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2nd Annual Nursing Practice Preceptor Reception
Strong Receiving Its 2nd International Quality Designation for Nursing

Strong Memorial Hospital has been redesignated as a Nursing Magnet Hospital, the highest and most prestigious honor an organization can receive for excellence in nursing and quality patient care. The international quality nursing designation is awarded to only about five percent of hospitals in the country.

The American Nurses Credentialing Center, the largest nurse credentialing organization and a subsidiary of the American Nurses Association (ANA), unanimously approved the Magnet redesignation for Strong Memorial and the University of Rochester Medical Center.

Strong Memorial was first designated as a Magnet Hospital in August 2004, when it became the first hospital in the Rochester region to receive this recognition of nursing excellence. The redesignation highlights the work and accomplishments of the nurses at Strong and their continued commitment to continuously improve patient care and the health of the community.

“It was obvious that your organization has continued to grow and strengthen your programs over the past four years,” said Gail A. Wolf, DSN, RN, FAAN, chair of the Commission on the Magnet Recognition Program.

The redesignation comes after more than a year of extensive documentation and evaluation of the nursing programs at Strong. The American Nurses Credentialing Center studied almost 100 criteria in evaluating the quality of nursing.

The term “Magnet Status” originates from a group of 41 hospitals that were able to recruit and retain nurses during a national nursing shortage in the 1980s, thereby serving as a “magnet” for the profession. Strong was one of those original “reputational Magnet hospitals.”

Research has shown that Magnet-designated hospitals outperform their peers in recruiting and retaining nurses, vital activities, especially given projections that a national shortage of nurses will only get worse in the coming decade. Documentation shows that nurses at Magnet hospitals consider them good places to work, and the hospitals themselves have lower turnover and vacancy rates.

A study in the Journal of Nursing Administration found that Magnet hospitals are “infused with quality care, nurse autonomy, informal and non-rigid verbal communication, innovation, bringing out the best in each individual, and striving for excellence.” Research also has shown that high quality nursing creates a “halo” effect, making a hospital more attractive to nurses’ colleagues such as physicians. Researchers who have compared Magnet hospitals to other health care institutions have found that Magnet hospitals enjoy better outcomes, including lower mortality rates for patients. Likewise, patients and nurses alike report increased satisfaction. And nurses at Magnet hospitals perceive the care being given by their institutions as better.

The rigorous process of re-designation for Magnet Status began in 2007, when a group of nursing professionals formed a steering committee and started documenting the practice of nursing throughout Strong. Their analysis focused on 14 key nursing standards: assessment, diagnosis, identification of outcomes, planning, implementation, evaluation, quality of care and administrative practice, performance appraisal, education, collegiality, ethics, collaboration, research and resource utilization.

“When all of the documents and narratives were pulled together, we had more than 4,500 pages of best practices to submit,” said Stephanie Von Bacho, MS, RN, Magnet Project Director. “The quality of work done by nurses at our institution continues to set the standard for excellence in nursing care.”

Four nurse appraisers from American Nurses Credentialing Center and the Magnet Recognition Program visited for four days in October for a comprehensive review of Strong’s Nursing Practice. During their visit, the appraisers met with more than 800 nurses, physicians, employees in other disciplines, and the executive leadership. The team visited every nursing unit and toured other departments. They discussed Strong and Strong nurses with patients, visitors, health-care team members, and other employees.

“I am honored and privileged to work with such superb and professional nurses as we have here at Strong,” Patricia Wittzel RN, MS, MBA, Medical Center associate vice president and chief nursing officer at Strong.
The Magnet Ambassador Experience

Ten staff nurses had the opportunity to be “Ambassadors” for nursing during the Magnet site visit. These nurses were partnered with a Magnet Surveyor and served as host and guide during their stay.

Written by
Melissa Derlith, RN, BSN -
Magnet Ambassador, Level 2 Staff Nurse 6-16

The celebration of nursing excellence at Strong Memorial Hospital truly began on Oct. 27. A team of four appraisers and a fellow (appraiser in training) sent from the American Nurses Credentialing Center (ANCC) arrived and began their journey to experience why nursing at Strong ranks amongst the best nationwide. Over the four-day period, surveyors visited each and every patient care unit/area, and met with many hospital leaders. They were given the opportunity not only to listen, but also to question why we are worthy of Magnet status.

An individual from each patient area was selected to represent their unit. This “Magnet Champion” was asked to articulate why nursing is special on their unit and also to explain initiatives and projects underway.

