, facilitators, and participants transformed the scope of the program itself. What began as a reminder of our professional and ethical obligations to the nursing profession evolved into a brainstorming session for how the general principles of Role-based Practice could be applied to the clinical practice of nursing.

NURSES AS PRACTITIONERS, LEADERS, SCIENTISTS, AND TRANSFERORS OF KNOWLEDGE

Participants were encouraged to shift their approach to practice by striving to be a "role-based" nurse rather than a "task based" one. To determine the stability of the patient condition, a role-based nurse must apply the Models of Professional Practice: the nurse as Practitioner, Leader, Scientist, and Transferor of Knowledge. A clinician/practitioner recognizes that for each task a nurse performs, there is a corresponding professional responsibility and accountability. In the leadership role, a nurse is a decision-maker and coordinator of care. As a scientist, a nurse ensures his or her practice is evidence-based and that institution approved protocols are utilized. Most importantly, a nurse's ongoing role as a transferor of knowledge is invoked when discussing the plan of care with patients, their loved ones, and with other members of the healthcare team.

Robin Cleary, BSN, RN, CCRN, remarked that the program gave her a better appreciation of how crucial the handoff report is for sharing vital pieces of information and the real impact it can have on one's shift and, in turn, on patient care outcome. Christopher Hernando, MSN, RN, who is actively involved in the hospital's nursing quality

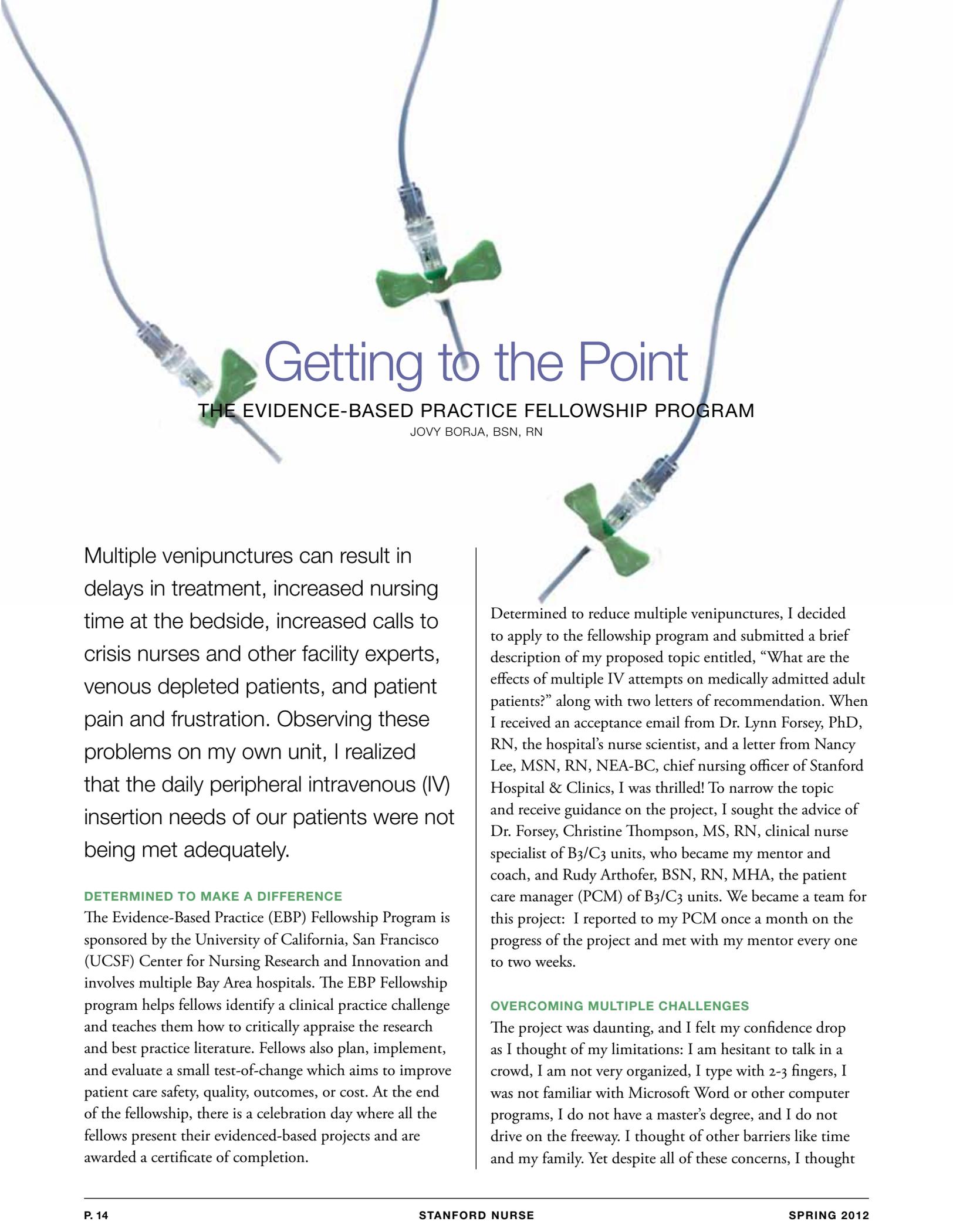
program, appreciated being reminded of the significance of evidence-based practice by keeping abreast of current literature applicable to the clinical setting where he practices, embracing research efforts and innovation, and paying attention to quality improvement and patient safety. As a result of participating in the program, he realized how vital this area of nursing science is, and he hopes to continue to improve upon his skills and incorporate new methodology into his professional nursing practice.

