On the Path:
Evidence Based Care at the Bedside
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From the Chief Nursing Officer
Jessica Jordan RN, BSN, MS, CIC
Chief Nursing Officer

Our third edition of the ValleyCare Nurse Magazine focuses on Nursing Evidence-Based Practice, Research and Innovation. While you read our Spring edition you will meet the members of our Nursing Research Council. You will also have the opportunity to read articles written by direct care nurses, which are the result of many opportunities offered through ValleyCare. In 2006, Nursing sponsored the first Nursing Research Contest and this was kicked off with an educational session on Evidence-Based Practice by Jessica Jordan. The following year Dr. Faye Bower, from Holy Names University, presented on Nursing Research and in 2008 we joined the UCSF Center for Nursing Research and Innovation which provided a three-part Clinical Research Series. These courses enabled our direct care nurses to further hone their skills, research the “burning questions” of their practice in their areas of specialty, design projects and document their outcomes.

There could be no better time to make this the subject of the ValleyCare Nurse Magazine since Nurse’s Day, which is celebrated around the world, commemorates the birth of Florence Nightingale. Ms. Nightingale not only was the “Lady with the Lamp” who gave care and hope to the soldiers she served, she was a pioneer in the visual presentation of information and the use of statistical graphics. She used the Nightingale Rose Diagram to illustrate seasonal sources of patient mortality in the military field hospital she managed. Nightingale called a compilation of such diagrams a “coxcomb”. She made extensive use of coxcombs, to present reports to Members of Parliament about the conditions of medical care in the Crimean war.

ValleyCare Nurses do amazing work and have shared their results to colleagues outside of ValleyCare at venues such as VHA, Beacon, and other Professional organizations. We have made vast strides in: Improving Door to Intervention Times for STEMI Patients, Improving Out-of-ICU Code Blues with the Rapid Response Team, Reducing Ventilator Associated Pneumonias with Protocols for Ventilator Care, Reducing Sepsis Mortality with Early Goal Directed Sepsis Protocols, Improving Neurological Outcomes in Cardiac Arrest Patients with the Therapeutic Hypothermia Protocols and Reducing CHF Readmissions. All of these and more have been nurse driven, collaborative partnerships designed to reduce morbidity and mortality for our patients.

In this era of healthcare reform with an increasing focus on the use of evidence-based protocols, nursing research has never been more important to help guide our practice and improve our patient’s outcomes. Nurses will be at the forefront of healthcare reform, however it ends up looking, not only because of our competence and compassion but also because of our desire to continually improve the care of our patients.

If Ms. Nightingale could do this while working with thousands of soldiers in her care, we can and should follow in her footsteps to improve and share our nursing practices through research and innovation. Happy Nurses’ Week and thank you for everything that you do for our patients each and every day.

Sincerely,

Jessica Jordan
Meet the Nurse Research Council

ValleyCare nurses have a long history of interest and active participation in research. Clinical trials (ISIS and GUSTO) conducted during the mid 1980’s with thrombolytic medications for the treatment of suspected myocardial infarction patients, solidified the interest ValleyCare nurses had to participate in data collection and eventually conduct research of their own.

In 2008 the Nursing Research Council was formed. Original members were all Master’s degree prepared and spent time developing the Research Council Charter, Policy, a research and evidence-based practice framework, internet website for Nursing Research and production of the Research Council Publication. All of the groundwork was designed to offer information and guide the research process for the direct care nurse providing patient care. This group is dedicated to advance the professional practice of nursing through scientific inquiry, use of evidence-based practice and practice integration of relevant nursing research for ValleyCare Health System.

Early collaboration with UCSF assisted the Research Council members with education and guidance through the research process. Classes offered to nursing staff by the UCSF nurse researchers encouraged the professional nurse to explore evidence-based practice and design studies to experience the research process. From these classes many studies developed. Clinically induced hypothermia, use of lidocaine infiltration for IV starts and how to encourage staff to adopt the practice, early ambulation for ventilator dependent patients, family visitation in the PACU are just a few of the many subjects being explored.

Participating nurses are excited and motivated and the Research Council looks forward to active participation from the professional nurse at the bedside.

The Members:

Martha Brown MSN, RN, CPAN (Chair) has been an RN for the ValleyCare Health system since 1980. As an RN in the ICU and Emergency Department she learned about how actions by the nurse influence patient outcomes and has been excited to see how the tremendous increase in evidence-based practice going on at the bedside. We no longer are tied to doing a task “just because” but are recognized for finding a better way and proving it! As Nurse Manager for Perioperative Services for the majority of her career, Martha has seen the tremendous change and advances that have been made to influence the safety and wellbeing of the surgical patient population. Something as simple as making sure the patient has a normal temperature when they go into surgery can improve their ability to heal. It is these kinds of changes that can have a big impact, and I applaud the profession of nursing for recognizing how important it is for all of us to participate in the quest to provide our patients with safe and evidence-based care.

Shelley Barnhill BSN, MA, RN-C (2008-2011 Chair) has worked in perinatal nursing for over 25 years and currently works in Maternal Child as the Perinatal Educator. Shelley is an ACLS, BLS and NRP instructor and certified in Inpatient Obstetrics and Electronic Fetal Monitoring. Shelley’s passion is perinatal safety, working towards optimizing healthy outcomes for mothers and their babies. Shelley had the opportunity to travel to Azerbaijan and Kosovo, with ValleyCare Health System and American Internation Health Alliance, and teach nurses and doctors neonatal resuscitation. It was an opportunity of a lifetime and showed that education and training are essential to providing safe care anywhere in the world. Shelley and MaryKay Dunn developed the Evidence-Based Education Module on the Research Council webpage. Shelley is excited to see nurses bringing evidence to the bedside!

