RUSH
OAK PARK HOSPITAL

2017 NURSING ANNUAL REPORT

WE ARE RUSH OAK PARK HOSPITAL

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

WE ARE INNOVATIVE PATIENT & FAMILY FOCUSED CARE THAT SUPPORTS & SUSTAINS WELLNESS

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FOUNDATION OF NURSING

OUR PROFESSIONAL PRACTICE MODEL

Rush Oak Park Hospital's Professional Nursing Practice Model is a picture of our practice identity. Relationships and Caring encircle and support all that we do as ROPH nurses. Supported by and through this, Technical Expertise, Evidence-Based Practice and Critical Thinking work in synergy to propel us as nurses towards Leadership of the complex healthcare environment to meet the needs of our patients and the environment.

REVOLUTIONIZING OUR ROLES

Professional nurses at Rush Oak Park Hospital (ROPH) are revolutionizing their roles in our care delivery model. Taking a lead in population management, Clinical Nurse Leaders (CNLs) have expanded their responsibilities to include case management of individual patients, development of complex care plans to optimize care as a means of avoiding 30-day readmissions and improving nursing knowledge in all facets of nursing care. Nurses promote nursing excellence through proactive assessment of quality care, retrospective audits of performance, and peer assessments of professional practice. It is exciting to watch the ownership of nursing professional practice as embraced by the Nursing Professional Governance Organization (NPGO). The voice of the front-line nurse caregiver is as valued as any nurse in any specialty area including the Chief Nursing Officer (CNO).

I delight in the respect garnered by the ROPH nurses in problem-solving processes while working in concert with physicians and ancillary departments. I revel in the community recognition of ROPH nurses, be it in teaching healthy lifestyles, providing health screening in clinics, or packaging food for the food pantry. ROPH nurses use loving care in practicing their profession in all settings. That loving care has brought an unprecedented number of patients to our Emergency Department while maintaining shortest wait times, high patient satisfaction and best practice management of stroke and cardiac events. Subsequently, to expand our role in cardiology care, we are now the home for the Rush system Cardiac Rehabilitation Program. Nurses are active in planning a new Emergency Department. The NPGO is innovative in recognizing and supporting the need for more clinical sites for colleges of nursing on a 24/7 basis. NPGO is capitalizing on the 14% MSN-educated bedside RNs to offer clinical instructors who are current, relevant and available for those clinical rotations. ROPH nurses are unique and insightful as they innovate to meet the impending healthcare demand for more nurses and intervene for the future care needs of our community. ROPH

Karen Mayer
PhD, RN, MHA, NEA-BC, FACHE
Vice President of Patient Care Services,
Chief Nursing Officer

EMPOWERING STAKEHOLDERS

It is no surprise that the theme of nursing excellence has continued this past year at Rush Oak Park Hospital.

After receiving the ANCC® Magnet Designation last year, ROPH nurses didn't rest on their laurels. Our nurses recognize the importance of diligence in improving nursing practice and providing excellent care. They demonstrated this commitment by again receiving the Gold Seal of Approval from the Joint Commission for inpatient diabetes care. With this latest approval, ROPH nurses can boast a decade of excellent nursing care in diabetes. In addition to this notable achievement, our nurses remain committed to improving our practice at the bedside through unit-based education, unit and hospital quality improvement projects and interdisciplinary collaboration.

THE JOINT COMMISSION
INPATIENT DIABETES CERTIFICATION

Despite the pursuit of excellence, gaps in nursing care can occur. Our nurses don't shy away from these challenges. To address these nursing practice concerns, task forces are created. Professional Governance at Rush Oak Park Hospital supports these initiatives, which empowers all nurses to be stakeholders in the care they provide.

Our nurses have remained committed to excellence outside the walls of Rush Oak Park Hospital by improving the health of our community. Our nurses volunteer their time by providing blood pressure screenings at food pantries and healthcare education for the homeless population at Housing Forward. Our nurses can be seen distributing water and providing first aid at local foot races. Coat and book drives are organized and provide vital resources to vulnerable populations within our community.

We, the ROPH nurses, celebrate a year of many successful accomplishments. As we continue our journey of excellence, we remember that the well-being of our patients and families is at the center of all we do. ROPH

Colleen Chierici
BSN, RN
President-Elect NPGO

WE ARE NPGO

NURSING PROFESSIONAL GOVERNANCE ORGANIZATION

EVERY NURSING PRACTICE AREA IS REPRESENTED

EXECUTIVE COMMITTEE REPS

President, President Elect, 3Center, 6West, Ambulatory Clinics, APNs, Cath Lab/IR, CNL, CNO, Employee Health, Endoscopy, ER, ICU, Nursing Practice, Nursing Supervisors, OR, PACU, Quality, Rehab, Same Day Surgery, Skilled Care Unit, Telemetry and Wound Care Clinic

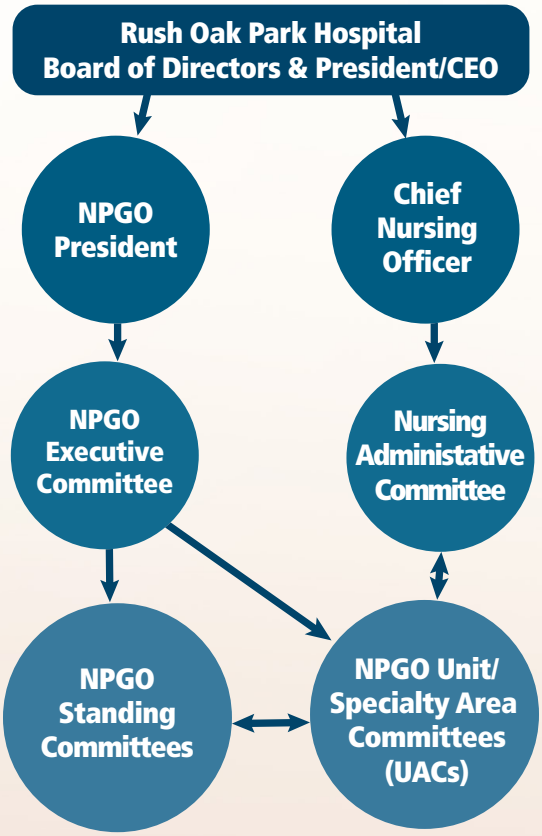
NPGO STANDING COMMITTEES

Peer Review Council, Evidence-Based Practice & Research, Education, Clinical Standards of Practice and Care, Staffing Nurse Advisory Board, Magnet Stars, Awards and Recognition, APN Practice Council, Nursing Excellence

NPGO UNIT/SPECIALTY AREA COMMITTEES

3Center, 6West, Ambulatory Clinics, Cath Lab/IR, Endoscopy, ER, ICU, New Grad Float/Resource, OR, PACU, Rehab, Same-Day Surgery, Skilled Care Unit, Telemetry, Wound Care Clinic

HOW IS NPGO ORGANIZED?



Autonomy has, as its basic components, personal accountability, shared power and influence.
An autonomous nursing staff is feasible. It is professionally exciting. It cannot be done for nurses; it must be done by them.

(Christman, 1976)

OUR NURSES

294 NURSES

- **68** REGISTERED NURSE 1
- **107** REGISTERED NURSE 2
- **46** REGISTERED NURSE 3

- **11** CLINICAL NURSE LEADERS
- **15** ADVANCED PRACTICE REGISTERED NURSES
- **20** NURSING ADMINISTRATION
- **27** NURSE SPECIALISTS