LEADING TO LASTING CHANGE

These colleagues were asked whether the course inspired them to make changes in their nursing practice. For Robin the course served as "a comprehensive reminder of who we are professionally, or at least who we want to be." She felt particularly empowered by the section of the ANA Code of Ethics that reminds nurses of their duty to "participate in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare, consistent with the values of the profession through individual and collective action."¹ As a result, she felt that she should strive to present herself in the hospital as someone who was autonomous in her practice. This notion seemed to excite her to the point of even wanting to become a resource to the national and international nursing community. As for Christopher, the Professional Role-based Practice course helped him better understand and clearly articulate his role as a healthcare professional within the interdisciplinary team while taking care of the patient, ensuring patient safety, and improving patient outcomes. He gained a greater grasp of the direction in which the nursing profession is evolving and the self-empowerment the profession imparts.

The nurses represented different levels of experience and hospital seniority; therefore they had various views of the program. However, most participants came out of the program motivated to take ownership of their profession and become stronger clinicians. In general, the participants felt privileged to be registered nurses. **SN**

¹ *American Nurses Association Code of Ethics for Nurses with Interpretive Statements*, (July 2001): Provision 6.



Getting to the Point

THE EVIDENCE-BASED PRACTICE FELLOWSHIP PROGRAM

JOVY BORJA, BSN, RN

Multiple venipunctures can result in delays in treatment, increased nursing time at the bedside, increased calls to crisis nurses and other facility experts, venous depleted patients, and patient pain and frustration. Observing these problems on my own unit, I realized that the daily peripheral intravenous (IV) insertion needs of our patients were not being met adequately.

DETERMINED TO MAKE A DIFFERENCE

The Evidence-Based Practice (EBP) Fellowship Program is sponsored by the University of California, San Francisco (UCSF) Center for Nursing Research and Innovation and involves multiple Bay Area hospitals. The EBP Fellowship program helps fellows identify a clinical practice challenge and teaches them how to critically appraise the research and best practice literature. Fellows also plan, implement, and evaluate a small test-of-change which aims to improve patient care safety, quality, outcomes, or cost. At the end of the fellowship, there is a celebration day where all the fellows present their evidenced-based projects and are awarded a certificate of completion.

Determined to reduce multiple venipunctures, I decided to apply to the fellowship program and submitted a brief description of my proposed topic entitled, “What are the effects of multiple IV attempts on medically admitted adult patients?” along with two letters of recommendation. When I received an acceptance email from Dr. Lynn Forsey, PhD, RN, the hospital’s nurse scientist, and a letter from Nancy Lee, MSN, RN, NEA-BC, chief nursing officer of Stanford Hospital & Clinics, I was thrilled! To narrow the topic and receive guidance on the project, I sought the advice of Dr. Forsey, Christine Thompson, MS, RN, clinical nurse specialist of B3/C3 units, who became my mentor and coach, and Rudy Arthofer, BSN, RN, MHA, the patient care manager (PCM) of B3/C3 units. We became a team for this project: I reported to my PCM once a month on the progress of the project and met with my mentor every one to two weeks.

OVERCOMING MULTIPLE CHALLENGES

The project was daunting, and I felt my confidence drop as I thought of my limitations: I am hesitant to talk in a crowd, I am not very organized, I type with 2-3 fingers, I was not familiar with Microsoft Word or other computer programs, I do not have a master’s degree, and I do not drive on the freeway. I thought of other barriers like time and my family. Yet despite all of these concerns, I thought

of the patients and my colleagues, and how they would benefit from this project. My passion to make a change was my driving force.

Workshops were held to assist the fellows through their projects, during which we listened and learned from vibrant and inspirational speakers such as the past EBP Program director, Nancy Donaldson, PhD, RN, director of the Center for Nursing Research and Innovation, and Annette Nasr, nurse scientist at Lucile Packard Children's Hospital. The workshops also acted as a support group, during which fellows discussed project breakthroughs and barriers. As I worked with the other fellows, my limitations, which seemed huge at first, became insignificant. I established camaraderie with nurses from other units and other hospitals. I was often hesitant to speak in a crowd, however, with my co-fellows' encouragement, I overcame my public speaking reservations. Each of us had a chance to rehearse among ourselves and refine our presentation styles before the celebration day. I also rehearsed my presentation with my coach. Because my youngest son started covering his ears after hearing my presentation repeatedly, I rehearsed in the garden in front of my plants.