Erin Bashaw MSN, RN-C has a Masters in Nursing Administration and a B.S. in Health Science. She is working on completing her Doctorate in Nursing Practice. She has worked in healthcare for nearly 15 years. Before coming to ValleyCare in 2004, Erin worked at Alta Bates as a C.N.A. and ward clerk on a 60-bed surgical unit. Erin is passionate about transforming leadership relationships with bedside care givers and administration, creating the next generation of healthcare leaders and increasing bedside autonomy for all nurses as a professional practice. She believes that happy nurses are able to provide exceptional care which equals happy patients and better patient outcomes.
Mary K. Dunn MSN, RN. I have been a nurse for 28 years, 22 of those employed with ValleyCare Health System. I have worked in ICU, PACU and Preop Testing throughout my career. For eight years, I have been in the Nurse Educator role, first in Perioperative Services and presently with Staff Development. I have always been interested in finding inventive ways to provide education and access to evidence, for the direct-care nurse, working with new technologies like video and the web. This interest has remained a focus for me on the Research Council. How do we as a council help the direct-care nurse gain easy access to literature, guidelines and standards in their work day? Not only for quick reference, but to stimulate ideas for evidence-based research projects. Please come join us during these exciting times. Twitter anyone?

Karen S. Lounsbury DNP, RN-BC In 1989 when I began my career at ValleyCare it was in Critical Care. I was fortunate to be a member of the Thrombolytic Task Force during the days of the GUSTO and ASCENT studies and collected data for those studies. During the Doctor of Nursing Practice program at the University of San Francisco, I was reintroduced to Research through an Evidence-Based Practice class. When the Research Council formed in 2008, I wanted to be part of this exciting new Council. The three Evidence-Based Practice classes provided by the Center for Nursing Research & Innovation from the University of California San Francisco were wonderful. We were able to develop our PICO questions, receive feedback from the consultants and other participants. The Toolkit the Nursing Research & Innovation consultants developed for us is very useful for our projects.

Janine Pinks NP, PA-C, MSN has a diverse professional background with 23 years of nursing experience. I have worked in several areas of nursing including the emergency room and neonatal intensive care. The last 17 years I have specialized in adult open heart surgery and the last eight years has worked as an advanced practitioner. I have been involved in the startup and participate in many public education programs on heart disease. I am also involved in staff development and education. I joined the research council because it is important that we stay current and practice evidence-based nursing to ensure that our patients continue to have the best possible outcomes. I earned my Masters of Science in Nursing at the University of California, Sacramento, and FNP/PA Certification at California State University, Davis.

Bernie Revak RN, MSN, PHN, CIC. I have been a nurse at ValleyCare since 1981, working in almost all areas of nursing and the hospital including clinical and non-clinical areas. I am the Director for Infection Control, Public Health, and Outpatient Clinics. Infection Control is so challenging in the current climate of healthcare with all of the emerging super bugs and increasing regulatory mandates. Being board certified in Infection Control and Prevention and actively participating in the local chapter of Association for Professionals in Infection Control and Epidemiology (APIC) helps manage the unpredictable world of emerging infections. Focused on getting the message of prevention to staff for minimizing the transmission of healthcare infections and providing safe patient care, “Gel In and Gel Out” is the mantra.

MaryJo Schaarschmidt MSN, CPNP, CNS, RNC-NIC, earned her BSN from the University of San Francisco, her MSN at UC San Francisco and her post graduate PNP at Indiana University Purdue University. During these past 8 years at ValleyCare, MaryJo has acted as the CNS for the NICU and Pediatrics. She helped with the NICU renovation and pediatric partnership with UCSF. Process improvement, measures to increase patient safety, mentoring, staff education, and program development are all guided by Evidence-Based Practice. Highlights of EBP within the Maternal Child Department here at ValleyCare are: national recognition for our program that allows nurses to initiate BiliChecks on all babies with a systematic approach to identifying and treating hyperbilirubinemia; medication safety measures put in place house-wide for all pediatric patients such as the syringe pump with medication library, weight-based ordering with pre-printed orders sets and standardized medication concentrations, and independent double checking between MDs, pharmacists and nurses; minimizing the availability of heparin in the NICU; simulation-based training for high risk deliveries, neonatal resuscitation and pediatrics emergencies; and TeamSTEPPS training allowing for increased communication and role development between multi-disciplinary services.
Achieving Door-to-Balloon Times: Medical Center Teamwork Strategies

Karen Dynek MSN, RN, CCRN, ACC-CCA

An ST elevation myocardial infarction (STEMI) is a life-threatening emergency, often a sign that a major coronary artery supplying blood and oxygen to the heart muscle is 100% blocked. Time is muscle. Rapid recognition and triage of these patients to percutaneous coronary intervention (PCI) reduces mortality and morbidity. Strong teamwork and communication from emergency medical services (EMS) to the Emergency Department (ED) to the Cardiac Catheterization Lab will ensure a safe and rapid triage to life-saving PCI.

BACKGROUND:
ValleyCare Health System has a long history of focus on the care of STEMI patients. In the mid-1980s, ValleyCare participated in cutting-edge thrombolytic research studies such as ISIS for streptokinase and GUSTO for tPA (tissue plasminogen activator). Both streptokinase and tPA are clot-dissolving drugs. A foundation for our current practice was built then, with an appreciation for the importance of identifying the critical intervals of door-to-data (ECG), data-to-decision, and decision-to-drug.

In 1995, ValleyCare began participation in the National Registry of Myocardial Infarction (NRMI) which continued for a decade and eventually evolved into the current American College of Cardiology (ACC)/American Heart Association (AHA) ACTION-Get With the Guidelines myocardial infarction registry. Core measures and national guidelines for care of the myocardial infarction (MI) patients are developed based on the data collected from those registries, truly evidence-based practice. In 2000, ValleyCare moved forward with a plan to treat STEMI patients with primary PCI. This reflected the national move away from primary thrombolytic therapy to balloon angioplasty and stents based on ACC/AHA guidelines. ValleyCare did not have cardiac surgery at the time, so a proposal was made to the California Department of Health Services that ValleyCare go forward with primary PCI with no cardiac surgery on site. The proposal was written by the Cardiac Resource Nurse and approved by Senior Administration. State permission was granted, and ValleyCare became one of very few centers in the United States and California to provide this service.

Using the lessons learned from our experience with the thrombolytic studies, we focused on building teamwork and communication between the ED, Cath Lab, and CCU. We looked at the time intervals; door-to-data (ECG), data-to-decision (Cardiac Team Alert), decision-to-Cath Lab, and overall door-to-balloon (angioplasty). A timeline sheet was developed which serves as a nursing and physician order sheet for the preparation of the STEMI patient for PCI from the ED to the Cath Lab. The timeline sheet has been edited over time to reflect evidence-based changes in care. Our focus is on process and how to best make the process work so we provide safe and rapid care to our STEMI patients. We successfully treated our first Cath Lab STEMI patient with PCI in October of 2000.