Teamwork, opportunity for advancement, exceptional management, and caring staff members were among the answers unit champions gave to explain why nurses here love our jobs. Evidence-based practices, how research affects care, and what we do each and every day to improve our performance also were topics of conversation. Nurses throughout the hospital were excited to highlight the dynamic initiatives taking place.

Throughout the four-day visit we exemplified a professional, inspired, motivated team of individuals who share and work together to achieve the objectives set forth by our leaders. As a Magnet Ambassador, I not only had an opportunity to showcase my unit, I also had the unique opportunity to serve as guide for one of the members of the survey team.

Thank you to all who participated. The journey does not end here. Continue to strive for excellence each and every day. Our patients count on us.

Primary Ambassadors:
Cathy Snider, Senior Level III RN, Ambulatory
Katie Borchers, Level III, Pediatrics
Kurt Braselton, Level III, Psychiatry
Emily Showers, Level III, Cancer Center
Melissa Derleth, Level II, Med/Surg

Secondary Ambassadors:
Kim Chappell, Level III RN, Ortho Offsite
Lisa Jarman, Level II Cancer Center
Bess Griffin, Level II, Cardiovascular
Callie Toombs, Level II, Pediatrics
Annie Zimmerman, Level III, Pediatrics

Left to right - Ann Zimmerman, Kim Chappell, Cathy Snider, Kurt Braselton and Lisa Jarman

Melissa Derlith and Magnet Fellow Norine Watson

Katie Borchers and Kim Chappell
Transforming Care at the Bedside: Pressure Ulcer Prevention Made E.A.S.Y.

Mary Comerford, RN, MSN, FNP, NEA-BC
Cindy Berry, RN, BS
Linda Schmitt, RN, BSN

As of Oct. 1, 2008, the Centers for Medicare and Medicaid Services (CMS) stopped reimbursing Medicare and Medicaid certified hospitals for the additional costs associated with treating Stage III and IV hospital-acquired pressure ulcers that were not present on admission. During 2008, the Institute for Healthcare Improvement (IHI) medical/surgical group also assembled a Pressure Ulcer Prevention Task Force to develop an evidence-based pressure ulcer prevention program to reduce the number of hospital-acquired pressure ulcers to zero per 1,000 patient days.

At Strong Memorial Hospital, a multidisciplinary Pressure Ulcer Prevention Task Force was convened, with representation from several adult medical/surgical units, the Cardiovascular Center, nursing leadership, wound ostomy care nurses, nutrition, physical therapy, and value analysis. The task force began by reviewing the current literature and examining the hospital’s current pressure ulcer prevention guidelines. A standardized approach was developed, focusing on four interventions that have demonstrated the greatest success in preventing hospital-acquired pressure ulcers (eating, activity, staying dry, and changing the behavior of you, the provider - E.A.S.Y.). The interventions include optimizing nutrition, reducing friction, maintaining mobility, and managing moisture. Required interventions are listed for patients not meeting the desired goals under each component.

Nurses and patient care technicians on all medical/surgical units, 6-1400, 6-3400, Observation Unit 1, Observation Unit 2, the Cardiovascular Center, and 8-1200 were oriented to the process as part of the transformation plan. Each unit assembled a unit-based E.A.S.Y. Skin Care Team, which is responsible for weekly data collection, attending the E.A.S.Y. Pressure Ulcer Task Force meetings, and disseminating information and program changes to staff. The diagram to the left outlines the components of the program and serves as a resource for staff, with standardized interventions outlined for patients who do not meet the identified goals for each category. A modified program is being developed for patients in the Emergency Department, Post Anesthesia Care Unit, and the Strong Surgical Center.

Consultation was obtained from the Clinical Nursing Research Center to assist in the development of an audit tool to monitor compliance with the E.A.S.Y. Pressure Ulcer Prevention Program. Data are being collected weekly at the unit level and monthly compliance graphs are being created and shared with staff. In addition, data from the quarterly Pressure Ulcer Prevalence Study are reviewed to measure the effectiveness of the program.