The hard work and preparation paid off with a successful celebration day for all Bay Area fellows. The event was well attended by hospital directors, managers, coaches, site coordinators, colleagues, friends, and family members. My presentation was entitled "Vascular Access Device Therapeutic Road Map (Algorithm) - A Guide to Decide." My clinical question or PICO (Population, Intervention, Comparison, Outcome) question was, "Will the use of a systematic assessment and planning algorithm decrease multiple venipunctures?"

After the celebration day, the Stanford fellows were invited to be members of the hospital's Research Council and were asked to present at Nursing Grand Rounds. They were also asked to speak at different shared governance councils and committees, write an executive summary, create an abstract, and present a poster for the Research Council Open House and for Research Day.

VASCULAR ACCESS DEVICE THERAPEUTIC ROADMAP: "A GUIDE TO DECIDE"

EVIDENCED-BASED PROJECT BY
JOVY BORJA, BSN, RN

Data were collected from a retrospective electronic chart review of patients' days of stay and of nursing documentation on the type of IV access, the number of peripheral IVs since admission and the number of attempts per peripheral IV. A vascular access algorithm based on the Infusion Nursing Society's (INS) best practices was created and introduced to the unit. Additional in-services were provided and feedback surveys were conducted to the nursing staff focusing on the application of the algorithm and documentation in the sign-out notes. Observational validation data was also collected on the number of patients with peripheral IVs, those with new peripheral IVs and the number of attempts per peripheral IV insertion.

Being an EBP fellow is being a catalyst, a change agent. I learned a valuable lesson: that no matter one's limitations, if you let your passion drive you and do it for the right reasons, it may lead to doors of endless possibilities. I developed an algorithm to decrease multiple venipunctures, which is being reviewed for the hospital's Policy and Procedure Manual. I was awarded the Most Valuable Poster award in clinical research at the 2010 Infusion Nurses Society's Annual Convention in Kentucky, and I received recognition from Stanford Hospital & Clinics for an innovation project for the Magnet surveyors' report.

I invite each nurse to take the challenge, to become an EBP fellow, and to carry the torch of Stanford Hospital & Clinics' quest for clinical excellence as we care, discover, and educate. **SN**

"It is not the man of great native talent who wins but he who pushes his talent, however small, to its utmost capacity." —ANONYMOUS

Flying to New Heights

STANFORD LIFE FLIGHT: A COMMEMORATIVE PERSPECTIVE

GERALYN MARTINEZ, MS, RN

In May 1984, Stanford Life Flight airlifted a 70-year-old woman critically injured in a motor vehicle crash in Santa Cruz to Stanford Hospital & Clinics. That pioneering flight launched an air medical transport service that would change the healthcare landscape of Northern California.

Initially, Stanford's flight program was staffed with a pilot/physician/nurse team flying in an Alouette III helicopter. Today, a Stanford flight crew, consisting of a pilot and two flight nurses in an EC 145 aircraft, completes about 700 transports each year. Nearly 70 percent of these transports are inter-facility transfers, while 30 percent are emergency or "scene" calls.

The history of air medical transport in recent decades parallels major developments in emergency care and technology in both flight medicine and aviation. This evolution of emergency medical care and aviation technology has led to decreased morbidity and mortality in critically ill and injured patients, and greater safety for the flight team. Life Flight's objective is to "bring Stanford to the patient" by providing tertiary care resources and expertise for the patient and staff at community hospitals throughout Northern California. Following are two case studies that illustrate the range of medical missions Stanford Life Flight undertakes.

CASE STUDY: TRAUMA

It began as a routine freeway traffic collision call for the California Highway Patrol officer. As he exited his vehicle, a big rig truck suddenly rolled down the hill, pinning him against his patrol car. The trailer then dragged and threw him into the slow lane where he lay unconscious. 911 was called and the fire department arrived to stabilize the officer, who was then flown to the trauma center at Stanford Hospital & Clinics where he was treated for head, chest, and shoulder injuries. He has fully recovered and has returned to active duty.

Recalling the event, the veteran officer still marvels at the speediness of the eleven-minute flight and the expertise and professionalism of the ground and air crews. From the scene to the Level I trauma center, these crews met the objective of patient treatment within the "Golden Hour"—the sixty-minute window between a traumatic incident and the delivery of definitive care at a trauma center.

Currently, there are approximately 300 helicopter Emergency Medical System (EMS) programs with an estimated 900 medical helicopters in operation. Advances such as wireless technology and integrated communication systems have brought substantial improvements in out-of-hospital care.

Trauma care has undergone significant changes since the inception of Stanford Life Flight. Trends in trauma care that have improved patient outcomes are: advances in pre-hospital care, the advent of critical care transport, improved neurological care services, and increased safety awareness. The increasing use of evidence-based medicine has been the major agent of change in medical practice over the past 25 years.¹ Dr. Marshal Isaacs, Medical Director of the Dallas Fire-Rescue Department, credits the integration of the best available research evidence with clinical expertise and patient presentations for much of the improved patient outcomes. He says, both flight programs and emergency departments believe care processes utilized in other areas of medicine must also be good for patients in the back of a helicopter.