In 2003, researchers from the Yale New Haven Center for Outcomes Research and Evaluation contacted ValleyCare regarding our consistently excellent treatment times for STEMI patients based on NRMI data. ValleyCare became one of eleven United States hospitals profiled in the manuscript published in The Journal of the American College of Cardiology (JACC) in 2005 “Achieving Door-to-Balloon Times That Meet Quality Guidelines: How Do Successful Hospitals Do It?” (Hospital names are blinded in the article but a researcher verified that ValleyCare is hospital #10.)

In October of 2005, ValleyCare Medical Center submitted an application to become a Cardiac Receiving Center (CRC) for Alameda County Emergency Medical Services (ALCO-EMS). ValleyCare met all criteria under the Alameda County Health and Safety Code, Division 2.5, Sections 1797.67, 1798, and 1798.170, and the application was accepted. ALCO EMS is enrolled in the American Heart Association’s Mission Lifeline program which recognizes the importance of specialized Cardiac Receiving Centers to provide the best care for STEMI patients.
In 2007, ValleyCare became a member of the Door-to-Balloon (D2B) Alliance. The D2B Alliance grew out of the Yale New Haven interviews which identified key factors to achieving door-to-balloon times that meet or are below the 90-minute D2B time recommended by the ACC and the AHA. These strategies are:
• ED physician activates the Cath Lab
• One call activates the Cath Lab
• Cath Lab team is ready to begin the procedure within 20 to 30 minutes of the page.
• Prompt feedback to the ED and Cath Lab staff about D2B times
• Senior management commitment
• Team-based approach
• Using a pre-hospital ECG to activate the Cath Lab

METHODS:
In an effort to continually improve our process, we began monthly STEMI meetings in January of 2009. These meetings are attended by senior management, ED physicians and Cardiologists, ED and Cath Lab staff, a representative from CCU, and occasionally by representatives from pharmacy and the lab. EMS personnel are also invited to attend, but as yet have not. As a group, we analyze every D2B interval for every STEMI patient and make recommendations for improvement to our process, a reflection of structural empowerment.

In September of 2009, improving door-to-balloon time for STEMI patients was identified as a project for the ValleyCare Performance Improvement team. The team is chaired by the ED nurse Director and co-facilitated with the Quality Management RN. Measurements were obtained by a current core measure abstraction process, and a 100% case review and timeline breakdown by the Cardiac Resource Nurse. A special icon for the ED computerized tracking board was devised and implemented by the Emergency Department RN Information Technologist/Database Administrator. To ensure prompt feedback about D2B times, STEMI bulletin boards are mounted in the ED, Cath Lab, and Cardiology reading room. These boards display graphs showing the D2B intervals for all STEMI patients. ValleyCare’s goal is D2B < 60 minutes. “STEMI Stars” are displayed for each STEMI PCI < 60 minutes. On each STEMI Star are listed the date, D2B time, and all staff involved in caring for the patient from EMS, ED, and Cath Lab. ED and Cath Lab staff often express pride when named on a STEMI Star! The ED plans a larger STEMI board near the ambulance entrance so that the EMS personnel will be able to easily view the graphs and stars. Especially prompt feedback from the Cath Lab to the ED occurs when the

ValleyCare Quarterly STEMI Door-to-Balloon (D2B) Data
Cath Lab monitor nurse calls the ED after the first balloon inflation to share the D2B time. If they are able, ED nurses and techs will often watch part or all of the PCI procedure. The Cardiac Resource Nurse also provides before and after pictures of the culprit coronary artery correlated with the STEMI ECG for the STEMI board in the ED.

OUTCOMES:
A goal of the STEMI group was realized when we purchased modems for the Lifepaks of EMS ambulances serving the ValleyCare area. Wireless transmission of STEMI 12-lead ECGs started in March of 2010. The ED physician activates a Cardiac Team Alert prior to patient arrival based on interpretation of the transmitted ECG. Currently ValleyCare meets all seven strategies identified by the D2B Alliance.

For the last three years, ValleyCare Health System has proudly won a Gold Performance Achievement Award bestowed by the American College of Cardiology (ACC), American Heart Association (AHA), and the American College of Emergency Physicians, the Society of Chest Pain Centers, and the Society of Hospital Medicine (SHM). The award is for “improvement in the treatment of acute myocardial infarction patients through implementation of ACTION Registry-GWTG and in-hospital initiation of the American College of Cardiology/American Heart Association STEMI/NSTEMI Clinical Guideline recommendations.” The Cardiac Resource Nurse is now a speaker for the American Heart Association, presenting ValleyCare Medical Center’s strategies for D2B process improvement at a large conference in Sacramento in January of 2010 and an East Coast webinar with a Cardiologist from Berkshire Medical Center in Massachusetts in April of 2010.

By using a teamwork approach to focus on our process, we consistently improve our STEMI care which in turn leads to a more rapid time to treatment.

From the 3rd and 4th quarters of 2008 to the present 1st quarter of 2011, D2B times have been reduced by 20 minutes.

If a Cardiologist is present, a very rapid Emergency Department triage occurs. The shortest door to Cath Lab time yet achieved is 11 minutes.

All members of the STEMI team look for practical ways to cut several minutes from the ED to Cath Lab time. Currently the Cath Lab team arrives, begins Cath Lab set up, and goes to the ED to retrieve the patient. We are discussing the possibility of the ED bringing the patient to the Cath Lab following a call from the first Cath Lab team member to arrive. This would:

- Save time for the Cath Lab
- The ED would transport while the Cath Lab sets up
- Direct communication between the ED nurses and Cath Lab nurses would occur in the Cath Lab
- Critical patient information would be exchanged very quickly
- Cath Lab and ED nurses would work together as a team to get the patient ready

The success of the ED Timeline/Order sheet led to the development of an order sheet for the rapid triage of an in-house patient that develops sudden onset of chest pain and ST elevation on ECG. The order sheet was developed and instituted in 2010.

The monthly STEMI meetings are now an integral part of the ValleyCare Medical Center culture and we are pleased that a plan is in effect to block off Cath Lab time so that nurses, CVT, and radiology technologists will be able to attend during working hours. We are also pleased that several personnel from ALCO-EMS will be attending our May STEMI meeting.