The E.A.S.Y. Pressure Ulcer Task Force meets every two weeks to obtain feedback from staff, identify areas for improvement and develop action plans to improve patient outcomes. Since the beginning of the program in late August 2008, several patient care areas outside the medical/surgical service have expressed an interest in participating in this initiative. Future plans include making this program available to all patient care areas, assisting with program modifications as needed, streamlining the documentation process, and evaluating its impact on pressure ulcer prevalence.
Background

Antibiotic-resistant infections such as MRSA and VRE occur most frequently among patients who undergo invasive medical procedures or who have weakened immune systems and are being treated in hospitals and health care facilities such as nursing homes and dialysis centers. MRSA in health care settings commonly causes serious and potentially life-threatening infections, such as bloodstream infections, surgical site infections, or pneumonia.

In the case of MRSA, patients who already have an MRSA infection or who carry the bacteria on their bodies but do not have symptoms (colonized) are the most common sources of transmission. The main mode of transmission to other patients is by human hands, especially health care workers’ hands. Hands may become contaminated with MRSA bacteria by contact with infected or colonized patients. If appropriate hand hygiene and contact precautions are not instituted, the bacteria can be spread when the health care worker touches other patients.

People infected with antibiotic-resistant organisms are more likely to have longer and more expensive hospital stays, and may be more likely to die as a result of the infection. When the drug of choice for treating their infection doesn’t work, they require treatment with second- or third-choice medicines that may be less effective, more toxic and more expensive, according to the Centers for Disease Control.

The Role of the Safety Officer/Infection Prevention Liaison Nurse in Tackling this Patient Safety Issue

Last November, training began for the new role of Safety/Infection Prevention Liaison Nurses. This training helped us see there were opportunities to improve our clinical encounters with patients flagged for MRSA and VRE. In some areas, we lacked consistency in identifying these patients upon arrival for visits and instituting the required contact precautions. Opportunities for obtaining surveillance cultures were missed. We recognized we needed to get our hands around this problem.

Beginning January of 2008, Cindy Dennison, RN, Ambulatory Medicine Clinic, Corine Donals, RN, and Laura Kulikowski, RN, Outpatient Pediatrics, Suzanne Kolb, RN, Women’s Health Practice, David Clinton, RN, ID Clinic and the safety officers across all ambulatory care settings started working with their interdisciplinary teams to implement standardized practices for clinical interaction with patients flagged as having MRSA or VRE. Cindy initially met with all staff, including providers, at their unit Clinic Council meeting to discuss her role as the Safety Nurse and the implementation of the MRSA/VRE isolation and surveillance culture process. Staff were given additional educational sessions on MRSA/VRE including
In Ambulatory Care

a meeting with our Infection Prevention Practitioner.
All providers and staff were taught the proper isolation
procedures for MRSA and VRE. It was reinforced to staff the
proper use of gloves for MRSA and the use of gloves and
gowns for VRE with all direct patient contact. Proper hand
washing and the use of Caviwipes for cleaning the rooms
also was discussed.

As Ambulatory Medicine staff began to roll out the
program, it became clear that there also was a need for
patient education on VRE and MRSA. Patients, who
had been flagged for an infection from several years ago,
worried why we were now starting to check cultures and
use contact precautions when they came in for their
appointments. Patients were given handouts prepared by
the infection prevention liaison nurses on VRE or
MRSA, and educated on the process and rationale of the
surveillance cultures.

Here are some of the strategies the safety/infection
prevention liaison nurses have established in Primary Care
Medicine/Pediatrics and other ambulatory care settings:

- We began by adding the ICF flag to our
  encounter forms.

- Each day an APR (or other staff member) prints out
  the Encounter list of patients flagged for VRE or
  MRSA from IDX for that day.

- Clinical Technologists (or other staff member) highlight
  these flagged patients on the provider’s schedules.

- The Clinical Technologists have a list of flagged patients
  for the day at their workstation so they are able to
  implement precautions when the patient arrives.
  They are also able to check the encounter form
  which is coded for pt’s on precautions with either an
  O (ORSAR/MRSA) or an S (VRE).

- In some areas, from the daily MRSA list, staff began
  to enter a new problem of Penicillin-resistant Infection
  to our patient’s problem list in the outpatient electronic
  medical record.

- In Pediatrics, the nurses making same-day
  appointments were asked to be aware of the flagged
  status of a patient when scheduling an illness visits.
  The charge nurse was notified of a flagged patient’s
  appointment to add them to the daily list.

- The APR preparing the paperwork upon the arrival
  of these patients began highlighting the ICF flag on
  the encounter form.

- The Charge Nurse began placing a contact precaution
  sign, a completed lab requisition and a swab in with
  the patient’s paperwork. To make this possible,
  Pediatrics placed a hanging file near the charge nurse
  which contains laminated—precaution signs, neon
  pink MRSA+ labels, and double culture swabs.