CASE STUDY: AORTIC DISSECTION

A 46-year old male was training for his next triathlon when he experienced sudden chest pain. Upon arrival at the Alta Bates Emergency Department in Berkeley, he was diagnosed with a Type A aortic dissection requiring immediate cardiovascular surgery. The transfer to Stanford Hospital involved coordinated teamwork. The patient was transported from the hospital to the helicopter waiting at the landing zone that had been quickly established by police and fire personnel. He recalls feeling the sun on his face and hearing the sound of the helicopter rotor. Most memorable to him, however, was the voice of his flight nurse during the 17-minute flight. “Stay with me, we’re getting close...” she told him. Ten hours later he emerged from surgery with a new mechanical aortic heart valve and Dacron tube graft in his aorta. Now, he says, he is “appreciative every day for the resources of Stanford Hospital and the collaboration between the public safety agencies and Life Flight.”

Among the most time-critical surgical emergencies are ruptured aneurysms and aortic dissections. Dr. Robert C. Robbins, Chairman of the Department of Cardiothoracic Surgery at Stanford, says untreated acute aortic dissections are associated with a mortality rate of one percent per hour.² The key to survival is having trained personnel expeditiously transport the patient to an institution that has the capability to operate on such patients.

The Stanford Life Flight team works in collaboration with many medical and surgical services throughout the hospital in order to provide the highest quality medical care. Initiating protocols that have been developed with Stanford’s specialized departments ensures that the therapy delivered by the flight team is a direct extension of the care provided at the medical center.

One of the challenges in EMS aviation is the size, weight, and durability of medical devices, especially monitors and life support equipment. Today, critically ill patients can be safely transported using miniaturized, lighter-weight, more durable and efficient transport medical equipment. A small, portable intra-aortic balloon pump, a less cumbersome ventricular assist device, and the ever-expanding skill set of the flight crew make transport of an unstable patient more feasible, resulting in better patient outcomes.

BENEFITTING FROM ADVANCES IN AVIATION

Among the many changes over the past 25 years:

- Transition from single engine to twin engine aircraft
- Use of Instrument Flight Rules in addition to Visual Flight Rules
- Utilization of Global Positioning Systems for scene location
- Implementation of Crew Resource Management (CRM) training for air medical crews
- Transition to Nomex flight suits and full flight helmets to increase crew safety

“At Life Flight, the culture of safety comes first. The flight program offers the best equipment, staff, and training with no pressure to fly in less-than-ideal conditions,” states Doug Evans, Lead Pilot. The emphasis on CRM also allows each member of the flight crew to be empowered to veto a flight if they deem it necessary for safety reasons.

“Stanford Life Flight’s mission has always been to fly as safely, efficiently, and comfortably as possible to help ensure the best possible outcome for the patient,” said Captain Everett Croes, III (retired), one of the two original Stanford Life Flight pilots. “The biggest challenge now for the industry is safety and to prevent accidents and crashes from happening. Life Flight has always met or exceeded the industry standard for EMS helicopter operations.”

Stanford Life Flight’s experience in EMS aviation over the last quarter century has paralleled the industry’s evolution. By embracing the concepts of evidence-based medicine, appropriate use of new technology, advanced crew training, and improved aircraft safety and equipment, its dedicated team of professionals continues to meet the needs of patients while adapting to changes in health care delivery. **SN**

¹ Melnyk, B, Fineout-Overholt, E. *Evidence-based practice in nursing & healthcare*. 1st ed. Philadelphia: Lippincott, Williams and Wilkins; 2005.