EDUCATION

69% NURSES WITH BSN

and

14% NURSES WITH MSN OR HIGHER

CERTIFICATIONS

54% NURSES CERTIFIED

PROFESSIONAL ORGANIZATIONS

54% NURSES INVOLVED

with

57 ORGANIZATIONS

BOARD MEMBERSHIPS

12 NURSES

OUR FACILITY

89,170 *visits* DURING 2017

237 LICENSED BEDS

7.3% ALL-CAUSE READMISSION RATE

TURNOVER RATE

>25% IN 2007

9%

140 STUDENTS FACILITATED

FROM FOUR DIFFERENT ACADEMIC PARTNERS

9 ON-GOING RESEARCH STUDIES

ONE *percent* REGISTERED NURSE VACANCY

OUR INTERVENTIONS

CAUTI
9.2% IN 2007

0% MEETING MAGNET

CLABSI
2.3% IN 2007

1.38% MEETING MAGNET

HAPI
24% IN 2007

0.76% MEETING MAGNET

FALLS with INJURY

1.03% MEETING MAGNET

AMBULATORY NURSE SENSITIVE INDICATOR
WCC, ENDO, SDS, CCL/IR

OUTPERFORMING ALL BENCHMARKS MEETING MAGNET
ON ALL MEASURES

CORE MEASURES
CHF, AMI, VACCINES, SCIP

100% MEETING MAGNET
COMPLIANCE

NURSING ENGAGEMENT

OUTPERFORMING BENCHMARKS IN 17/18 AREAS MEETING MAGNET

INSTITUTION-WIDE AWARDS

MAGNET RECOGNIZED — AMERICAN NURSES CREDENTIALING CENTER

ANCC MAGNET RECOGNITION
MARCH 2016

★★★★ CENTERS OF MEDICARE & MEDICAID SERVICES (CMS)
FOUR STAR PATIENT RATING

★★★★★ CENTERS OF MEDICARE & MEDICAID SERVICES (CMS)
FIVE STAR SKILLED CARE RATING

LEAPFROG HOSPITAL SAFETY GRADE
LEAPFROG GRADE A
FOR PATIENT SAFETY

1st
THE FIRST HOSPITAL IN THE WESTERN SUBURBS TO OFFER A NEW MINIMALLY INVASIVE TREATMENT FOR
PERIPHERAL ARTERY DISEASE
USING OPTIC COHERENCE TOMOGRAPHY

THE JOINT COMMISSION
TOP PERFORMER ON KEY QUALITY MEASURES

THE JOINT COMMISSION
INPATIENT DIABETES CERTIFICATION

THE JOINT COMMISSION
PRIMARY STROKE CENTER CERTIFICATION

RECOGNIZED AS A
LEADER IN LGBT HEALTHCARE EQUALTIY
BY THE HUMAN RIGHTS CAMPAIGN FOUNDATION

ENERGY STAR
U.S. ENVIRONMENTAL PROTECTION AGENCY'S
ENERGY STAR CERTIFICATION

NURSES IMPROVING CARE FOR HEALTHSYSTEM ELDERS
NICHE
STAGE 3
"SENIOR FRIENDLY"
DESIGNATION

ACS NSQIP
AMERICAN COLLEGE OF SURGEONS NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM
TOP SURGICAL HOSPITAL

U.S. NEWS & WORLD REPORT RATED ROPH A
HIGH PERFORMING HOSPITAL
FOR IN CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) & HEART FAILURE CARE

THELEAPFROGGROUP TOP GENERAL HOSPITAL 2016
ONE OF ONLY 56 HOSPITALS
TOP GENERAL HOSPITAL AWARD

COMPASSION IN PRACTICE

COMMUNITY PARTNERSHIP TO IMPROVE HEALTH AWARENESS

Excerpts taken with permission from: Stewart, E. (2017) A program to increase health promotion for women in residential treatment for substance abuse disorders. Rush College of Nursing Paper

A Women's Treatment Center (WTC) in the region treats women who have suffered from substance abuse as well as their families. The mission of the WTC is to provide women with continuum of care, tools for recovery and parenting skills to maintain a sober lifestyle as they rebuild their life and future. The services provided are as follows: detox, residential treatment for pregnant/postpartum women, women with children and women without children, outpatient treatment, recovery home, methadone clinic, children's services, criminal justice program and parenting classes and counseling. Elizabeth Stewart, Unit Director of the Skilled Care Unit at ROPH, as part of her Doctorate of Nursing Practice in Advanced Public Health, worked to implement a set of important health promotion strategies to improve outcomes in both the clients as well as the staff of this WTC.

Beth described in her final paper and presentation that health promotion is important to the process of recovery from substance abuse. She describes that people with substance use disorders have higher rates of both infectious disease and chronic illness coupled with lower levels of self-care related to their substance use than the general population (Kelly, et al, 2015). She found that health promotion activities such as screenings, health education, exercise, journaling and smoke cessation during recovery have been linked to extended lengths of sobriety (Bradbury-Goals, 2013; Fareed et. Al, 2010; Weinstock, Barry & Petry, 2008) In the population that lives at the WTC, the rates of some of these illnesses are far greater than those of the national average for the same illness. Hepatitis incidence is at 10.9% compared with 1% nationwide, HIV/AIDS incidence is at 3.2%% compared to less than 1%, sexually transmitted infections incidence is at 8.8% compared to less than 1%, respiratory disease incidence is at 24.8% compared with 11.3% and anemia incidence at the WTC is at 10.6% compared with less than 1% in the general population (Center, 2016; Centers for Disease Control and Prevention (CDC) 2016a; CDC, 2016b; CDC, 2016c; Healthy People 2020, 2016; American Society of Hematology, 2016).

Beth engaged administrators, clients and nurses in a variety of activities to elicit feedback on how to best impact these important disparities. Through surveys, interviews and focus groups, she gathered information on how to implement a program that would best meet the needs of the organization in addressing health promotion of the clients at the center. A weekly Health Awareness Group (HA) had previously been established at the Cnter to attend to the need for health promotion as part of the treatment program, however clients and staff expressed dissatisfaction with processes around this program. There was a concern that the program was not evidence based, lacked structures such as a formalized curriculum and was not supportive of Department of Alcohol and Drug Abuse (DASA) regulations to which the WTC is responsible to adhere. Surveys of the nursing staff elicited that 90% of WTC nurses did not feel they had the necessary resources to effectively lead the HA. Clients expressed that the HA meetings were often chaotic and disorganized.

As Beth began to utilize this feedback to create a comprehensive strategy to improve these gaps, her program goal was to "increase self-management of health issues and positive lifestyle choices in women being treated on Residential Units 2 and 4 at the WTC." She utilized the Theory of Planned Behavior to guide the interventions. This theory was supportive because it stipulates that if a behavior change is desired, a change in the level of intention must be facilitated through the changes in the attitudes and beliefs about subjects norms and perceived behavioral control (Ajzen, 2001).

OBJECTIVES

Implementation of this program was done in multiple phases. Early inclusion of principles related to professional governance structures and behaviors helped propel the success of both nurse empowerment and client benefit in the program. The objectives for the program were:

- Create a nurse education committee to guide program development and to manage evaluation and sustainability of the program.
- Develop a standardized, evidence-based curriculum for use by nurses in already established weekly HA Groups.
- Formalize the Center's institutional structures supporting the HA Groups.
- Create evaluation tools for use as a part of a formalized evaluation plan.

OUTCOMES

All 10 nurses at the WTC completed surveys before education and curriculum roll out. In the pre-survey, only 10% of the nurses agreed that they possessed the knowledge and had adequate resources to lead the HA Group. Post survey elicited that 90% of them felt they had the knowledge and the resources to be successful. Nurses particularly discussed improved knowledge related to nutrition and chronic disease management.

36 client chart audits were conducted before program implementation and 33 were audited post program implementation for nurse observations of client behavior. The mean percentage of documented engaged clients compared with disengaged increased from 67% pre-program to 74% post-program. Some activities that highlighted this engagement were clients reading out loud, asking questions, speaking about the topic and/or participating in the activities. Pre- and post-tests were given each week of the HA program. Correct answers increased an average of 28% for the clients who attended the nutrition/infectious disease session; 90% for the 24 clients who attended the physical activity/chronic disease session and 43% for the 20 clients who attended the smoking cessation/substance abuse and the body session.

Because literature links engagement in health-promoting activities and continued recovery from substance use (Bradbury-Golas, 2013) and because regular health screening and health education lead to reduced drug use (Fareed et.al., 2010), it was imperative for a program like this to be developed at the WTC. A program may have failed and not made an impact if developed without the engagement of the clinical staff and administrators in professionally stimulating work. Beth's work to standardize, empower and advocate for the nurses at the WTC was the first step in impacting the overall health outcomes of the clients at the WTC. The curriculum content and activities directly met the unique needs and health promotion topics very uniquely needed in this vulnerable population. ROPH is proud to have had Beth's leadership in a community setting, improving nursing practice and patient outcomes and transforming healthcare for the better. Outcomes of this project were impressive and the WTC was very thankful to have had Beth contributing through her DNP in this capacity. ROPH

Ajzen, I. (2002). **The Theory of Planned Behavior.** *In van Lange, P.A.M., Kruglanski, A.W., & Higgins, E.T. (Eds.), Handbook of theories of social psychology (pp. 438-459). New York: Lawrence Erlbaum Associates.*

American Society of Hematology. (2016). **Anemia.** *Retrieved from:http://www.hematology.org/Patients/Anemia/*

Bradbury-Golas, K. (2013). **Health promotion and prevention strategies.** *Nursing Clinics Of North America, 48(3).*