- The precaution sign was attached to the door frame of
  the patient’s room to alert providers and other staff.

- Peds Providers now either swab or order swabbing of
  the patient for surveillance, having reviewed the
  microbiology section of the record for previous results.

- The safety nurses became the resource for providers
  and staff regarding MRSA and VRE, presenting in-
  services to the interdisciplinary team.

- In Women’s Health Practice, a new question block was
  added to the OB new prenatal intake electronic form
  “Infection History” in September 2008 to specifically
  address patient knowledge of ID status, and steps taken
  to address the issue. Their goal is to clear patients prior
  to admission for delivery.

- In the ID clinic, the interdisciplinary team has been
doing surveillance cultures and following up on them
for years. In 2008, the ID clinic periodically asked their
patients to audit the clinical staff’s compliance with
expected hand hygiene practices during the visit.

- In many areas, the safety nurses became the “go-
  between” encouraging providers to notify us of new
  patients with an antibiotic-resistant infection or
  patients with two negative surveillance cultures.
  We began calling ID to have them remove flags
  as appropriate.

- Having met with ID, unit clinical staff were educated
  on the proper practices to assist with timely cleaning
  the exam rooms upon discharge of patients with
  antibiotic-resistant infections, thereby decreasing exam
  room turn around time.

Initially, we did not know how many patients with
MRSA/VRE we had in our settings. We recently have begun
getting a report from Flowcast, our outpatient registration
system, that provides us that information retrospectively by
area on a monthly basis. For example, currently there are
106 patients with MRSA in Pediatric Practice, our primary
care clinic. To date, the staff has cleared 11 patients. For
Ambulatory Care Medicine, in January 2008, there were 160
patients flagged for either VRE or MRSA. As of November
2008, there were 110 patients flagged. This group has been
able to clear 38 patients off precautions. This number is
always changing as new patients are being added while others
are cleared.

As these initiatives continue with the communication and
collaboration of the interdisciplinary teams, we are moving
forward in our ambulatory care settings. We have increased
adherence to these best practice standards. Room down time
has been minimized. The staff’s involvement has been key to
the successes we have had. Staff are now identifying these
patients and are eager to do the right things to prevent the
transmission of these infections. According to Ms. Donals,
“The cry for “safety nurse” and the question that follows is a
daily occurrence. And it is music to our ears.”
Have you seen Dixon and Jean? They are high-fidelity SimBaby® mannequins, and the two newest members of the Pediatric Simulation Team. With a very generous donation from Dixon and Jean Gannett last year, Golisano Children’s Hospital at Strong was able to purchase the two mannequins as well as two medium-fidelity Megacode Kid© mannequins.

The use of simulation in health care education has been a mainstay for many years, but mannequins provided little feedback and interaction for the learners. In the past few years, technology has improved so that higher-fidelity mannequins now can perform a myriad of functions including breathing and breath sounds, receiving IV fluids, real-time vital signs on a monitor and even talking (or crying in the case of Dixon and Jean). Essentially, they create a very realistic environment where nurses and physicians can practice the management of acute-care situations without putting patient safety at risk. In addition, the entire practice session is video-recorded so that debriefing and review of the events can occur easily.

Running the simulation program is an interdisciplinary effort involving nurses, physicians, and technical support. Dr. Elise van der Jagt, a pediatric critical care physician, began the URMC Pediatric Simulation Program last year after a sabbatical investigating this educational modality and serves as its Director. Pam Hensel, a pediatric critical care nurse and now one of the simulation faculty at the School of Nursing, has worked for many years with Dr. van der Jagt in the area of resuscitation. Given her extensive experience in running monthly pediatric mock codes in the Children’s Hospital, she was a logical choice to represent nursing. Dr. Caren Gellin, one of the Children’s Hospital’s former pediatric chief residents, joined us during the summer and is a Simulation Instructor and the Pediatric Simulation Program Coordinator. Finally, there is invaluable technical support from David Leven and Eric Rynerson from the Office of Educational Resources.

Since simulations are interdisciplinary in nature, specific learning objectives for each simulation session are uniquely tailored to both nurses and physicians. Each month there are four sessions for inpatient nursing and medical staff, including cardiac, respiratory, and shock scenarios, with an emphasis on teamwork and communication. Last spring, SimBaby© was used for videotaping scenarios for Pediatric Pain Education Day for Pediatric Nurses. The video continues to be used to facilitate discussion during the pain lecture taught by Kathy Rideout in Pediatric Nursing Orientation. In addition, simulation scenarios using SimBaby© have recently been integrated into pediatric nursing orientation.