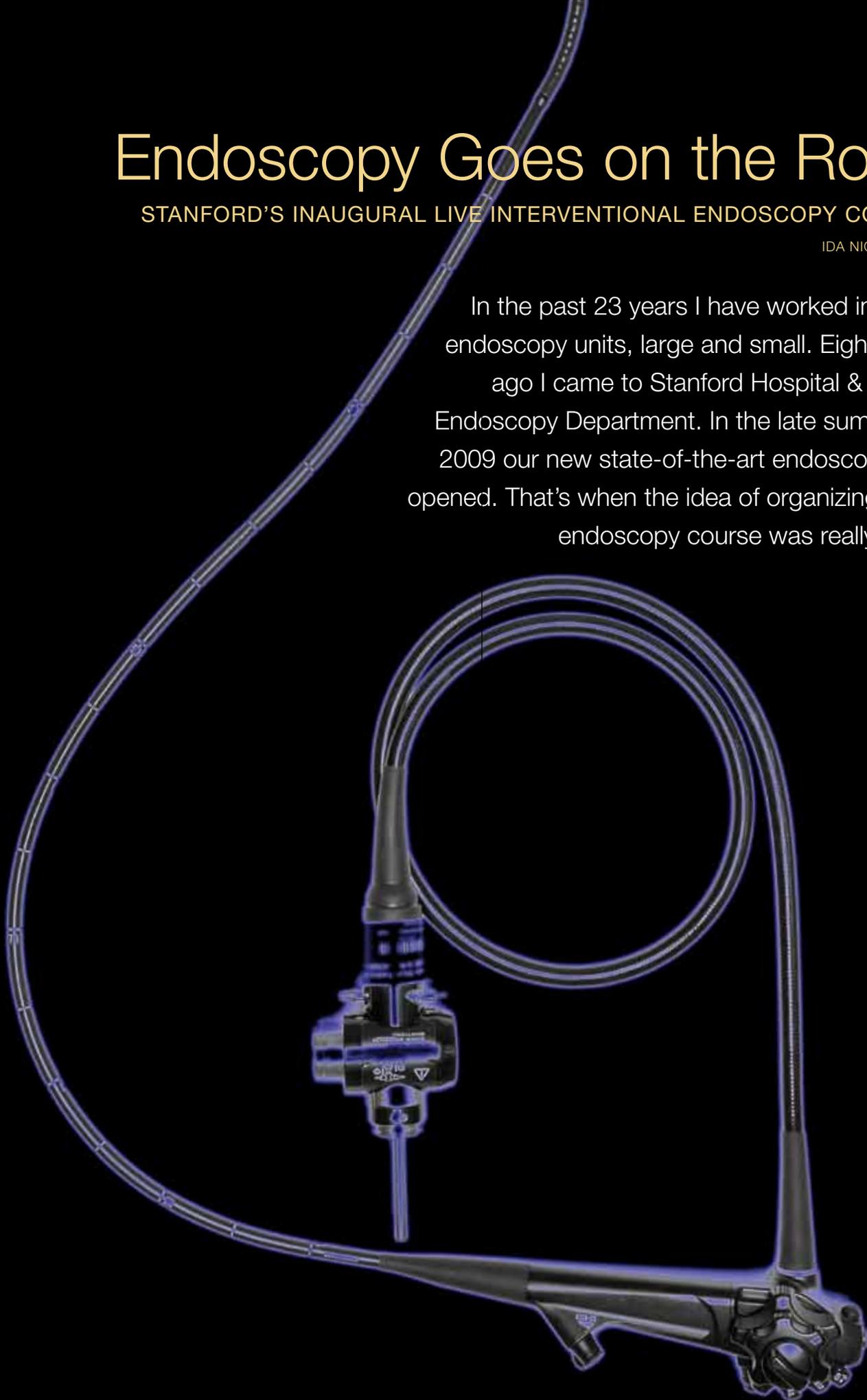
² Tsai, TT, Nienaber, CA, Eagle, KA. Acute aortic syndromes. *Circulation* 2005; 112:3802-13.

Endoscopy Goes on the Road

STANFORD'S INAUGURAL LIVE INTERVENTIONAL ENDOSCOPY COURSE

IDA NICHOLS, RN

In the past 23 years I have worked in many endoscopy units, large and small. Eight years ago I came to Stanford Hospital & Clinics Endoscopy Department. In the late summer of 2009 our new state-of-the-art endoscopy unit opened. That's when the idea of organizing a live endoscopy course was really born.





Hands-on sessions during the live endoscopy course.

For several years I traveled to other hospitals to attend live endoscopy courses and conferences. Last January I approached Subhas Banerjee, MD, the medical director of endoscopy at Stanford Hospital & Clinics, about hosting a conference at Stanford. Dr. Banerjee was very enthusiastic and we began to plan a conference for fall 2011 with help from the Center for Education and Professional Development.

We decided the conference would contain three sections, each designed to enhance the endoscopy nurses' skills and understanding of complex cases. The first session consisted of lectures summarizing recent advances in interventional endoscopy presented by Stanford medical staff. Among the well-received lecture topics were "Endoscopic Mucosal Resection" by Shai Friedland, MD, "Endoscopic Retrograde Cholangiopancreatography (ERCP) Overview" by Subhas Banerjee, MD, and "Endoscopic Ultrasound (EUS) Overview" by Ann Chen, MD, and Walter Park, MD.

The second portion involved a "hands-on" session, providing an opportunity for nurses to practice and gain familiarity with endoscopic devices. Stations included EUS, control of bleeding/hemostasis, foreign body management, and ERCP. Members of the endoscopy nursing team, as well as representatives from various companies who supply endoscopic equipment, were on hand to assist and teach attendees in the use of instruments and techniques required for complex endoscopy procedures.

Finally, the third session featured the televised transmission of live cases scheduled in our unit. ERCP with SEMS

placement, ablation of Barrett's esophagus, and EUS with fine needle aspiration were among the procedures performed. The program planners heartily thanked and appreciated the patients for their willingness to participate in the conference. Their consent enabled viewing of complex and therapeutic treatment modalities to practicing nurses, thereby enriching their expertise and treatment of their own patient populations.

The program received positive feedback from the nurses who attended the course. Remarks from nurse attendees included, "The course is very informative and hands-on experience is very helpful," "Loved the doctors' presentations and live interaction!" and "I will apply procedural information you provided in my daily practice."