CDC. (2016). **Hepatitis C FAQs for the public.** *Retrieved from: http://www.cdc.gov/hepatitis/hcv/cfaq.htm#cFAQ22*

CDC. (2016). H**IV in the United States: At a glance.** *Retrieved from: http://www.cdc.gov/hiv/statistics/overview/ataglance.html*

Centers for Disease Control and Prevention. (2016). **Reported STDs in the United States 2015: National data for chlamydia, gonorrhea, and syphilis,.** *Retrieved from: http://www.cdc.gov/nchhstp/newsroom/docs/factsheets/std-trends-508.pdf*

Healthy People 2020. (2016). **Respiratory diseases.** *Retrieved from:https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases*

Fareed, A., Musselman, D., Byrd-Sellers, J., Vayalapalli, S., Casarella, J., Drexler, K., & Phillips, L. (2010). **Onsite Basic Health Screening and Brief Health Counseling of Chronic Medical Conditions for Veterans in Methadone Maintenance Treatment.** *Journal Of Addiction Medicine, 4(3), 160-166.*

Kelly, P.J., Baker, A.L., Deane, F.P., Callister, R., Collins, C.E., Oldmeadow, C., Attia, J.R., Townsend, C.J., Ingram, I., Byrne, G., & Keane, C.A. (2015). **Study protocol: a stepped wedge cluster randomized controlled trial of a healthy lifestyle intervention for people attending residential substance abuse treatment.** *BMC Public Health 15(465).*

Weinstock, J., Barry, D., & Petry, N.M. (2008). **Exercise-related activities are associated with positive outcome in contingency management treatment for substance use disorders.** *Addictive Behaviors 33, 1072-1075*

IMPLEMENTING THE PROGRAM

PHASE 1 ESTABLISHING AN EDUCATION COMMITTEE

EDUCATION COMMITTEE FORMED
- 3 Nurses: 2 Frontline Nurses and 1 Clinical Coordinator

HEALTH AWARENESS CURRICULUM DEVELOPED
- Processes Secured
- Room Reservation
- Schedules so that units do not overlap

EVALUATION METHODS DEVELOPED
- Pre/Post Tests Created

ENGAGEMENT MEASUREMENT TOOL ADAPTED
- Adapted from Behavioral Observation of Students in School scale
- Helps to meet DASA requirements for individualized evaluation of clients during group sessions
- Nurse Survey Developed

PHASE 2 CREATING AN EVIDENCE-BASED CURRICULUM

CURRICULUM TOPICS:
- Week 1
  - Healthy Recovery (HR): Nutrition
  - Health Topic (HT): Infectious Disease
- Week 2
  - HR: Physical Activity
  - HT: Chronic Disease
- Week 3
  - HR: Nutrition: Health Literacy Frame
  - HT: Health Literacy
- Week 4
  - HR: Smoking Cessation
  - HT: Substance abuse effects on body and Stress

FORMAT OF CURRICULUM:
- Four, 90 Minute sessions per client
- 5 min: Introduction
- 5 min: Meditation
- 35 min: Healthy Recovery
  - Evidence Based: Healthy Recovery Program
- 45 min: Health Topic
  - Evidence Based: Content from CDC, NIH, etc
- Curriculum was color coded, included a thumb drive with power points and videos, laminated flip charts developed, printed sheets and activities included.

NURSE LEADER GUIDE
- Development of a detailed nurse leader guide helped promote a sustained, standardized program.

EVALUATION MECHANISMS DEVELOPED:
- Pre/Post Tests Created
- Engagement Measurement Tool Adapted
- Adapted from Behavioral Observation of Students in School scale
- Helps to meet DASA requirements for individualized evaluation of clients during group sessions
- Nurse Survey Developed

PHASE 3 EDUCATING NURSES AND ONGOING EDUCATION COMMITTEE MEETING

4-HOUR NURSE EDUCATION SESSIONS
- Introduction to Shared/Professional Governance
- Information on population assessment and program
- Standardization of Processes
- Detailed Orientation to New Curriculum
- Introduction to Engagement Scale Tool

PHASE 4 ADDRESSING INSTITUTIONAL SYSTEMS

- Via Nurse feedback several institutional systems that had been seen as challenging were reviewed, standardized and reconfigured as needed.

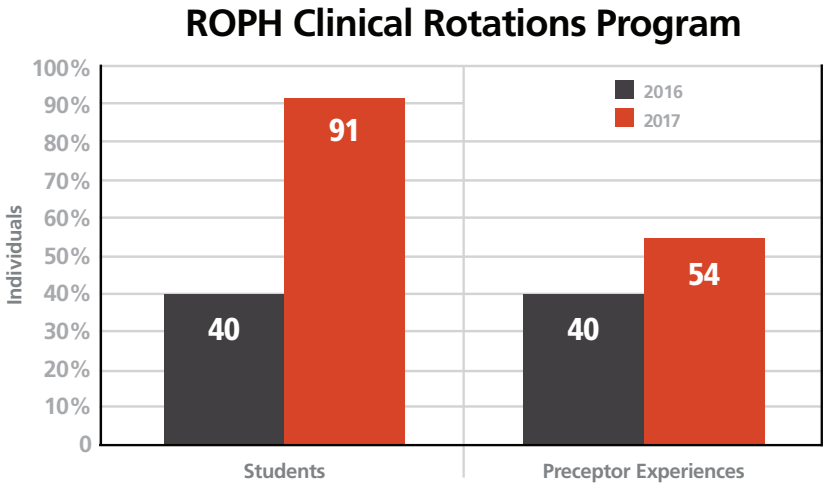
PHASE 5 SUSTAINABILITY PLANNING

- Nurse Education Committee Meetings scheduled for next year
- Executive Summary: Orientation and handoff of new program to new Deputy Director and other Key Stakeholders
- Program Evaluation Checklist Developed
- Communication line between Education Committee and Quality Department created
- Quality Reports "ordered" quarterly
- Client Satisfaction Results
- Length of Stay Results

GETTING AHEAD OF IT

STUDENT CLINICAL ROTATION MODEL

Many sources are documenting and predicting a nursing shortage. This impending shortage is multifactorial. Firstly, the shortage will be caused by a projected decreased supply of nurses in the workforce. This is due to the following reasons: 1. Nurses who may have naturally left the work force have remained during the economic instability in recent years, as those nurses retire, the artificial effect of their presence in the workforce will be evident, 2. Nursing schools report shortages in faculty and clinical rotations which lessens the profession's ability to prepare nurses and 3. There is an existent high attrition rate in nursing due to the demands of the profession- the average turnover rate across the country is approximately 17.2%. (Snavely, 2015; Nursing Solutions, 2015).



ROPH nurses take accountability for adequate nurse staffing in all clinical areas and have developed a strategic plan to prepare for this nursing shortage, both at ROPH and within the healthcare community as a whole. ROPH outperforms the national average for low nurse turnover rate and has worked diligently to achieve a current rate of 9% for 2017. While this retention positively impacts the staffing at ROPH, the goal of improving retention was aimed at preventing burnout and stress. Another opportunity for professional ownership to avoid

a nursing shortage lies with the preparation of increasing numbers of nursing students through partnerships with area colleges of nursing. "The preparation of an expanded workforce… will require… advances in the education of nurses across all levels… expanding nursing faculty, increasing the capacity of nursing schools, and redesigning nursing education to assure that it can produce an adequate number of well-prepared nurses able to meet current and future health care demands" (IOM, 2010; Macy, 2016).

In the past, ROPH had requests from numerous colleges of nursing for clinical rotations of varying types. Previous mindsets regarding these requests limited the amount of clinical rotations that ROPH would accommodate. Karen Mayer, the CNO, realized the link between clinical rotations and the preparation of future nurse employees for both ROPH and the nuring community was not being considered. In Spring of 2017, the Nursing Professional Governance Organization Executuve Committee led a new initiative to expand the number of clinical rotations that ROPH could accommodate and to greatly support the ongoing faculty shortage. The goal was for all clinical sites and shifts to maximize their contribution for preparation of new nurses. Throughout this new initiative, a strong collaboration with several area schools of nursing was established, namely, Rush University College of Nursing, Dominican University, Loyola University and Lewis University. Aside from placing prelicensure students, ROPH partners with schools to facilitate many doctoral level student projects and clinicals as well as post-licensure clinical nurse leader (CNL) students learning the CNL role as it is modeled at ROPH.

Through these various partnerships, ROPH has been able to participate in an advisory capacity to some of these schools, serving to help troubleshoot how they can accommodate a greater volume of students. Additionally, ROPH direct care nurses and unit leadership have given input through a series of meetings to ascertain what resources are needed to ensure accommodation of a greater volume of students.