With Dixon and Jean on board, pediatric simulation has become a reality and has paved the way for a future of innovative health care education at the Golisano Children’s Hospital.
I’ve always thought that abstracts and research papers are for those with more education and better ideas than I have. Last winter, when my friend led me to a Research Grand Rounds on “Writing the Perfect Abstract”, I thought at the time that I had better things to do and figured that the contact hours would be the one thing I would get from it. I was completely wrong. I listened to Diane Mick, PhD, RN, FNAP outline how to develop an abstract and it sounded easy! I actually perked up and took notes.

I realized while I was listening to the presentation that many of us working in the Emergency Department (ED) think of new ideas to try as we struggle, at times, with overcrowding and boarders. I thought to myself “There are a million things we could put out there”. As a result, I walked away from that meeting with much more than those contact hours.

I decided to give writing an abstract a try. I chose one of the ideas we were currently trying in the ED and made that fateful appointment to discuss my idea with Gail Ingersoll, EdD, RN, FAAN, FNAP, Director of the Clinical Nursing Research Center. Gail began our meeting by asking me which conference I would like to attend to present my work. I had no clue! I just wanted to write an abstract and say that I had done it. I had no idea I would actually submit it to a national conference. We did some online searching and decided to submit a poster abstract for the 2008 Emergency Nurses’ Association (ENA) Annual Conference in Minneapolis. Gail downloaded the specifics from the ENA website, and then told me all I would need to write was a one page outline of the idea for my abstract. I laughed as I walked away from her office. I thought “One page to be accepted by the annual ENA conference?” I decided that at least this was a learning process I could apply towards school. I submitted my page to Gail and Diane. Two hours after I turned in my paper via email I got it back with some suggestions for revisions. I made the revisions and then submitted it to the ENA through their website. I received an email kindly thanking me for my submission and letting me know that within 4 months I would receive notification of my acceptance or denial.

March 2008 arrived and with it an invitation to present a poster at the ENA Annual Conference. “Stunned” doesn’t even describe what I was thinking. I only wanted to write an abstract. What was I going to do for a poster presentation?

I emailed Gail and Diane without even thinking. Along with congratulations, I was encouraged to come down to Diane’s office to discuss putting together a scientific poster. The meeting went well, and I walked away thinking again “That’s it? That’s all I have to put on a poster?” Diane guided me through how to assemble a poster, how to order a poster draft from the University Copy Center, what to do about taking handouts and business cards to the conference, and how to transport the poster safely. Diane brought up things I didn’t even know I should have been asking about. It was very comforting to know someone had been through this before and was happy to help me out.

I attended the ENA Conference and presented my professional poster with confidence. As a result of the topic displayed on my eye-catching poster, I met many new colleagues who were interested in my work related to TEDI Nurses (Trauma-ED-Intensive Care Unit [ICU] nurses). Several senior nursing colleagues from the conference encouraged me to publish my work. I was overwhelmed by the thought of taking on that beast. Upon returning home I ran into Diane in the hallway. I mentioned the publishing idea as a joke and she said the Research Center could help me with that too. I’m now in the process of creating a manuscript.

Abstract thinking? No problem with people like Gail Ingersoll and others in the Research Center available to show you the way. I would do it again, and I wouldn’t even need the incentive of contact hours to encourage me to attend those Grand Rounds.
In October, the University of Rochester Medical Center received its second Medal of Honor from the U.S. Department of Health and Human Services for our efforts in organ and tissue donation and transplantation. The medal, awarded for a greater than 75 percent donor conversion rate, is given annually at the National Learning Congress on Donation and Transplantation. Additionally, the Finger Lakes Donor Recovery Network (FLDRN) received the Medal of Honor for a greater than 10 percent donation rate after cardiac death.

The National Learning Congress on Donation and Transplantation began in 2003. The annual meeting presents best practices and patient stories to a national audience of organ procurement organizations (OPOs), donor hospitals and transplant centers. URMC has been participating in the Learning Congress since its inception and was represented this year by Rich Padula and Bill Sainsbury from the FLDRN, Nancy Freeland and Tara Sacco (donor hospital representatives) and Pat Milot and Tedd Vineyard (transplant center representatives). Those who attend the conference are able to collaborate with local, regional and national representatives to improve the care of our organ and tissue donors and recipients by sharing best practices, bold offers and bold requests.