An unexpected benefit of developing and hosting the conference was the positive effect it had on our Stanford endoscopy nursing team. The team researched assigned topics in preparation for teaching the attendees. As a result, each staff member gained confidence in his or her skill level, as well as a new level of expertise in therapeutic and interventional endoscopy. The staff created teaching and informational documents as teaching aids for the course that will be used for in-services and orientation of new staff in the future.

As a result of this program's success, Stanford will offer an annual live endoscopy course to showcase the latest in advancements in the field. The next conference is scheduled for fall 2012. [SN](#)

The Other Side of Paradise

A MEDICAL MISSION TO FIJI

RANJANNA PRATAP, MSN, RN

Nurses establish trusting relationships with strangers on a daily basis. I advocate for patients I have just met. I spend each shift building trust with my patients, implementing their care, and helping them navigate through the hospital.

Yet there are many times when nurses cannot establish a nurturing relationship with their own loved ones. After immigrating to the United States, my family returned to Fiji only twice to visit. Time flew by and in November 2008, my paternal grandmother, or *Aji*, died in Fiji. When it came to caring and advocating for my *Aji*, I felt that I had failed.

GOING HOME AGAIN

Perhaps it was this experience that led me to the nonprofit group Fiji Aid International (FAI). FAI was founded in 2000 to serve the impoverished people of Fiji. The mission of the organization is to provide free medical care to people in need, regardless of race, religion, or color. With encouragement from a close cousin, I contacted the founder of FAI, Damyenti Chandra, and was invited to join the 2011 Medical Mission. I was assigned to volunteer at the FAI clinic in Nandovi, a rural area in the outskirts of Nadi.

People based in Fiji staff the clinic year-round. Each July and August, foreign medical teams consisting of physicians, nurses, and midwives visit to volunteer their services to the clinic.

As I stepped off the plane into Nadi, a major city in Fiji, a flood of childhood memories came rushing back. I quickly wiped away my tears and walked into the county I had not seen for 16 years. The next morning was my first day of work. Outside of a controlled hospital environment, I felt like a deer in headlights, at a total loss as to what to do. I also found myself struggling to speak correct Hindi, instead speaking “hinglish,” a jumbled combination of Hindi and English that I was accustomed to speaking with family. A large percentage of patients I encountered spoke little or no English, therefore it was important for me to speak and translate correctly for the non-Hindi speaking medical team members.

After my first day, I felt more comfortable at the clinic. I immersed myself in doing countless finger sticks and blood pressures as well as providing education on prevention of diabetes and hypertension. The clinic saw patients of all ethnic backgrounds, both indigenous Fijian and Indo-Fijian. Often times, I ended up talking with patients as they waited to be seen by the clinic doctor, which gave me the opportunity to learn more about Fiji and its people, including some of the underlying social issues facing Fijian women.

BONDS BETWEEN WOMEN

It saddened me to learn that Fijian women must overcome many barriers to receive care that is easily accessible in the United States. Transportation is one of these barriers—many women come from hundreds of miles away, but commuting by taxi or bus is still too costly for many. To better serve the needs of the women, the clinic arranged with a local tour company to provide shuttle services. The clinic provided free pap smears to the underprivileged and many women took advantage of this. As I triaged patients, one of the women whispered to me that she looks forward to the summer clinic because she “gets good care” from us. She also said that coming to the clinic was a bonding experience for many of the women.

Fiji has one of the highest incidences of breast and cervical cancer in the South Pacific. Two large contributors are lack of education and awareness about women’s cancers, as well as limited access to care. Many women die unnecessarily due to undiagnosed or late-diagnosed cancers. I was taken aback to learn that women often do not disclose to their husbands that they are coming to our clinic, as this is frowned upon. Fiji also has a growing prevalence of HIV and AIDS, so the medical team took every possible opportunity to talk to women about the importance of safe sexual practices and the right to say, “no.”

Aside from volunteering at the clinic, I also had had the opportunity to provide care at a nonprofit settlement and an outreach center based out of a school. Volunteering at all of these places opened my eyes to the challenges of life in

Fiji. I saw how the Fijians embraced our medical team with open arms and with the deepest of gratitude. Often times I sat on the front porch of the clinic and watched buses full of tourists roar past the clinic. I wondered if they knew that behind the stunning beaches there were people who lived such impoverished lives.

CARING FOR SOMEONE ELSE’S GRANDMOTHER

One day at the clinic, a distraught young man inquired if his mother, who had fallen after becoming grief-stricken over the death of her husband, could be seen. The son had heard of the clinic and came to ask for assistance on her behalf. His mother lived 45 minutes away in a town called Savu Savu, and was on her way to the clinic by bus. My heart sank when I saw the woman. She appeared very fragile and emaciated, and instantly my *Aji* came into my mind. She reached out and I took her hand and guided her to the examination table. She was extremely anxious and in pain. All of a sudden my “hinglish” started flowing as I explained to her the plan of care. She held tightly to my hand and listened intently to every word. The team physicians, Drs. Holmer and Goodhall examined her as I continued to comfort her. It was determined that she required more complex care than our clinic could provide and needed to be hospitalized. Arrangements were made for her to be admitted to the closest hospital. As she was leaving, she looked at me and thanked me. I blinked away tears and wondered who had comforted my grandmother when she was ailing. I felt a hand on my shoulder and I looked up and saw Chandra standing next to me. She patted my shoulder and said, “You did good, kiddo.” **SN**