Teamwork, communication, and committed focus on process are an ongoing and necessary challenge to ensure safe and high-quality care for our STEMI patients. It is a commitment that we gladly make every day.

REFERENCES:

American College of Cardiology National Cardiovascular Data Registry (NCDR) - Quality Measurement for the Cath Lab. www.ncdr.com.


**Progressive Mobility**

**Angelina Daco RN, CCTN, CCRN**

Every specialty of Nursing realizes the effects of immobility on our patients both physically and mentally. This realization has led to the development of Progressive Upright Mobility Programs within Intensive Care settings to improve patient outcomes and improve overall mobility. These programs have led to a decrease in length of stay in Intensive Care, overall improvement in cardiovascular and muscle function, stabilization of hemodynamic measures, decrease in pressure ulcer rates, and a decrease in body stress during hospital stay. While physicians are certainly key stakeholders in the delivery and creation of Progressive Upright Mobility Programs, this is a nurse driven initiative. (De Jonghe, 2004, p. 1117) (Morris, 2007, p. 19)

The complications of immobility are considerable, and each body system comes with its own list of complications. Table 1 describes the complications of immobility for each body system. Prolonged immobilization, according to Kubo, can cause “cardiovascular deconditioning” (Akiko, p. 8) in which the patient’s cardiovascular function deteriorates over time due to immobility. One can normally see this occur within three to four days of bedrest! Many of our Intensive Care patients with Adult Respiratory Distress Syndrome (ARDS), Sepsis, and other complicated diagnoses are immobile not just for three or four days, but for weeks at a time! Orthostatic intolerance is considered a symptom of cardiovascular de-conditioning. How does this happen? Confined to bedrest for most of our waking hours and lying down while we sleep, the lack of variation between standing, sitting, and lying down decreases the amount of orthostatic movement. When patients are immobile, orthostatic hypotension increases which can result in “falls, labile blood pressure, and other complications that may increase hospital length of stay.” (Akiko, p. 8)

Muscle wasting, or musculoskeletal de-conditioning, is also a complication of prolonged immobility. When we are immobile, our muscles lose their contractility and strength, thus resulting in atrophy. Up to 1.5% of our strength can decline with each day of immobility due to prolonged bedrest. Our large muscle groups utilized in walking and upright movement are the groups that deteriorate first and at the most rapid rate! While it may take only a few weeks to lose the muscle strength and acquire extensive atrophy, it may take many months of Physical Therapy and rehabilitation to regain the muscle lost! (Akiko, p. 8) All the more reason to create and maintain a Progressive Mobility Program in the Intensive Care Unit settings.

Here at ValleyCare, the Intensive Care Unit Nursing Staff recognized the need for a Progressive Mobility Program after attending the Slice of NTI Nursing Conference in April, 2010. While working with Dr. Nancy Donaldson as Evidence-Based Practice Fellows, Renuka Sivakumaran RN, Lisa Glasgow RN, Phyllis Yau-Chan RN, and Angelina Daco RN reviewed the evidence for the use of such a program in our Intensive Care Units. Much of the evidence indicated that nursing should not only be moving the patients into upright positions for periods of time each day, but that passive range of motion exercises should also be performed daily for all joints to avoid contractures and joint wasting. (Morris, 2007, p. 3)

While we are still in the design phase of the Progressive Mobility Program, we are

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Intradermal Lidocaine: Nurse Perceptions and Barriers for Practice Implementation

Erin Bashaw MSN, RN-C and Jolene Duffey BSN, RN

The purpose of this study was two-fold. The first to identify barriers for practice implementation of intradermal lidocaine infiltration, used as a pretreatment to reduce patients' pain, discomfort, fear, anxiety (while increasing patient satisfaction with less painful IV starts). The second focus was to initiate a change in nursing practice based on current literature; to provide the nurses with optional ways of starting IVs to minimize patients' pain, discomfort, fear, anxiety and increase satisfaction.

BACKGROUND: The practice of using intradermal lidocaine for IV starts was frequently used by nurses in the Pre-op and Maternal Child/Labor and Delivery departments. Nurses in these units, often remarked that patients seem to “prefer” this method of IV start. Because the use of intradermal lidocaine was effective in both reducing IV start pain and increasing patient satisfaction the Preoperative Nurses were desirous of encouraging the practice in all patient care areas. The Preoperative Nurse representative on the Nurse Practice Council brought the idea forward for discussion. Supporting this was an internal research project, previously conducted by the pre-operative department about the use of intradermally bacteriostatic normal saline with benzyl alcohol versus buffered 1% lidocaine hydrochloride prior to IV cannulation, in reducing patient's pain and and increasing satisfaction associated with IV starts. The study found that both agents were equally effective in reducing patient’s pain and increasing satisfaction associated with IV starts.

Based on this information, a study was conducted to investigate nurse perceptions about intradermal lidocaine’s use and barriers for practice implementation.

RESEARCH METHOD: A descriptive study was conducted, using a pre-survey/post-survey design. Both quantitative and qualitative data was collected. The pre-survey sample was collected over a period of one week in April of 2010 from all shifts of bedside nurses that were willing to complete the survey. A total of 100 surveys were returned. The post-survey sample was collected over a period of one week in April of 2011 from all shifts of bedside nurses that were willing to complete the survey. A total of 71 surveys were returned.
IMPLEMENTATION: In April of 2010, an educational campaign was initiated to increase awareness and complete competency of the standardized procedure protocol that allowed bedside nurses to administer intradermal lidocaine prior to IV starts for the purpose of minimizing patient discomfort during the introduction of an intravenous cannula.

Approximately 400 bedside nurses, over a period of four months, completed the competency training and demonstrated proper technique when starting IVs using this method. Buffered lidocaine was stocked on every medical/surgical unit of the hospital to increase access and encourage the use. The multi-use vial was exchanged for a new vial by pharmacy every 24 hours to maintain effectiveness and potency of the buffered lidocaine. Education was reinforced through occasional check ins with staff, and encouraging nurses to offer the technique as an option for IV starts.