The Medal of Honor represents the hard work and dedication of the staff involved in organ and tissue donation at URMC. For the past 18 months, a multidisciplinary Donor Council, co-chaired by Nancy Freeland and Dr. Robert Holloway, has met monthly to identify areas for improvement and develop strategies to meet the nationally set benchmarks. The Donor Council has developed and implemented Catastrophic Brain Injury Guidelines to assist clinicians in caring for potential donors. A checklist for determination of death by neurological criteria, SH 1036, was revised to include confirmatory testing and some pediatric parameters. Another Donor Council initiative was the revision of the SMH Policy 5.1, Determination of Death, to clarify who could complete the checklist and to incorporate Department of Health regulation changes related to donation after cardiac death donors. The Donor Council now is working on integrating the recent New York State Donor Consent Registry guidelines into existing policies.

A sub-committee of the Council, the Organ and Tissue Donation Workgroup, was formed under the guidance of Nancy Freeland. This group includes nursing representatives from the six adult critical care and progressive care units, the pediatric intensive care unit and the emergency department, as well as a representative from the FLDRN and the Rochester Eye and Tissue Bank (RETB). Recently, the Kessler Family Burn Trauma Unit has developed a unit-based organ and tissue donation committee.

In the next year, the various council and committee members will continue to strive for excellence in organ and tissue donation. The Medal of Honor will be displayed on the 8th level and BTICU. Additional activities planned include celebration of Donate Life Month in April, raising of the Donate Life Flag, the FLDRN Donor Service Area 2nd Annual Mini-Collaborative and various other community activities. For information on care of the donor and donation activities, visit the organ and tissue donation link on the Adult Critical Care Web site. Remember, one donor can save up to eight lives!

**URMC Donor Council Members**

Nancy Freeland, Co-chair  
Dr Robert Holloway, Co-chair  
SMH Administration Representatives  
Nursing representatives from ED, OR, adult and pediatric ICUs  
Physician and Provider representatives from ED, ICUs, Ethics, Palliative Care, Neurology, Neurosurgery, Anesthesia, & Transplant Surgery  
Respiratory Therapy  
Finger Lakes Donor Recovery Network (FLDRN)  
Executive Director, Procurement Coordinators, & Hospital Development Specialist  
Rochester Eye & Tissue Bank (RETB) Representatives  
Chaplain Services  
Laboratory Services  
Social Work Services  
Pharmacy Service
Left to right: Bill Sainsbury (FLDRN), Tara Sacco (SMH), Nancy Freeland (SMH), and Rich Padula (FLDRN)

**URMC Organ & Tissue Donation Workgroup Members**

Nancy Freeland - Chair
Michele Smits - FLDRN
Nancy Eckerd - FLDRN
Gary Guiste - FLDRN
Bob Bray - RETB
Tara Sacco - BTICU
Mary Cole - BTICU
Luba Fingerut - CVICU
Gretchen Bernstein - MICU
Alycia Onderdonk - SICU
Mark Ott - Pulmonary Step-down/ICU
Florence Ndongwa - Surgical Step-down /ICU
Leah Allen - Emergency Department
Valerie Cansdale - PICU

**BTICU Organ and Tissue Donation Committee Members**

Jamie Richardson
Mary Cole
Tara Sacco
Tammy McClung
Sarah Zea
Crystal Flight
Brent Snipes
Anne Dowdell
Sarah Leathersich
As you all know, the Professional Nursing Council (PNC) is Nursing Practice’s Shared Governance Model at Strong. PNC is the avenue for decision making and change throughout nursing. Staff representatives from each nursing unit meet once a month to discuss important topics such as professional development, safety, research, finances, patient and nurse satisfaction, and much more. We continue to strive to report all of the information to Nursing Practice, and to each nursing unit.

Thank you to everyone who participated in the Magnet Redesignation Process. From collecting information, to writing documents, to demonstrating excellence through our site visit, everything was a success. We received Magnet re-designation in January 2009.

A special thank you to the Magnet Unit Champions; their hard work and dedication shined through during the unit visits. Staff were energized and confident when speaking about unit initiatives. Words like “research” and “performance improvement” were heard throughout the hospital!

Please look for upcoming information regarding the Professional Image Committee. See additional information in an article in this newsletter. Thanks to all for your help through the pilot and survey. Staff recommendations were made to the Professional Nursing Council.