Ranjanna Pratap, MSN, RN, pictured here during an outreach program at Koroipita settlement

NURSEWEEK 2011

Celebrating our Nurses and How Much They Care





NURSES TRUSTED to CARE



Lighting the Way

LINDA J. BRACKEN, EdM, MPA, RN, CEN, BC-NE

In September 2011, the Marc and Laura Andreessen Emergency Department at Stanford Hospital & Clinics was awarded the Emergency Nurses' Association Lantern Award.

Garrett Chan, PhD, APRN, FAEN, FPCN, FAAN, lead advanced practice nurse and associate clinical director of the emergency department/clinical decision area, Patrice Callagy, MPA, MSN, RN, CEN, assistant patient care manager, and Linda J. Bracken, EdM, MPA, RN, CEN, BC-NE, patient care manager, traveled to Tampa, Florida to represent the Emergency Department (ED) and accept the award.

The Lantern Award, as described by the Emergency Nurses' Association, "is a recognition award granted to emergency departments that exemplify exceptional and innovative performance as it relates to leadership in practice, education, advocacy, and research." An emergency department honored with the Lantern Award must demonstrate a commitment to quality, a healthy work environment, and accomplishments in incorporating evidence-based practice and innovation into emergency care.

WINNING FACTORS

At Stanford, the use of shared governance and the formation of six councils have played a large role in the success of the ED. The ED Call Back Nurse project was highlighted as a successful and innovative program. The call back nurses speak with many patients each day, helping them connect with clinic appointments, answering questions related to recent ED visits, and increasing patient satisfaction with a personal touch.



Patient satisfaction scores were discussed as an example of opportunities for improvement in customer service. The ED instituted a comprehensive approach to dealing with patient satisfaction, focusing on improving communication between staff and patients, decreasing throughput times, facilitating access to the ED, and enhancing the physical plant.

Other topics included in the application process were mitigation of violence in the ED workplace, security and the metal detector, Gallup scores, and systems and processes for throughput. Communication using C-I-Care principles was a key element discussed as a standard for the

ED staff with each other and with patients. Exemplars presented in the application included why a traveling nurse chose to apply for a permanent position in the ED, how safe patient care is ensured, communication handoff processes, fall prevention, and emergency preparedness.

To demonstrate how the ED focuses on promoting education, the ED explained how the staff is trained through education programs and competency validation. The methods for orienting new staff and ongoing nursing staff development were also described; for example, each nurse is required to attain and continue certification for Basic Life Support, Pediatric Advanced Life Support, Advanced Cardiac Life Support, Trauma Nursing Core Courses, and Stroke Education.

All of the staff in the ED are thankful for the generous donations from Marc and Laura Andreessen, who are helping us achieve Stanford Hospital & Clinics' mission of healing humanity through science and compassion, one patient at a time. **SN**

In Recognition

ARTICLES AND PUBLICATIONS

Kelly Cook: "Ventricular Tachycardia Associated with Cardiomyopathy," *Cardiac Arrhythmia Management, A Practical Guide for Nurses and Allied Professionals*. Wiley-Blackwell, 2011.

Joan Forte: How to Build a Successful Business Case for a Falls-Reduction Program. *American Nurse Today*, March 2011.

Amina Huda: High Rate of Unemployment After Liver Transplantation: Analysis of the United Network for Organ Sharing Database, *Liver Transplantation*, December 2011.

Anne Klevay: Another Perspective on Finger Replantation Surgery: Nursing Support for the Psychological Levels of Recovery, *Journal of Trauma Nursing*, January/March 2011.

Peter Miskin: Why do Nurses Fail to Recognize Delirium in Hospitalized Elderly Patients? *Nurse Together*, September 2010.

Marika O'baire-Kark: Another Perspective on Finger Replantation Surgery: Nursing Support for the Psychological Levels of Recovery. *Journal of Trauma Nursing*, January/March 2011.

Linda Ottoboni: *Cardiac Arrhythmia Management, A Practical Guide for Nurses and Allied Professionals*. Wiley-Blackwell, 2011.

Christine Schurman: Phase II trial of anastrozole plus goserelin in the treatment of hormone receptor-positive, metastatic carcinoma of the breast in premenopausal women. *Journal of Clinical Oncology*, September 2010.

Julie Shinn: High prevalence of corrected QT interval prolongation in acutely ill patients is associated with mortality: results of the QT in Practice (QTIP) Study. *Critical Care Medicine*, February 2012.

Angela Tsiperfal: *Cardiac Arrhythmia Management, A Practical Guide for Nurses and Allied Professionals*. Wiley-Blackwell, 2011.