RESULTS: The results of the pre-survey indicated that only 22% of nurses were aware that using intradermal infiltration of lidocaine prior to starting an IV is a standardized nursing procedure. 33% of the nurses had completed the competency prior to the educational campaign. 41% were unsure if they had completed the competency or stated they did not know how to use the method. 41% of the nurses surveyed stated that they had access to buffered lidocaine. 25% of the nurses stated that they preferred to start IVs using the buffered lidocaine method. 58% answered that the use of lidocaine prior to starting an IV would minimize patient discomfort during the introduction of an intravenous cannula. 33% answered that the use of lidocaine makes IV starts more difficult, 37% believed it obscures the vein, 40% thought two site infiltrations would cause more pain and 44% thought it is more likely to cause an infection at the site due to two punctures.

The results of the post-survey indicated that 66% of nurses are aware that using intradermal infiltration of lidocaine prior to starting an IV is a standardized nursing procedure. 83% of the nurses surveyed had completed the competency since the educational campaign. 16% were unsure if they had completed the competency or stated they did not know how to use the method. 19% of the nurses surveyed stated that they had access to buffered lidocaine. 19% of the nurses stated that they preferred to start IVs using the buffered lidocaine method. 63% answered that the use of lidocaine prior to starting an IVs would minimize patient discomfort during the introduction of an intravenous cannula. 47% answered that the use of lidocaine makes IV starts more difficult, 47% believed it obscures the vein, 52% thought two site infiltrations would cause more pain and 35% thought it is more likely to cause an infection at the site due to two punctures.

EVALUATION: This study found numerous positive results as well as some surprising results. Awareness of the standardized nursing procedure increased by 44% as a result of the educational campaign about the policy and procedure and there was a 50% increase in the competency completion. However, 16% of the surveyed nurses were still uncertain if they had completed the competency which raised some concern since approximately 400 nurses were trained on this particular IV start method. Surprisingly, there was a huge decrease in awareness about access to buffered lidocaine despite the buffered lidocaine was put on most units in the hospital. The placement of the lidocaine on the units was reinforced during the education sessions. Despite its accessibility, there was a 22% decrease in awareness about buffered lidocaine access. There was also a 6% decrease in nurses’ preference about starting IVs with the use of lidocaine. There was only a 5% increase in nurse’s perception that this method would minimize patient discomfort during the introduction of an intravenous cannula. There was a 14% increase in discernment that the use of lidocaine makes IV starts more difficult, 10% increased belief that it obscures the vein and 12% increase in the perception that two site infiltrations would cause more pain. There was a 9% decrease in belief that two punctures would cause an infection at the site of IV insertion despite nurses’ concern that any unnecessary puncture of the skin would put the patient at higher risk for infection, especially at the IV insertion site.

CONCLUSION: Despite current literature, an internal survey and an intentional educational campaign to increase the use of buffered lidocaine to reduce patient’s pain during IV starts, nursing perceptions and practice could not be changed. The policy and procedure was not mandatory and nurses were only expected to offer lidocaine to patients if they perceived it as a benefit for that particular patient. Further research should be done on this topic and the possibility of making the practice mandatory for all IV starts without contraindication could ultimately change practice.

REFERENCES:


Maternal Child Patient Safety Program
Shelley Barnhill, RN-C, BSN, MA and Gina Teebles, RN-C, BSN.

A major focus in perinatal nursing is creating a safe, high reliability environment for patients. Errors in the perinatal setting have a double impact as both mother and her fetus/neonate are at risk for injury. Research shows that having a comprehensive patient safety plan obstetrical adverse events.

As part of our effort to bring evidence to the bedside, the Maternal Child Department implemented a Perinatal Safety Program. The program is based on the Institute for Healthcare Improvement Perinatal Collaborative model focusing on reducing harm to the patient. The three components of the program are: reduce variation; communication and teamwork and patient/family centered care. Research shows that reducing variation in practice, improving communication and teamwork and including the patient and family in care planning and decisions improves maternal - neonatal safety as well as patient satisfaction.

Simulation Promotes Highly Reliable Teams

Standardizing electronic fetal monitoring (EFM): EFM is a major component of the labor and delivery nurses role and an area of increased medical-legal liability. Research shows when labor and delivery nurses and obstetricians use standardized nomenclature to describe fetal heart rate (FHR) patterns as well as using specific categories for pattern identification, variation is reduced and communication is enhanced, thereby improving patient safety. The Department of OB/GYN approved use of the National Institute of Child Heath and Human Development (NICHD) definitions and guidelines for FHR interpretation as well as creating FHR Pattern Notification Guidelines. All labor and delivery nurses received mandatory education on the changes in terminology and FHR Categories as well as interventions and management. Laminated copies of the terminology, categories and pattern notification guidelines were attached to the EFM in every patient’s room to use as a reference.

Simulation: Research shows that using either low or high fidelity combined team training improves team performance and patient outcomes, especially in critical situations. Maternal Child schedules multidisciplinary and interdepartmental drills and low fidelity simulation. Our simulations include maternal, neonatal and pediatric emergency scenarios. All departments who support patients in the Maternal Child Department participate including physicians, nursing, respiratory therapy, laboratory and the nursing supervisors.

Our format transformed from drills to the simulation methodology which includes briefing, scenarios, videotaping and debriefing. During debriefing, areas for improvement are identified by all staff who participate in the simulation. We have observed results within the department that are consistent with the literature; including quantitative improvements in response time and qualitative improvements surrounding comfort and individual performance. Our ongoing plan includes a minimum of annual participation by all staff in scheduled, ongoing simulations.

Team STEPPS: The need for team training was identified in our drills and simulation as an opportunity for improvement, especially in the areas of role delineation and communication. ValleyCare chose the Team STEPPS model, which was developed by the...
Department of Defense Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality (AHRQ), as a training program for the Maternal Child Department. Team STEPPS was chosen as it is evidence-based, comprehensive training with a focus of improving quality and safety in healthcare. A multidisciplinary team was sent to Seattle, Washington for the formal training program in August, 2010 including three nurses, an obstetrician, a respiratory therapist, a neonatal hospitalist and a representative from quality management. In the Fall of 2010, staff from all departments who care for patients in Maternal Child received Team STEPPS training. Attendees included obstetricians, pediatricians, neonatal hospitalists, maternal child staff, respiratory therapists, nursing supervisors, laboratory and anesthesia.