Look out for upcoming PNC events. National Nurses’ Week and Community Service offerings are just some of the exciting projects we’re working on! The Council is always looking for new members to work on these exciting projects and seeks representation from every service. Please see Cathy Snider if you are interested in learning more.

The Professional Nursing Council is proud to announce the election of our 2009 officers. Cathy Snider from Ambulatory Service’s Internal Medicine Clinic has been elected Chair of PNC. Ann Zimmerman from Pediatric Service’s Adolescent Unit has been elected Vice Chair and Kristen Moulten, RN, BSN, has been elected secretary. Please congratulate and welcome our new Chair and Vice Chair into their roles.

Thank you to all of the Professional Nursing Council members for your hard work and dedication. Please see your Unit Representative, or e-mail us with any questions or an interest in joining the Council.

Thank you,

Katie Borchers, RN, BSN
Cathy Snider, RN, BSN
Chair, Professional Nursing Council
Vice Chair, Professional Nursing Council

A note from Katie:

Thank you to everyone for a wonderful two-year term as your Professional Nursing Council Chair. It has been an honor and privilege working on projects and participating in events with you. Our Shared Governance model has an incredible power to make change in Nursing Practice, and I have learned so much through the facilitation of these initiatives. Thank you to the Professional Nursing Council for all of your hard work, innovative ideas and enthusiasm; your dedication to making positive change in Nursing Practice is commendable.

Thank you especially to my 4-1600 home and Jeanne Kirby, the Professional Image Committee, the Financial Accountability Council, Pat Witzel, Dan Nowak, Cathy Snider, and Stephanie Von Bacho. Your support has been amazing!
Submitted by: Lisa A. Brophy, MS, RN, NEA-BC

After the successful pilot of Clinical Documentation in January 2008 on 5-3400 and 5-1600, all adult and cardiovascular general care in-patient units (Medical/Surgical, Cardiovascular, Cancer, and Ob-GYN nursing services) have successfully transitioned to documenting electronically in the Clinical Documentation system. The patient data now documented by these areas includes:

- Admission History or Adult Interdisciplinary Risk Screen
- SMH 423
- Shift assessments or physical assessments
- Vital signs
- Intake and output
- CIWA or Clinical Institute Withdrawal Assessment for Alcohol
- Patient Education or SMH education record
- Progress notes

Tips and Reminders for those using Clinical Documentation:
- Remember there are certain characters that CANNOT be used when documenting in CIS. They include:

@ ~ _ \ { } | $ ^

Future rollouts . . .
- An electronic SBAR and pre-operative checklist have been developed and tested and will be rolled out in early 2009!
- The pediatric team has been assembled and is currently working on building pediatric documentation screens.
- 5-1200 will include a multidisciplinary approach. All services will transition to the electronic record!

Changes to our policy include visibly displaying your role “ID pull tag,” wearing scrub tops and/or scrub jackets in clinical areas where it is appropriate, and updating business casual guidelines for applicable staff.

Again, thank you for all of your hard work. We have had tremendous participation through the Professional Image Committee members, staff who took part in the pilot, and the many staff who completed the survey.

Katie Borchers,
on behalf of the Professional Image Committee
The 2nd Annual Leadership Internship class completed work in August of 2008. The goal of the year long internship is to provide an opportunity for staff nurses to examine leadership roles in nursing, prepare staff nurses for leadership roles at the bedside and develop leadership skills in nurses interested in future management and administrative roles. Participants attended monthly classes, had an opportunity to shadow nursing leaders and completed an evidence based leadership project.

Sixteen nurses participated in the 2007-2008 internship. Five teams were formed. Each team identified a project focus. Working with a project mentor and using the tools and skills learned through the internship, each team developed a poster abstract to present their work and findings.

1. Mentoring: Dean Chatfield, Doug Diver, and Patty McNichols.
   This group explored whether having an identified mentor has an influence on retention of new nurses at Strong Memorial Hospital. The investigation points to encouraging a formal mentoring program. Findings included increased job satisfaction and comfort in asking questions that lead to improved learning.

2. Navigating Transitions into Leadership: Kurt Braselton, Sharon Maddock, Ann McCarthy, and Kate Ostrander.
   This group looked at role expectations of new leaders and its correlation to retention in the position. The project gained insight into the common stressors Nurse Leaders experience during the initial adjustment to a leadership position. Time to learn and receive support was a major need for new leaders.