To address these issues, two conference rooms were designated with lockers for student/faculty usage in the organization. Additional computers and workspaces were purchased for the units and directions about available parking were distributed. RN precepting of students education is being developed both within ROPH and through partnership with colleges. A ROPH point person has been assigned to be the liaison for both the colleges and the organizational needs. A rotation information sheet was created to be completed by the faculty and posted on each unit regarding the specifics and learning objectives of their groups. Feedback was given to the schools regarding the availability of off-shifts and increased preceptor availability if students were able to follow an individual RN schedule rather than a whole class placed on a unit on a set day and week.

Increased rotations on off-shifts, weekends and with preceptors is being realized. Perhaps one of the most valuable contributions that ROPH has made towards this program is the recruitment of nurses to be clinical instructors. Through negotiations with both ROPH HR and partner HR departments, ROPH RNs have the opportunity to work as an instructor for .1 or .2 FTE within their 1.0 or 0.9 without needing to have overtime hours during the semester. The partner college then reimburses ROPH for the instructor time and the RN maintains their benefits as a ROPH employee. This has incentivized a valuable pipeline of instructors to area schools struggling to find enough faculty.

ROPH is committed to ongoing pursuit of the preparation of the next generation of nurses. Please see graphic display of the increases made in only 2 years. ROPH leaders are seeking to proactively lead this initiative recognizing if all hospitals increased clinical site availability by 50%, the increased college enrollment might obliterate the pending RN shortage. The vision of ROPH nursing is to be a 24/7 nursing teaching facility that champions this concept and creates an excellent stream of nurses for the future. ROPH

IMPROVEMENT INITIATIVES

Some of the opportunities and changes have been made as a result of this ongoing initiative and growing partnerships.

ROPH IMPROVEMENT INITIATIVES/AREAS

FACILITY
- Conference rooms designed and designated for students with, lockers, refrigerator space for lunches, mobile computers, thermometers, seating, and parking.

PRECEPTOR
- Need for competency education regarding precepting students
- Availability for RN orientees

COMMUNICATION
- Notice of preceptor assignments so that no student shows up without planning
- Better understanding of which activities of patient care each group of students can safely perform.
- Clinical Instructor job role defined and developed
- RNs had interest in being faculty, but were deterred by the fact that they would lose their full time FTE status and thus have a benefits change- Karen Mayer advocated for HR to cover full FTE and have colleges reimburse ROPH for time as instructors.

PARTNER IMPROVEMENT INITIATIVES/AREAS

CLINICAL INSTRUCTOR
- Need to improve the matching of faculty to clinical area of expertise
- Instructor clinical experience may be dated
- Expand faculty knowledge and student experience of non-acute settings such as ambulatory and perioperative

ROPH RN EMPLOYEES AS FACULTY
- Full time benefits needed, only less than part-time positions available as clinical instructors.
- Not interested in working over 40 hrs/week as a second job.
- Onboarding education for clinical instructors varied and unstructured

SCHEDULING
- Colleges all seeking only Tuesday/Thursday day shift rotations, due to didactic content on other days
- Early morning didactic classes impede pm or night clinical scheduling
- Faculty not available to work off shifts or weekends
- Focus on inpatient care
- Students never experience full load of patients
- Students never experience reality of off-shift or weekend hours
- When organization is willing for 24/7 rotations, schools may have opportunity to alter teaching structure which will assist with increased volume of student prep through clinical rotations.

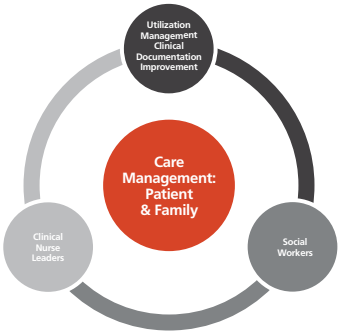
CONNECTORS IN CHIEF

CNL ROLE CHANGE CATALYZES THE TEAM & OUTCOMES

As presented in the past in Rush Oak Park Hospital (ROPH) Annual Reports from Nursing, the Clinical Nurse Leader (CNL) role has been integral to patient outcomes, staff engagement and interdisciplinary collaboration. The CNL role was originally piloted in 2012 on the Telemetry unit with a focus on the Congestive Heart Failure population. Initial success with Centers for Medicare and Medicaid core measure compliance relative to that population as well as a decreased readmission rate fostered replication in the ICU and on 6 West, another Medical Surgical Unit for other patient populations.

In 2015 and 2016, there was a movement within the Rush System for Health to redesign the Care Delivery Model relative to care management. A partnership between social worker and clinical expert care manager roles was established. This change, which was directed by NPGO based on the widespread success the CNLs had accomplished, initiated the formation of a separate unit for the CNLs at ROPH, under one Unit Director (UD), with matrix reporting to the Rush System for Health Care Management department and the Chief Nursing Officer. The creation of this unit allowed for the creation of standardized role competencies, education and metric responsibilities house wide so a comprehensive CNL Program could be established at ROPH. Denise Wienand was hired as the UD of the CNL Program in 2016 and the CNL structure was shifted to allow for at least one CNL to partner with one Social Worker (SW) per unit on care management needs. Karen Mayer, CNO, ROPH and the Unit Directors from each patient care unit partnered together to create a budget neutral CNL Program expansion. This partnership has been key to ongoing programmatic success as regular meetings between the unit management and CNL program leadership seek to find optimal ways to meet both the unit needs as well as organizational needs.

Under the direction of NPGO Executive and Education Committees, the CNLs assumed responsibility of housewide nursing-related educational programs and needs. It became evident that the CNLs were integral to many organizational initiatives. Each CNL was assigned as a support to various initiatives such as The Joint Commission Diabetes and Stroke certifications, ANCC Magnet Designation, NICHE Designation, IDPH Regulatory requirements, Colleges of Nursing Programs and Community Engagement, to name a few.



The CNL role does not detract from the expertise of any one discipline, rather they function as connectors between the disciplines and the patient's care plan, with an emphasis on improving patient education, outcomes and seamless coordina-

tion throughout the continuum. The CNL support the MDs for Core Measure compliance, transitions of care, advanced care planning and complex care planning. The CNLs connect with the RNs on quality metrics, education support, patient flow and patient education. The CNLs lead interdisciplinary rounds every day, reviewing complex and high utilizer cases on a daily basis, with participation from the entire interdisciplinary team. The CNLs connect with APNs both within the hospital and in the ambulatory or skilled nursing environment to assure safe transition or to divert unnecessary admissions. The CNLs communicate with ambulatory RNs and administrators to create better continuity of the patients care plan, to ensure follow-up appointments are made and to ensure the environment is safe when leaving the hospital.

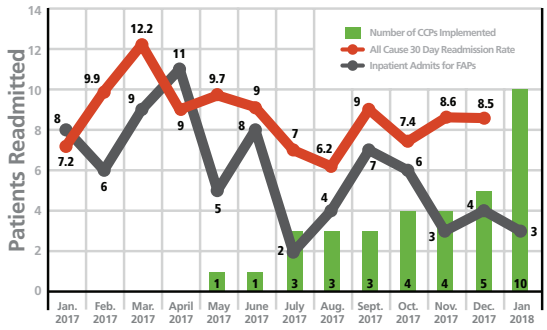
CNLs were added to other key areas such as the Emergency Department (ED), 3 center-orthopedic and medical surgical population, the Skilled Care Unit and Rehab units. With an emphasis on the CNL as partner to SW on every unit, the CNLs had to redefine their job description, associated competencies and attend specialized education. Some examples of the specialized education that CNLs have received are: Rush Leadership Academy, American Academy of Ambulatory Care Nursing (AAACN) Care Coordination and Transitions Management core curriculum, Milliman and Interqual education to assess best level of care, research competency modules to prepare the CNL group for institutional review board (IRB) usage and study, and National Incident Management System (NIMS) to prepare the group for disaster and emergency management.

One major initiative the CNLs have led is to develop, in partnership with the interdisciplinary team and Dr. Michael Silver, CMO, ROPH, the creation of complex care plans and high utilizer group plans to better meet the needs of the most complex patients. These plans function to guide intervention upon arrival to the ED to enact evidence-based care coordination strategies that troubleshoot the patient's ongoing physical, social, psychological or emotional needs. These have been successful at reducing the incidence of these patients' admissions so they are able to thrive in the community and at home more independently.