Changes we have implemented include interdisciplinary board report and incorporation of Team STEPPS concepts and techniques in daily practice and simulations. An initial teamwork survey was completed by all participants prior to training and staff will complete the same survey as a post-assessment in approximately six months. Results will be evaluated and shared with all team members.

**R-SBAR:** SBAR originated in the military as a standardized way of communicating which allows a standardized method of giving and receiving feedback. ValleyCare adopted SBAR several years ago as a universal tool for communication. In critical situations, especially on night shift when care providers are woken up, it is important to quickly get the physician’s attention using key words or attention grabbing phrases. Maternal Child implemented the R-SBAR. R-SBAR starts with “recommendation” rather than situation. The nurse uses key phrases such as “I need you to come in now,” “I need you to evaluate this patient” etc… Use of the R in R-SBAR promotes the sender and receiver having shared mental model, followed by SBAR standard format for sending recurring information as

![Simulations include Maternal, Neonatal and Pediatric Emergency Scenarios](image)

Current evidence shows that early activation of an ETP can improve patient outcomes and recommends nurse activation to expedite the process. Results from post partum hemorrhage simulation drills also showed that earlier activation of the ETP would have resulted in faster lab draws, results and blood preparation. Based on the evidence, the team re-evaluated the ETP and a practice change was implemented allowing nurse activation. Nurse activation allows for lab to draw the patient and the blood bank to dispense units of uncrossmatched blood to the unit without the physician being at the bedside. This means that when the physician arrives lab results will be available and the cross match process will be initiated thus expediting critical care of the patient.

**Back to the Bedside:** Evidence shows that giving and receiving report at the bedside decreases communication errors and improves patient safety. Bedside report also increases patient involvement in their care. Maternal Child has adopted the theme “Nothing About Me Without Me,” where staff partner with their patients. We have implemented a report process that includes the off going and oncoming nurse going to the bedside. The off going nurse introduces the oncoming nurse, checks IV solutions, lines, pumps and emergency equipment, the plan of care is reviewed and goals are mutually agreed upon and the patient white boards are updated.

**Surgical Pause:** Unintended retention of a foreign body is among the top ten Sentinel Events reported to TJC and retained surgical items (RSI) continues to be a difficult problem to eradicate.
Patient safety is an ongoing process that requires constant review of current evidence and evaluating practice. Our Patient Safety Program continues to evolve. Using evidence-based practice we can make changes that improve patient safety and patient outcomes. Other areas we are working on include continuing education including a Journal Club that meets monthly; monthly evidence-based nursing education modules, implementing interdisciplinary monthly FHR reviews, expanding standardization in post partum hemorrhage management and the list goes on! Additionally we have a very active Mother Baby Council that has many projects in the works.

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Red Sash for Safety: A Review of Observational Research Findings

Jeanette Kitt BSN, RN, CCRN

The Institute of Medicine (IOM) in their 2007 report, Preventing Medication Errors, reported an estimated 1.5 million people are injured by medication errors every year (IOM, 2007). The estimated cost of these errors is estimated at billions of dollars. One method for reducing medication errors is by decreasing interruptions of nurses during medication preparation and administration.

Some of the methods found in the literature used to decrease interruptions during medication administration are described below. (Anthony, Wieneck, Bauer, Daly, & Anthony 2010; Pape, 2008; Richards, 2008)

Signs: Signs used in the Nursing unit or in proximity to the medication preparation area to request staff members or visitors to maintain a quiet environment and avoid interruptions during medication administration.

Vests: Vests worn by nurses during medication administration provide a visual cue to other staff or visitors to avoid interruptions during medication administration. Nurses in Kaiser South San Francisco documented at 47% decrease in medication errors over five months of vest use during medication administration.

Leadership: Nurse leaders rounding on units to demonstrate support for the new interruption reduction process.

Observational audits: audits by charge nurses, managers or other auditors provide data on actual (not reported) behavior during medication preparation and administration.

No interruption zones: Red duct tape around all areas where medication are prepared such as medication carts or medication dispensing device in critical care units.

The nurse conducting the observational study attended the Evidence-Based Practice class presented by the University of California at San Francisco. Using the information from the Evidence-Based Practice class, the nurse developed a PICO question and a study design. (PICO is a mnemonic used to describe the four elements of a good clinical foreground question. P--Patient, I-Intervention, C-Comparison, O-Outcome.)

A baseline survey was conducted over 5 non-consecutive dates in June and July of 2010. For consistency, nineteen medication passes were observed by a single observer during the 0900 medication passes. It was note there were 69 interruptions during the 19 observed medication passes.

The original plan was for the nurses to wear brightly colored vests. This was reviewed at the Nurse Practice Council and the direct care nurses stated they would prefer to wear colored sashes. The nurses requested sash material that could be wiped with approved cleaning agents. Another consideration was avoiding any latex material. The Materials Liaison RN searched for a material for the sashes. Finally, the Nurse Practice Council approved a red, non-latex, stretch band used by physical therapy for exercises.

Cost for a roll of red sash material was $44.19 for 25 yards. An average of 5 feet (approximately 1.67 yards) was needed for one red sash. One roll would produce approximately 15 sashes at a cost of $2.95 each. The red sashes were kept in a bin near the medication cart. Nurses were instructed to use the sashes and clean them after their shift or if visibly soiled. In isolation rooms, the sashes were worn under a water proof isolation gown.

Research Question: Will interruptions of nurses during medication preparation and administration decrease if the nurse is wearing a brightly colored sash? (See photo of nurse wearing red sash)

RESULTS: Following education and posters describing the purpose of the red sashes on one nursing unit the change was implemented. The nurses were noted to wear the red sashes about 90% of the time at the beginning with a decrease to about 40% of the time when the second evaluation in September was completed. The same nurse conducted 18 observations of 0900 med passes over 5 days. During the second observation in September, a total of 55 interruptions were observed of all nurses wearing and not wearing sashes. The nurses wearing the red sashes were interrupted 22 times compared to the 33 times for nurses without red sashes. The nurses wearing red sashes were interrupted less frequently than those not wearing the sashes.