3. Communication: Ginny Towle
   This project looked at improving communication, collaboration and team work between all areas of perioperative services by instituting a shared governance model.

4. The Buzz . . . Staff Perceptions about Cultural Diversity: Jake Blaydes, Amy Chmielewski, and Cassidy Mincer.
   This group evaluated the implications of the cultural mismatch of our nursing force with our patient population. They were interested in whether nursing employees recognized this discrepancy and if they believed they were delivering culturally appropriate care.

   This group explored the benefits and barriers of nursing certification. The project included a thorough review of the certification process and recognition of certification at SMH and HH. The final step included benchmarking of findings with other nursing programs.

Congratulations to all participants on successful completion of the internship!
Katie Borchers, RN

OVERVIEW: Nursing is a wide-open field of possibilities. We, as nurses, have many career opportunities that can influence care at many different levels. But even as we seek different levels of nursing care, the knowledge and skills of a bedside nurse influence and guide us through our nursing practice. An interview with Sharon Martinez provided this insight. Her career has spanned from the bedside to the Director of Web Technology.

Sharon Martinez describes herself as self-driven. Gazing at her CV, a person could not be convinced otherwise. This member of the National Association of Women Business Owners (NAWBO), with a masters in Nursing Administration from Villanova University, portrays that the only setback in her career steered her into a new passion.

Beginning her career as a medical/surgical nurse who moved on to her love for cardiac critical care, Sharon eventually decided teaching was for her. After teaching burn care and cardiac care, Sharon later became a Director of Cardiac Care Nursing, and later a Director of Operations. This is the point Sharon encountered a setback that would change her path; she gave birth to her third child and was stressed with her work and family responsibilities.

Sharon then turned to consulting on health care management, a 10-year path. She worked helping companies comply with drug and alcohol regulations, writing policy manuals. She stresses the importance of believing in your self, and that thinking outside the box led her to this opportunity and new direction.

Sharon and her family moved and she joined the Marketing Department at the University of Rochester Medical Center, working on its Web site for consumers. From here she became the Director of Internet Marketing and in 2006 the Director of Web Technology, working on Web development.

Sharon believes she influences patient care by helping patients to be more informed. On the URMC Web site, patients can gather information about doctors, and make their experience better.

“Take a risk” is Sharon’s advice. How else could a nurse become manager, director of operations, consultant, VP, chief executive officer, and director of Web technology? Sharon’s career gives nurses the confidence to use their nursing skills to help people in an entirely different way.

KUDOS

Cindy Lucieer, RN, BSN, CAPA

Cindy has been elected to NYSPANA (New York State Perianesthesia Nurses Association) this year. Cindy is currently the SSC Unit Educator.

She has been a NYSPANA Chapter #14 member since 2001. She organized and hosted the NYSPANA State Conference in Rochester twice and it was a very successful.

She is an excellent leader and enjoys her leadership role. Under her leadership, Chapter 14 grew in membership and is a very active organization offering conferences. We congratulate Cindy and we are proud of her success and achievements.

Judy Sarglis-Sears, RN, BS, CPAN

Judy was elected Vice President for NYSPANA this year. She is currently a Post Anesthesia Care Unit RN.

Judy has been a very active member of Chapter #14 and she has held many committee positions. She is also a member of ASPAN (American Society Perianesthesia Nurses).

Judy has been a very valuable member of Chapter #14 and we congratulate her and are proud of her achievements.

Judy also served as member of exam construct and item writing committee for ABPANC for last 7 years.
The 2nd Annual Preceptor Reception was held at Mario’s Italian Steakhouse on October 22. More than 200 preceptors and new hires attended. This year we recognized outstanding preceptors from each service. They were presented with a certificate and a $25 gift certificate for the bookstore. The recipients were:

Ambulatory
Cancer Center
Cardiovascular
Critical Care

Kate Sheppard from Radiology
Mary Nebbia from 412
Michelle Rector from 714
Morgan Murphy from 328

Emergency Dept.
Med/Surg
OB/GYN
Pediatrics
Perioperative
Psychiatry

Ilse Rueckmann from Obs 1
Sue Coveny from 514
Jan DeMarco from 614
Jamie Martin from 414
Cindy Kelly from the 2nd floor OR
Pat Kenney from 390

The success of our new hires is directly reflective of the remarkable nurses who serve as preceptors. Thank you to all nursing staff and preceptors for your incredible hard work in supporting our new staff members!!