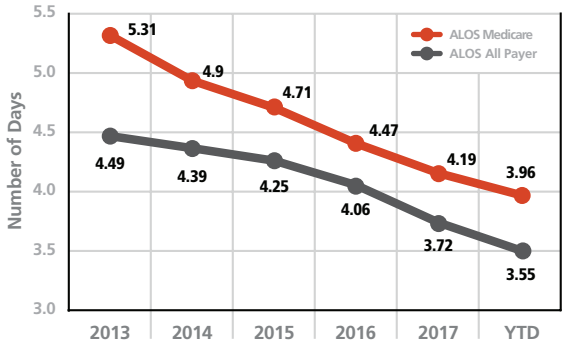
There are multiple other strategies within the CNL Program. A CNL-led admission process tracks outpatient goals and connects the team and patient with the overall care plan. The CNLs engage in discharge education both inpatient and outpatient. They engage in social determinant screening and meet weekly with SW to discuss outlier patients that are not meeting key benchmarks for care. They have developed several tools in the electronic medical record (EMR) to document their interactions with patients and staff, both inpatient and outpatient.

The CNL program scorecard reflects an emphasis on care coordination, education and organizational initiative support. They work to improve the 30-day all-cause readmission rate, decrease average length of stay, improve applicable quality indicators, enhance nursing staff engagement and interdisciplinary collaboration as measured in employee engagement surveys, and decrease observation case rates in the ED, improve efficiency of flow, communication and continuity throughout the organization. The CNL role has optimized interdisciplinary collaboration by functioning as a connector and advocate for the patients continuous provision of care across many clinical settings. They support staff via mentorship, real-time troubleshooting in the clinical setting and education. They are active in almost every organizational initiative at ROPH. Their energy is palpable and the benefit to our patients and staff is invaluable! ROPH

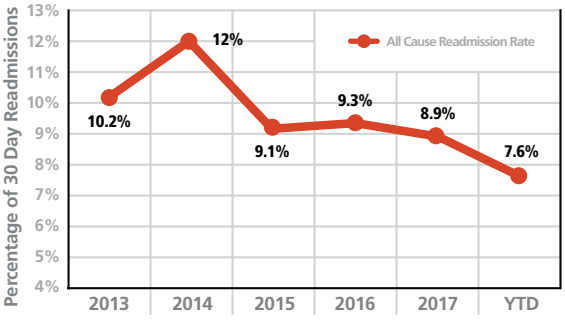
Complex Care Planning



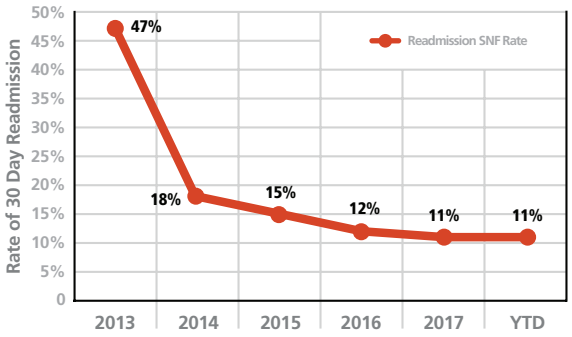
Average Length of Stay for All Payors & Medicare Patients



All Cause Readmission Rate



Readmission SNF Rate



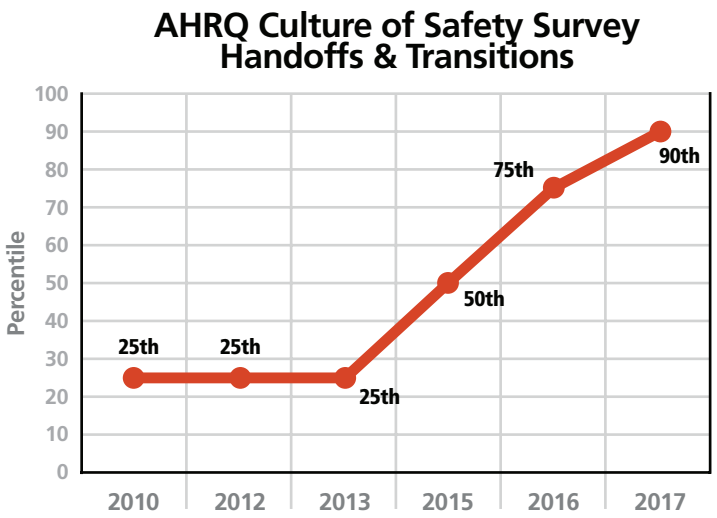
IMPROVING BEDSIDE HANDOFF

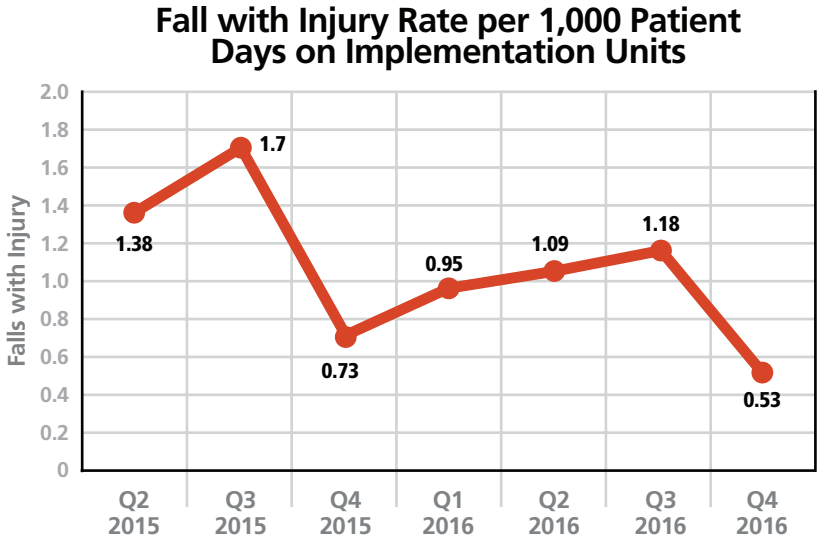
TRANSFORMING PATIENT SAFETY

Excerpts taken with permission from Cooper, A. (2017) Improving Patient Safety and Patient Satisfaction through Bedside Handoff. Rush College of Nursing DNP Presentation.

Transferring essential information about patient care is an integral component of communication in health care. Within healthcare organizations this is known as "handoff". Effective handoff supports the delivery of important safety and care coordination information from one caregiver to another so that the continuity of care can be seamless. The literature has been replete with examples of ineffective handoffs, especially during transitions, as they relate to increased adverse events and patient safety risks (Friesen, M., White, S., Byers, J. 2008). Angela Cooper, Director, Inpatient Nursing at Rush Oak Park Hospital (ROPH) sought advice and approval of the NPGO Executive Committee and unit UACs to study this important concept and seek improvements at ROPH as part of her Doctorate of Nursing Practice in Systems Leadership.

Angela utilized the Agency for Healthcare and Quality Research (AHRQ) Culture of Safety survey, performed yearly at ROPH, to measure impact of her project. Gleaning from the literature, she understood that staff perceptions of safety directly correlate with decreased adverse patient outcomes within the hospital environment (Huang, etal, 2010). With a focus on improving AHRQ Culture of Safety scores relative to staff perception of safety during handoffs, inpatient falls with injury rate, and a desire to increase the numbers of safety events reported as a reflector of a healthier environment, Angela put in place many important initiatives.

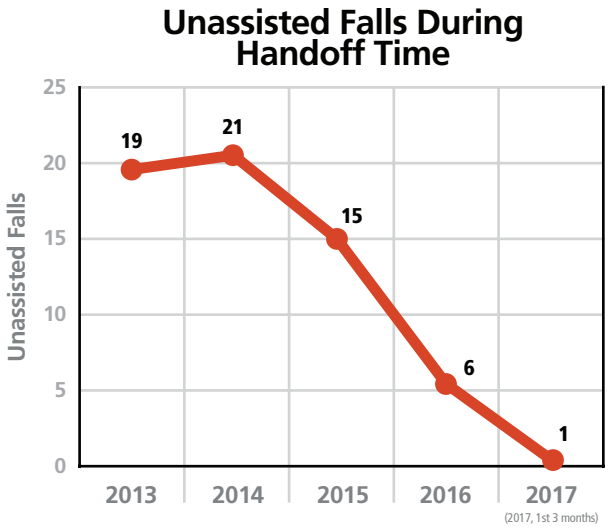




She reviewed the literature for themes that could guide her work. She found three themes that would have potential impact at ROPH: the importance of inconsistent communication, interruptions and bedside handoff formalization. With relation to inconsistent communication the literature described only 70-80% of information is documented in the electronic medical record (EMR), that inconsistent communication is linked to over 80% of adverse events and often times is the root cause of sentinel events (Popovich, 2011; Staggers and Biaz, 2013; TJC, n.d.) AHRQ and a variety of other sources discussed the fact that often errors occur as a result of interrruptions and that these errors can result in poor patient safety outcomes (AHRQ, 2015; Maughan, Lei and Cydulka, 2011; Spooner, etal, 2015). The literature was very supportive of effective bedside handoff as a means to improve patient safety and satisfaction, while also decreasing falls during change of shift and other adverse events throughout the rest of the shift (Radtke, 2013: AHRQ, n.d., Sand-Jeckin & Sherman, 2014; Kerr, etal, 2013; Rush, 2012).