EVALUATION: Interruptions to medication administration were noted to decrease in the nurses who wore red sashes. Compliance with wearing the sashes was identified as problematic. A decrease in the use of sashes from (90 to 40%) was observed during the course of the two month trial. The nurses were interviewed following the observations to understand the nurses’ perceptions of wearing or not wearing the sashes. Some of the reasons nurses gave for not wanting to wear sashes was a perceived increase in interruptions; nurses stated other care providers questioned why they were wearing red sashes. The nurses reported they did not like putting on and taking off the red sashes but did not offer acceptable alternatives (such as vests or no interruptions zones). Nurses expressed concerns whether the sashes could be cleaned effectively between nurses. Nurses also reported they would be more likely to wear their own sashes rather than sharing them with other nurses. Nurses also voiced concerns about wearing sashes into isolation rooms even under an isolation gown.

Intervention, C-Comparison, O-Outcome.
CONCLUSION:
Interruptions during medication administration are a well-documented risk to patient safety. Changing processes to decrease interruptions during medication administration have been successfully implemented at other facilities. The Nurse Practice Council at ValleyCare provided a sash that was cost effective and easily cleaned. Although a decrease in interruptions to medication administration was observed a majority of the nurses were not willing to continue wearing the red sashes. Some limitations of the study included the small sample size ($n=18$). The trial was conducted on one unit over a two month period. Only one unit received education on the change so nurses who floated onto the unit or other healthcare providers interrupted nurses asking about the sashes. In future trials, the education will be hospital-wide even if only one department participates in the change. A bar-coded medication administration is in the implementation process and further studies of interruptions to this system will be explored for the next project.

References:


RRT (Rapid Response Teams): Success
Barbara Murphy BSN, RN

In March of 2006, Valley Care responded to an IHI challenge to take part in “a campaign to make health care safer and more effective” by establishing our facility’s first Rapid Response Team (RRT).

Per IHI specifications, ValleyCare brought together “a team of clinicians who (would) bring critical care expertise to the patient bedside (or wherever needed)”. ValleyCare’s Rapid Response Team consists of a Critical Care RN and Respiratory Therapist. The role of the Rapid Response Team is to assess, stabilize, assist with communication, educate and support (staff), and assist with the transfer of patients to a higher level of care if necessary.

According to the IHI, “people die unnecessarily every single day in hospitals.” The goal of the RRT is to “respond to a spark before it becomes a forest fire.” Studies have shown that from 66%-70% of patients exhibit signs and symptoms of physiological instability within 6 to 8 hours of arrest. Early response and intervention is a key component to preventing patients from requiring full resuscitation. The RRT can also help reduce the need for transfer to the ICU by providing immediate evaluation and intervention to prevent a patient from further deterioration.

Since implementation of Valley Care’s Rapid Response Team, our facility has seen a 50% reduction in the number of Code Blue calls outside of the ICU (refer to Chart A). With an increase in the number of RRT calls, we are seeing a decrease in the number of Code Blue calls outside of the ICU (refer to Chart B). This is exactly what we set out to accomplish in 2006.

Congratulations on a job well done!

Reference:
http://www.ihi.org/IHI/Programs/Campaign
Fusion of Magnetism and Just Culture

Erin Bashaw MSN, RN, CNE  
Exploration of the association between Magnet Recognition and “Just Culture” is timely and uniquely aligned to produce a global healthcare culture shift that is focused on creating the safest healthcare through improvements in disclosure, transparency, and public reporting. The clinical relevance of this investigation illuminates the essential transformation of the healthcare systems towards excellence in nursing and exceptional patient outcomes by achieving Magnet Recognition and adopting a “Just Culture” to ensure a culture of safety.

Magnet History

designation is not a new phenomenon. Magnet designation began more than 25 years ago and has progressed to become the apex of achievement for nursing professionals and healthcare organizations. A task force was formed by the American Nurses Credentialing Center in 1981 to identify hospitals that had excellent patient outcomes, patient satisfaction, staff satisfaction, and nursing retention (ANCC, 2009). The task force identified 14 components of practice that created success for these particular organizations during a very volatile time in nursing history. The Magnet Recognition Program designated hospitals as “Magnet facilities” in the 1990’s. Nearly a decade later, long term-facilities and international organizations were invited to apply for Magnet designation. The Magnet Recognition Program is based on quality indicators and standards of nursing practice as defined in the newly revised 3rd edition (released in 2009) of the ANA Nursing Administration: Scope & Standards of Practice (American Nurses Credentialing Center,2009). In 2002, the program was officially named The Magnet Recognition Program; the standard for excellence in the industry. Healthcare organizations, hospitals, and nurses look to Magnet designated facilities for answers to achieving excellence in both nursing practice and practice standards (Wolf, Triolo & Ponte, 2008). Significance of Magnet designation means that an organization has created an infrastructure of interdisciplinary care that successfully integrates best practice, promotes the highest quality care, and produces unprecedented patient care outcomes, while promoting collaboration and shared-decision making (Armstrong & Laschinger, 2006). Magnet hospitals report higher levels of nurse satisfaction, patient satisfaction, improved quality of care, reduced errors, reduced falls, reduced number of hospital acquired pressure ulcers, and lower mortality rates (Drenkard, 2010). Magnet hospitals report better patient outcomes than non-magnet hospitals (Armstrong & Laschinger, 2006) and also tend to rank in the top 10 % for excellence throughout the nation (Drenkard, 2010). Additionally, nurses in Magnet designated facilities report that they are “more likely” to report errors and participate in error-related problem solving because they felt empowered by the culture of the organization and had supportive relationships with senior administration (Hughes, Chang & Mark, 2009). Magnet designation also has fiscal implications for healthcare organizations. Reducing length of stay, facilitating exceptional patient outcomes, higher patient and staff satisfaction levels, reducing occupational injury, lowering nursing turnover rates, and recruiting of outstanding experienced nurses translates into lower overall operational costs (Poduska, 2005).

Understanding “Just Culture”

“Just Culture” is a relatively new model for the healthcare industry, but is not a new concept. The theory of “Just Culture” was originated by James Reason in response to horrifically devastating events that occurred in three industries riddled with risk: the military, air traffic control, and nuclear power plants (Reason, 2000). Reason describes these organizations: “high reliability organizations” and dynamic organizations that are influenced by external and internal forces that are constantly changing, under intense time constraints, and have relatively few negative outcomes despite the likelihood of great catastrophe. The theory of “Just Culture” seeks to mitigate system failures in organizations, such as healthcare, that have inherently high levels of risk because they are operated by human beings who are known to be fallible. “Just Culture” promotes organizational learning by accepting that mistakes will happen, accountability by identifying behaviors that inherently expose organizations to risk, and building resilience by promoting industry safety.