APPOINTMENTS/AWARDS

Sandra Correia, President Elect, Air & Surface Transport Nurses Association, October 2010.

CONFERENCE PRESENTATIONS

Judith Alderman: "A Staff-Led Model for Reducing Inpatient Medication Administration Errors," *University Health System Consortium 2010 Quality & Safety Fall Forum*, San Diego, CA, September 2010.

JJ Baumann: "A Comparison of Serum Potassium Levels and Potassium Replacement RN Requirements in Cardiac Arrest Patients With and Without Therapeutic Hypothermia," *Neurocritical Care Society 8th Annual Meeting*, San Francisco, CA, September 2010.

Carol Bell: "Developing an Educational Initiative to Improve Response to Hypersensitivity and Acute Infusion Reaction Emergencies in an Outpatient Oncology Infusion Center," *Oncology Nursing Society Annual Congress*, Boston, MA, April 2011.

Jovy Borja: "VAD Therapeutic Road Map (Algorithm)," *Research Days 2010*, South San Francisco, CA, October 2010.

Kayla Butler: "Improving Patient Outcomes with Optimal Nutrition," *Research Days 2010*, South San Francisco, CA, October 2010.

Cecilia Cadet: "Management Design Increases Staff Satisfaction," *Academy of Medical-Surgical Nurses Annual Convention*, Las Vegas, NV, October 2010.

Lynn Forsey: "Principles of Good Measurement," *Research Days 2010*, South San Francisco, CA, October 2010.

Joan Forte: "Safe Patient Handling: Caring for the Caregiver," *National Teaching Institute & Critical Care Exposition*, American Association of Critical Care Nurses, Chicago, IL, April 2011.

Susan Hock-Hanson: "Making the Safe Patient Handling Program Succeed: Realities and Strategies," *West Coast Safe Patient Handling Conference*, San Diego, CA, September 2010.

Amina Huda: "Employment After Liver Transplantation," *American Association for the Study of Liver Disease*, Boston, MA, October 2010.

Jaime Hellman Jamieson: "Post-operative Education for Laryngectomy Patients," *Academy of Medical-Surgical Nursing*, Las Vegas, NV, October 2010.

Bree Jensen: "Standardizing Neurological Assessment in the Adult," *International Stroke Conference*, Los Angeles, CA, February 2011.

Anne Klevay: "Lateral Violence Among Nurses: Interrupting Bullying Behavior," *Psychiatric Nursing Conference*, San Francisco, CA, May 2011.

Carole Kulik-Lewis: "Making the Safe Patient Handling Program Succeed: Realities and Strategies," *West Coast Safe Patient Handling Conference*, San Diego, CA, September 2010.

Nancy Lee: "Safe Patient Handling, CNO Implications," *University Hospital Consortium 2010 Quality & Safety Fall Forum*, San Diego, CA, September 2010.

Sheryl Michelson: "Horizontal Violence: It Could Happen to You," *California Perfusion Society Fall Symposium*, South Lake Tahoe, NV, September 2010.

Ann Mitchell Ellsworth: "A Structured Management Design," *Academy of Medical-Surgical Nurses Annual Convention*, Las Vegas, NV, October 2010.

Nadine Nakazawa: "Challenges in the Accurate Identification of the Caval-Atrial Junction," *Association for Vascular Access Annual Scientific Meeting*, National Harbor, Maryland, September 2010.

Nadine Nakazawa: "Pathogenesis and Prevention of Central Line Associated Bloodstream Infections," *Asia Oncology Nursing Society Conference*, Taipei, Taiwan, October 2010.

Niall O'Donnell: "Haiti Response," *Totally Trauma*, Lake Tahoe, NV, October 2010.

Judy Passaglia: "CNS in Palliative Care," *Advanced Practice: The CNS as a Consultant*, California Association of Clinical Nurse Specialists, Palo Alto, CA, April 2010.

Ranjanna Pratap: "Know Before You Hold," *Research Days 2010*, South San Francisco, CA, October 2010.

Rich Quitevis: "Decreasing Length of Mechanical Ventilation in Cardiothoracic Surgery Patients: A Nursing Driven Practice Change," *ANCC National Magnet Conference*, Phoenix, AZ, October 2010.

Julie Racioppi: "Haiti Response," *Totally Trauma*, Lake Tahoe, NV, October 2010.

Julie Shinn: "Decreasing Length of Mechanical Ventilation in Cardiothoracic Surgery Patients: A Nursing Driven Practice Change," *2010 ANCC National Magnet Conference*, Phoenix, AZ, October 2010.

Hirut Truneh: "A Staff-Led Model for Reducing Inpatient Medication Administration Errors," *University Hospital Consortium 2010 Quality & Safety Fall Forum*, San Diego, CA, September 2010.

Kathleen Turner-Hubbard: "Managing Delirium in Hospitalized Patients," *Gerontological Advanced Practiced National Association National Conference*, Albuquerque, NM, September 2010.

Laura Zitella: "Managing Treatment Side Effects," *The North American Lymphoma Education Forum*, San Francisco, CA, September 2010.



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