Part of the planning for a focused improvement strategy aimed at improving patient safety through effective handoffs focused on meeting with stakeholders, surveys of staff relative to the topic of handoff, the development of a handoff process and comprehensive inpatient staff education related to that process. A standardized handoff flowsheet was created in the EMR and observations were performed of real-time handoff process. Ancillary departments within inpatient nursing received education as well.

Angela's project was implemented over the course of 2016 into 2017. Through Angela's leadership the 2017 AHRQ Culture of Safety Survey Handoffs and Transitions Section results increased to meeting the 90th percentile benchmark score. Historically, this score from 2010 to 2013 had remained stagnant at the 10th to 25th percentile, with some improvement in 2015 and 2016 up to the 50th percentile. This achievement underscores the important work that took place to engage staff in a solution, make that solution possible and standardize the process for sustainability. An indepth look at some of the questions in the safety handoffs



and transitions section showed some other important improvements. The question, "Important patient care information is often lost during shift changes "score was 55.6% in 2015, increased to 57.9% in 2016 and was 75% in 2017, moving the ROPH scores on this question from the 50th percentile to the 75th percentile. The question, "Shift changes are problematic for patients in this hospital" went from 47.1% in 2015 to 55.2% in 2016 to 75% in 2017, which moved the ROPH scores from the 50th percentile to the 75th percentile. Unassisted falls during handoff time decreased by 75%. Pre and post survey results showed internal staff perception of improvement of various handoff related activites.

The benefits of this project have impacted both staff satisfaction and patient safety. Subsequent to the outcomes achieved in the implementation units, Angela has worked to expand the project to an interdepartmental scope. She is seeking to include to procedural areas and implement within the direct admission process. We appreciate Angela's leadership, the leadership of NPGO and all the staff that contributed to this important culture of safety and patient safety initiative! ROPH

Agency for Healthcare Research and Quality. (2015). **Handoffs and Signouts.** *Retrieved from https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts*

Agency for Healthcare Research and Quality. (2015). **Hospital Survey on Patient Safety Culture.** *Retrieved fromhttp://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html*

Agency for Healthcare Research and Quality. (n.d.). **Nurse bedside shift report implementation handbook.** *Retrieved from http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy3/Strat3_Implement_Hndbook_508.pdf*

Friesen MA, White SV, Byers JF. (2008) **Handoffs: Implications for Nurses. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 34.** *Available from: https://www.ncbi.nlm.nih.gov/books/NBK2649/*

Huang, D. T., Clermont, G., Kong, L., Weissfeld, L. A., Sexton, J. B., Rowan, K. M., & Angus, D. C. (2010, April 9). **Intensive care unit safety culture and outcomes: a US multicenter study.** *International Journal for Quality in Health Care, 151-160. http://dx.doi.org/10.1093/intqhc/mzq017*

Kerr, D., Lu, S., & McKinlay, L. (2013). **Bedside handover enhances completion of nursing care and documentation. Journal of Nursing Care Quality, 28, 217-225.** *http://dx.doi.org/http://dx.doi.org.ezproxy.rush.edu/10.1097/NCQ.0b013e31828aa6e0*

Maughan, B. C., Lei, L., & Cydulka, R. K. (2011). **ED handoffs: Observed practices and communication errors. American Journal of Emergency Medicine, 29, 502-511.** *Retrieved from https://www-clinicalkey-com.ezproxy.rush.edu/#!/content/playContent/1-s2.0-S0735675709006263?returnurl=null&referrer=null*

Popovich, D. (2011). **Cultivating safety in handoff communication.** *Pediatric Nursing, 37(2), 55-60.*

Radtke, K. (2013, Jan-Feb). **Improving patient satisfaction with nursing communication using bedside shift report.** *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, 27(1), 19-25. http://dx.doi.org/http://dx.doi.org.ezproxy.rush.edu/10.1097/NUR.0b013e3182777011*

Rush, S. K. (2012, January). **Bedside reporting: Dynamic dialogue.** *Nursing Management, 43(1), 40-44. http://dx.doi.org/http://dx.doi.org.ezproxy.rush.edu/10.1097/01.NUMA.0000409923.61966.ac*

Sand-Jecklin, K., & Sherman, J. (2014, October). **A quantitative assessment of patient and nurse outcomes of bedside nursing report implementation.** *Journal of Clinical Nursing, 23, 2854-2863. http://dx.doi.org/http://dx.doi.org.ezproxy.rush.edu/10.1111/jocn.12575*

Spooner, A. J., Corley, A., Chaboyer, W., Hammond, N. E., & Fraser, J. F. (2015). **Measurement of the frequency and source of interruptions occurring during bedside nursing handover in the intensive care unit: An observational study.** *Australian Critical Care, 28(1), 19-23. http://dx.doi.org/http://dx.doi.org.ezproxy.rush.edu/10.1016/j.aucc.2014.04.002*

Staggers, N., & Blaz, J. W. (2013, Feb). **Research on nursing handoffs for medical and surgical settings: an Integrative review.** *Journal of Advanced Nursing, 69, 247-262. http://dx.doi.org/http://dx.doi.org/10.1111/j.1365-2648.2012.06087.x*

The Joint Commission. (n.d.). **Sentinel event data causes by event type 2004-2014.** *Retrieved from http://www.jointcommission.org/assets/1/18/Root_Causes_by_Event_Type_2004-2014.pdf*

SURVEY QUESTIONS	PRE-SURVEY (N=79)	PRE-SURVEY (N=79)
How many times are you interrupted during a typical handoff?	69% ANSWERED 2 OR MORE TIMES	52% ANSWERED 2 OR MORE TIMES
Do you feel that interruptions (during handoff) lead to errors in our current system?	65% YES	46% YES
Do you give handoff report at the bedside?	54% YES	92% YES
Following handoff report, do you feel that you have all the information that you need to take care of the patient?	68% YES	86% YES
Do you feel that giving report at the beside will improve/improves the care that you provide?	67% YES	78% YES

RESPONDING TO THE TRANSFORMATION OF HEALTH CARE

AMBULATORY ROLE GROWTH & NSI WORK UPDATES

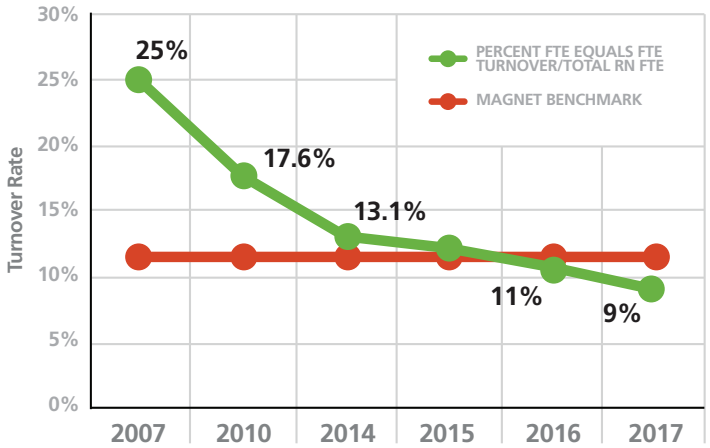
The American Academy of Ambulatory Care Nursing (AAACN) published a position paper on the Role of the Ambulatory RN in 2017. Underscoring the transformative change that is underway in healthcare where the focus on patient care is increasingly in the outpatient and community environment, this paper encouraged the empowerment and preparation of nurses in these settings. "Improving the health of our nation will require reframing our health care system from one that emphasizes acute, episodic, interventional care to one that engages patients and providers together, in health promotion, disease prevention and early intervention" (Bodenheimer, Bauer, Syer & Olayiwola, 2015) Ambulatory nurses work across the continuum of care, in many cases as the only nurse in each setting, and increasingly, they are managing complex patients with comorbidities and complex social determinants that make effective access to care problematic. "Ambulatory care RNs are well-prepared to assume an expanded role in the design and delivery of high quality care, defying traditional boundaries, while working in redefined interprofessional relationships, expanded community partnerships, and non-traditional health care settings"(AAACN, 2017).