Organizations that adopt the “Just Culture” model accept that errors occur
with and without negative outcomes. Each type of error is equally important to disclosure by those involved, because the act of error identification and reporting builds trust, transparency, quality care, and patient safety. “Just Culture” embraces system failures, errors, and weaknesses for the purpose of turning them into educational opportunities for improvement and learning (Mayer & Cronin, 2008).

There are three types of behaviors that contribute to errors: “Human Error”, “At-risk Behavior”, and “Reckless behavior.” Human error happens unintentionally and without mal-intent. At-risk behavior consists of acts that are designed to cut corners and save time, despite the known but seemingly justified danger. Reckless behavior consists of acts that disregard all safety measures (Reason, 2008).

Other industry experts have expanded the concept of “Just Culture”, such as David Marx and Lucian Leape. Marx (2001) argues that each person should be held accountable for their errors and thorough examination of the error is essential to determine the individual’s level of responsibility. Marx expands the concept of “Just Culture” to include a fourth domain of accountability: “knowing violation”. This action goes far beyond “reckless behavior”. Those that participate in this type of behavior knowingly do as at the risk of patient safety and have no regard for safety itself (Marx, 2001). Lucian Leape, founder of the Lucian Leap Institute, originated by National Patient Safety Foundation, is also considered a pioneer in patient safety. Leape also argues the necessity to identify individual accountability and responsibility for patient safety and the need to develop a systematic response to a healthcare culture of safety (Leape, Berwick, Clancy, et al. 2009).

Implementing a “Just Culture” that includes and expects disclosure and reporting from all employees creates trust within a healthcare system. Trust will help eliminate the barriers to disclosure that include fear of punitive action by leadership, retribution from senior leadership and fellow co-workers, criminalization of errors (Brous, 2008), and social isolation from colleagues.

According to one study, 40% of clinicians were too intimidated to report errors (Joint Commission, 2008). Non-clinicians were more likely to report errors than front-line caregivers (Singer, Gaba, Geppert, Sinaiko, Howard & Park, 2002).

“Just Culture” is not a non-punitive error reporting system. It does not negate the responsibility of the care giver’s accountability or organizational liability. Adopters of “Just Culture” recognize that errors need serious investigation and critical evaluation of facts (Dekker, 2007). Counseling, remediation, termination, and possible criminalization of errors are not removed from this theory (Hader, 2006). “Just Culture” seeks to promote organizational commitment to universal safety in healthcare by increasing awareness, self-awareness, error reporting education, performance, and industry compliance (Scalse, 2006). Additionally, “Just Culture” looks to prevent errors by looking forward and anticipating when and where errors may occur and how they can be prevented.

Magnet Recognition and “Just Culture”

The relationship between Magnet Recognition and “Just Culture” may not be obvious, but the benefits of the union are undeniably profound for the healthcare industry. “Just Culture” unites employees by creating shared responsibility in the pursuit of patient safety, increases quality of care and awareness, promotes nurse retention through trust, strengthens morale among staff pursuing excellence as a team, and maximizes opportunity of organizational learning. “Just Culture” transforms every mistake and every error into an opportunity to learn for the purpose of improving patient outcomes across the entire organization.

Translating “Just Culture” into Magnet Readiness

Structural Empowerment

Magnet Recognition is granted to organizations that create an infrastructure of collaboration among all staff members and fosters a culture of shared-decision making. According to one article, nurses reported feeling empowered, more satisfied with their work, more able to contribute to the organization as a whole, and more likely to report problems when related to quality of care issues (Armstrong & Laschinger, 2006) in hospitals that are able to make the “links” between structural empowerment, magnet, and culture of safety. Additionally, nurses who felt supported and empowered by their managers and organizations were more likely to stay at their current place of employment (Kliensman, 2004).

Exemplary Professional Practice

“Just Culture” has the potential to increase retention rates for hospitals, reinvent nurse administrators through a deeper understanding of transparency, disclosure, public reporting, and establishing the foundation for the transformation of nurse satisfaction. Not only does it promote personal development through critical self-evaluation and mastery of awareness, but will create better opportunities for achieving magnet status and the quality of patient care (Wagner, 2007). Magnet status is highly dependent on an organization’s ability to retain experienced nurses (Wagner, 2004). According to Spetz (2007), turnover decreases permanent staff satisfaction because of per diem nursing staff, registry nursing staff, and traveling nurse usage. One of the major considerations for attaining Magnet is the staff nurse retention rates (Upenieks, 2003). Nurses who feel compelled to promote safety and organizational unity are likely to stay at their current place of employment. Additionally, morbidity and mortality rates are lower at Magnet facilities because they tend to employee nurses who are more experienced, have higher levels of education, and have less turnover of nursing staff (Aiken, Clark, Sloane, Lake & Cheney, 2008).

Transformational Leadership

Leadership skills and management styles influence all aspects of nursing care because of the amount of time nurse managers and nurse administrators spend with front-line nurses and their ability to empower and engage staff. One study reported that an employee’s opinion of
their nurse manager or supervisor had greater impact on their intent to stay with an organization than their satisfaction with the organization itself (Ribelin, 2003). Another study, conducted in Australia, reported that the morale of nurses was greatly influenced by the nurse administrator and had a huge impact on retention, turnover, workplace health, and quality of care and safety issues (Day, Minichiello & Madision, 2006). Nurse administrators must have substantial knowledge of their organization to create opportunities for change and enhance programs and processes that create a culture of shared governance and commitment (Sokol, 2004).

**New Knowledge, Innovations & Improvements**

New knowledge is one of the biggest benefits of “Just Culture”. Exposing errors, mistakes, and weaknesses within the patient care domain and healthcare systems promotes opportunities for the entire organization to learn for the purpose of creating positive patient outcomes. “Just Culture” cultivates innovation and improvements by investigating errors and designing systematic efforts to prevent future one.

**Empirical Outcomes**

Empirical outcomes are the supporting data that hospitals and healthcare system collect over many years to prove that they have achieved the required elements of Magnetism. Success in the aforementioned areas would provide the evidence necessary to support Magnet readiness.

**References:**


ValleyCare Health System
Educating on Best Practices,
Throughout the Years