Ambulatory RNs at Rush Oak Park Hospital (ROPH) and Rush University Medical Center are well positioned to care for this burgeoning, complex, aging patient population. They have been included and recognized in achievement of ANCC Magnet Designation for both organizations. The 2019 standards for ANCC Magnet designation have emphasized the need for evidence from a variety of new ambulatory settings. ROPH ambulatory nurses will be key in ongoing recognition by the American Nurses Credentialing Center. Beyond Magnet recognition, however, ambulatory nurses at ROPH are included in a culture of nursing excellence through ongoing practice management. Nursing Professional Governance Organization (NPGO) unit advisory committee meetings, representation on NPGO's Executive Committee and inclusion in the Rush System clinical ladder for ambulatory nurses encourages advancing education and certification along with project management, community outreach and leadership in their own clinical settings. Recently the Rush College of Nursing Clinical Nurse Leader masters program student was interested in the primary care setting. The student was able to obtain an immersion experience in the North Riverside Rush Oak Park Physician's Group office. ROPH is proud to support academic centers working to prepare future nurses for this emerging healthcare setting.

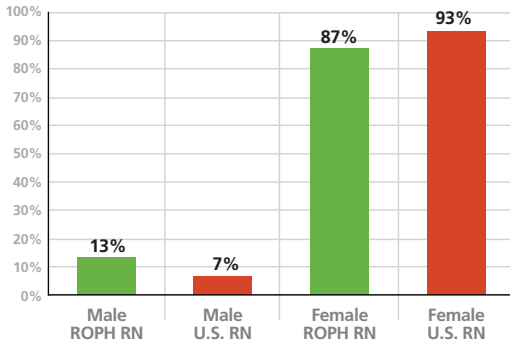
One ongoing national ambulatory initiative is that of the identification and development of Nurse Sensitive Indicators (NSI) for the ambulatory setting. Just as the inpatient setting developed NSIs over twenty years ago such as CAUTI, CLABSI, HAPU and Falls, the ambulatory setting is seeking to do the same to measure the important impact that nurses have on patients. ROPH has begun reporting NSIs for the ambulatory surgery areas and is included in the AAACN/CALNOC national pilot for it's primary care clinics. Both of these initiatives represent ROPH's continued trend of leadership within the nursing profession and it's ability to have a visionary response to the patient needs challenging healthcare around the world. ROPH

TURNOVER & DEMOGRAPHICS

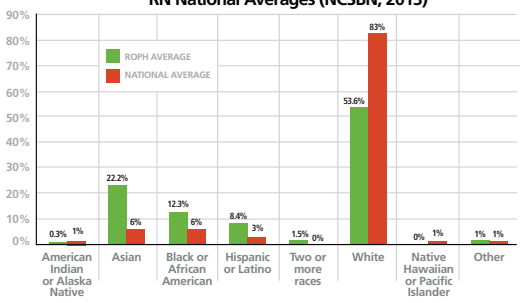
ROPH Journey to Retain Excellent Nurses



ROPH RN Gender Comparisons to U.S. RN Averages



ROPH RN Ethnicity/Race Compared to RN National Averages (NCSBN, 2013)



2017-2018

NURSING LEADERSHIP DEVELOPMENT & MENTORSHIP PROGRAM MENTEES

- Julie Griffiths
- Michelle Panock
- Elizabeth Hale
- Colleen Calhoun
- Colleen Chierici

ONGOING RESEARCH STUDIES

Catrambone, C. Illinois Emergency Department Asthma Surveillance Project. Multisite Study.

Mayer, K. Mealtime Difficulty Subjective vs Objective Assessment of Persons With Dementia in the Acute Care Setting.

M. Freitag and M. Heitschmidt, A Pilot Study of the Feasibility of Adapting CDC Surgical Site Infections and Multidrug Resistant Organism Incidence Measures to the National Database of Nursing Quality Indicators

M. Heitschmidt, Pet Pause: Impact of Pet Visitation on Hospital Workers

J. Sarazine, Mindfulness and Resilience for Nurses

M. Janik, Improvement of Inpatient Colonoscopy Preparation

B. Hatcher, K. Mayer, J. Grenier, Incivility Study

M. Browning, R. Start, L. Roberston, PNS Leaders, Interprofessional Shared Governance Index Study

D. Wienand, K. Mayer, CNL National Study

BEST PRACTICE DISSEMINATION

Hancock, B., Porter O'Grady, T., Mauer, M., Start, R. (2017) **AONE Dynamic Leadership for Shared Governance Conference Faculty Presentation.** *San Antonio, TX and Abu Dhabi, UAE.*

Jordan, A., Wienand, D. (2017) **A CNL Toolkit: Interventions to Ease Care transitions, Reduce Readmissions and Improve Satisfaction.** *IONL Webinar.*

Lavire, E., Schejbal, J., Wienand, D. (2017) **Strategies for the Clinical Nurse Leader in a Critical Care Setting to Improve Quality Measures, Patient Safety and Patient Satisfaction while Facilitating Care Transitions.** *CNLA Summit Podium.*

Mayer, K., Robertson, L., Start, R. (2017) **Engaging Millenials.** *ANCC Magnet Conference Podium.*

Mayer, Start. (2017) **Empowerment of Nurses through Professional Governance.** *Voice of Nursing Leadership Publication.*

Pavlak, D. (2016) **Automated Alerts Generated from Illinois' Extensively Drug Resistant Organism Registry Can Improve Awareness of Carbapenem-Resistant Enterobacteriaceae(CRE) Carriage at the Time of Hospital Admission.** *ID Week* 2016 Podium.

Start, Morin, Battaglia, Nelson, Sullivan (2017) **Registered Nurses Make a Difference with Ambulatory Care Nurse- Sensitive Indicators.** *Nursing Economics Vol. 35 No. 4.*

Start, R., Matlock, A., Brown,D., Aronow, H. (2017) **Ambulatory Nurse Sensitive Indicator Trends.** *CALNOC Podium.*

Start, R. (2017) **Magnet Trends regarding Ambulatory.** *Illinois Magnet Consortium Meeting. Lisle, Il.*

Start, R., Matlock, A. (2017) **Nurse Sensitive Indicator Updates Town Hall.** *AAACN Podium.*

Start, R., Brown, D., Matlock, A., May, N. (2017) **AAACN Preconference Presentation on Nurse Sensitive Indicators in Ambulatory.** *AAACN Podium*

Start, R., Morin, M., Matlock, A.. (2017) **Measure the impact of ambulatory nursing in a value-oriented health care system.** *World Health Care Congress Podium, Washington D.C.*

Start, R., Haas, S., Swan, BA. (2017) **Moving Nursing Forward: The Impact of Ambulatory Nursing.** *Rush NAA Nursing Networks Podium.*

Start, R., Matlock, A., Brown, D., Aronow, H. (2017) **Nurse Sensitive Value Measurement in Ambulatory.** *CALNOC Podium*

Start, R. (2017) **The Rapidly Shifting Paradigm: The Emergence of Ambulatory Nursing.** *IONL NC3 Webinar Presentation*

Hancock, B., Porter O'Grady, T., Mauer, M., Start, R. (2017) **AONE Dynamic Leadership for Shared Governance Conference Faculty Presentation**. *San Antonio, TX and Abu Dhabi, UAE*

Wienand, D., Start, R. and Mayer, K. (2017) **A Dynamic Duo: Transforming the Care Delivery System.** *ANCC Magnet Conference Podium*

Wienand, D. (2017) **The Role of the CNL. Society of Otorhinolaryngology and Head-Neck.** *Nurses 41st Annual Congress and Nursing Symposium Podium*

Wienand, D. (2017) **Care Delivery System Experts: A Unique Clinical Nurse Leader and Social Worker Team Approach for Achieving Better Outcomes.** *CNLA Summit Podium*

2015-2016

NURSING LEADERSHIP DEVELOPMENT & MENTORSHIP PROGRAM MENTEES

- Lauren Robertson
- Denise Wienand
- Annalie Wiltshire

BEST PRACTICE DISSEMINATION

Drum, K., Davis, K., Delaney, D., Gutierrez, E., Martenson, S., Quinn, B. (2015) **The Well Nurse.** *ENA Topic Brief. Institute for Quality, Safety and Injury Protection. 9-2015*

Gutierrez, E. (2016) **Meet me in Computed Tomography Suite: Decreasing Tissue Plasminogen Activator Door to Needle Time for Acute Ischemic Stroke Patients.** *JEN Online. VOl. 42: 1*

Gutierrez, E. (2014) **ENA Topic Brief: Compassion Fatigue.** *Retrieved from: https://www.ena.org/practice-research/Practice/Documents/CompassionFatigue.pdf*

Kleinpell, R., Lateef, O., Patel, G., and Start, R. (2015) **Caring for ICU Providers, Chapter 10, The Organization of Critical Care, Respiratory Medicine.** *18 DOE 10.1007/978-1-4939-0811-0_10, Springer Science +Business Media New York. Editors: D.C. Scales and G.D> Rubenfeld*

Martinez, K., Battaglia, R., Start, R., Mastal, P., Matlock, A. (2015) **Nursing-Sensitvie Indicators in Ambulatory Care.** *Nursing Economics. Jan-Feb 2015. Vol 33.No.1*

Mastal, Matlock, Start. (2016) **Capturing the Role of Nursing in Ambulatory Care: The Case for Meaningful Nurse Sensitive Measurement.** *Nursing Economics. Mar/Apr. 2016*

Matlock, Start, Brown, Aronow. (2016) **Ambulatory Care Nursing Sensitive Indicators.** *Nursing Management.6-2016*

Jordan, A., Mayer, K. and Start, R. (2016) **Behavioral Action Response Team (BART) Prevents and Responds to Workplace Violence.**

Martinez, K., May, N., Matlock, A., Start, R. (2015) **Establishing Ambulatory Nursing Sensitive Indicators.** *ANCC Magnet® Conference, Atlanta, Georgia*

Mayer,K., Arquilla-Maltby,L., Titze, J.& Start, R. (2015) **Coordinated Care Transitions Program: Advanced Practice Registered Nurses Enhance Care By Connecting With Patients in Long Term Care Settings.** *AONE National Conference, Phoenix, Arizona.*

Mayer, K., Evans-Bergman, C., Start, R., **Wound Care Clinic Benchmarkable Nurse Sensitive Indicators.** *AONE National Conference, Phoenix, Arizona.*

Mayer, K. **Subjective vs objective mealtime difficulty assessment in persons with dementia: A pilot study. Northwestern Hospital 7th Annual Nursing Research and Evidence-based Practice Symposium.** *Poster Presentation 3/2015*

Mayer, K. (2015). **Subjective vs objective mealtime difficulty assessment of persons with dementia in the acute care setting: A pilot study.** *Unpublished manuscript, College of Nursing, Rush University, Chicago, IL.*

Mayer, K. (2016). **Subjective vs objective mealtime difficulty assessment of persons with dementia in the acute care setting: A review of the literature.** *Unpublished manuscript, College of Nursing, Rush University, Chicago, IL.*

Mayer, K. (2016). **Subjective vs objective mealtime difficulty assessment of persons with dementia in the acute care setting.** *Unpublished manuscript, College of Nursing, Rush University, Chicago, IL.*

Morris, L., Bedon, A., McIntosh, E., & Whitmer, A. (2015). **Restoring Speech to Tracheostomy Patients.** *Critical Care Nurse 35 (6), 13-27.*

Start, Battaglia, Morin. (2016) **Nurse Sensitive Indicators for adaptation in the ambulatory care environment.** *Nursing Economics. Oct/Nov, 2016 Issue*

Start, R. Matlock, A.M., & Mastal, P. (2016). **Ambulatory nurse-sensitive indicator industry report: Meaningful measurement of nursing in the ambulatory patient care environment.** *Pitman, NJ: American Academy of Ambulatory Care Nursing.*

Weinand, D., Shah, P., Hatcher, B., Jordan, A., Grenier, J., Start, R. & Mayer, K. (2015) **Implementing the Clinical Nurse Leader Role: A Care Model Centered on Innovation, Efficiency, and Excellence.** *Approved for pending publication in Nurse Leader. 9/2015*

Start, R. and Nelson, D. (2015) **Taking the Lead: Creation of a Statewide Ambulatory Consortium to Advance Ambulatory Nursing Practice.** *AAACN National Conference, Orlando, Florida.*

Start, May and Morin. (2016) **Presentation to the American Nurses Credentialing Center's Commission on Magnet® regarding the state of Ambulatory Nurse Care Environment and associated available nurse sensitive indicators as well as recommendations to ANCC Magnet® Manual for 2018.** *Silver Spring, MD*

Start (2015) **"Engaging Staff in Shared Governance".** *American Organization of Nurse Executives Webinar*

Vasilj, A. (2015) **Improving Communication: Integrating Instant Notify in Nursing Practice.** *Teletracking Client Conference, Las Vegas, NV*

Wienand, D., Jordan, A., Schejbal, J. (2016) **A CNL Toolkit: Interventions to Ease Care Transitions, Reduce Readmissions, and Improve Satisfaction**

2014-2015

NURSING LEADERSHIP DEVELOPMENT & MENTORSHIP PROGRAM MENTEES

- Elizabeth Stewart
- Cristiane Bejarano
- Richard Auyeung
- Adam Spurlock

BEST PRACTICE DISSEMINATION

Cooper, A., Grenier, J., Hatcher, B., Jordan, A., Mayer, K., Shah, P., and Start, R., (2014) **Role of the CNL and Innovative Care Models.** *Illinois Organization of Nurse Leaders NC3 Committee Presentation.*

Maltby, L. (2014) **Improving Transitions Through Partnership Between Post-Acute Network and Academic Medical Center.** *Gerontological Advanced Practice Nurses Annual Convention.*

Maltby, L. **Palliative Care: Goals of Care Discussions and How to Put the Caring Back into Healthcare.** *Nursing Grand Rounds. Rush Oak Park Hospital.*

Maltby, L. (2014) **The Rush Coordinated Care Program.** *Nursing Grand Rounds. Rush Oak Park Hospital.*

Maltby, L. (2014) **Palliative Care and the Importance of Advanced Care Planning and Goals of Care Discussions.** *Case Management CNE. Rush Oak Park Hospital.*

Mayer, K. (2014) **Managing ED Throughput with an APRN Managed Fast Track.** *NC3- Illinois Organization of Nurse Leaders (IONL) & Metropolitan Chicago Healthcare Coalition (MCHC) Collaborative Webinar.*

Mayer, K. (2014) **The Road to Nursing "Systemness": Paved or Potholes.** *Gamma Phi Chapter of Sigma Theta Tau International & The Center for Excellence in Nursing Education Innovation and Scholarship (CENEIS), Rush University and again at Rush Oak Park Hospital, Podium Presentations.*

McIntosh, E., Morris, L., Whitmer, A. (2014) **The Importance of Tracheostomy Progression in the Intensive Care Unit.** *Critical Care Nurse. 34:40-48; doi: 10.4037/ccn2014722.*

Mcintosh, E., Morris, L., and Whitmer, A. (2013). **Tracheostomy Care and Complications in the Intensive Care Unit.** *Critical Care Nurse 33 (5), 18-30.http://ccn.aacnjournals.org/content/34/1/40.abstract*

Kleinpell, R., Start, R., McIntosh, E., Worobec. S. (2014) **Philanthropy as a Source of Funding for Nursing Initiatives.** *Nursing Administration Quarterly*

Start, R. (2014) **Owning the Future: Assuming Accountability for Leadership, Motivation and Health Promotion.** *Academy of Medical Surgical Nursing Chicago Chapter Symposium.*

Start, R. and Haas, S. (2014) **The Rapidly Shifting Paradigm: The emergence of ambulatory nursing.** *Illinois Organization of Nurse Leaders Annual Conference*

Start, R., and Mastal, P. (2014) **Town Hall: Report from Nurse Sensitive Indicator Taskforce and Facilitation of Discussion.** *American Academy of Ambulatory Care Nursing National Conference*

Start, R., May, N., Matlock, A. and Mastal, P. (2014) **Update from AAACN Task Force on Ambulatory Nursing Sensitive Indicators Presentation.** *American Academy of Ambulatory Care Nursing National Conference.*

Start, R. (2014) **AAACN Ambulatory Nurse Sensitive Indicators Task Force Update.** *American Academy of Ambulatory Care Nursing Viewpoint Publication.*

Start, R. Mcintosh, E., Catrambone, C., and Waskiewicz, M. (2014) **Promoting the growth and success of a shared governance organization: Lessons learned from 30 years of shared governance.** *American Nurse Today. Vol 8:11*

Start, R., Mayer,K., Reddy,T., Wilson, L., & Stewart, E.(2014) **Setting Best Practice: Realizing Synergy, Culture Change and Community Outreach**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