2012
MISSION HOSPITAL
NURSING ANNUAL REPORT
TABLE OF CONTENTS

Nursing Excellence Through:

Leadership .................................................................................................................................................. 4
Empowerment ............................................................................................................................................. 6
Professional Practice .................................................................................................................................. 15
New Knowledge, Innovations and Improvements ...................................................................................... 19
Empirical Outcomes .................................................................................................................................. 23

OUR BIG(GER) AIM

To get each patient to the desired outcome, first without harm, also without waste and with an exceptional experience for the patient and family.

All five Mission Health System Hospitals are united in achieving Our BIG(GER) Aim and collaborate in system-wide specialty councils to achieve this vision. Although this report focuses on Mission Hospital nurses, the four member hospitals’ nurses participate in similar initiatives. They are part of the system teams focused on improving health in western North Carolina by establishing standardized approaches to patient care based on current evidence, best practices, and national standards. Be sure to read the messages from the four member hospitals’ executive nurse leaders in the insert of this report, where their respective nursing staff’s 2012 accomplishments are highlighted.

Angel Medical Center, Franklin, NC
Blue Ridge Regional Hospital, Spruce Pine, NC
McDowell Hospital, Marion, NC
Mission Hospital, Asheville, NC
Transylvania Regional Hospital, Brevard, NC
Dear Friends and Colleagues,

The role of nurses in healthcare is changing at a rapid pace. There is much activity at the national and state levels to allow registered nurses and advanced practice registered nurses to practice to the full extent of their education and training.

At Mission Health we have embraced this by changing our care delivery model to incorporate certified nursing assistants (CNAs) as partners in patient care. By utilizing CNAs, we are allowing our nurses to focus on those patient-care activities required by their licensure. In addition to freeing up our nurses from tasks that can be delegated, we also redesigned the nursing documentation tool IView so that nurses can spend less time at the computer and more time at the bedside.

As we approach 2013, there will be great emphasis on developing standards of care across our health system so that the patient experience will be the same at each of our facilities. At the center of this initiative are nurses and nurse leaders from each of our member hospitals. It will be a tremendous opportunity to learn from one another as we incorporate best practices.

Mission Hospital and Mission Health are fortunate to have an incredible nursing staff whose focus is providing safe, effective and high-quality care for the patients and families of our region. It is a privilege to be in the midst of such great caregivers.

Kathleen Culhane Guyette, MSN, RN, NEA-BC
Senior Vice President of Patient Care Services
Mission Health
Dear Colleagues and Friends:

Since August 2012, I have enjoyed the distinct honor of serving as the Chief Nursing Officer at Mission Hospital. I have learned about many exemplars of nurses and other caregivers who give their very best so that our patients have an exceptional experience without harm or waste. In September, we celebrated the results of our successful Joint Commission visit. Congratulations on your work and efforts to achieve this amazing outcome!

Our frontline staff participated in value stream mapping across our hospital in areas such as the Emergency Department, sterile processing, surgical services, endoscopy, acute care services, psychiatric services, pharmacy and radiology, to name a few. Patients, families, staff and physician partners worked to improve efficiency that gave time back to our caregivers to spend with our patients.

Patient safety officers led interdisciplinary teams working closely with our physician partners and other team members to address patient safety events (PSE). This group of nurse leaders demonstrated outstanding clinical leadership and commitment to nursing excellence.

As a profession, nursing faces many challenges, including a nursing shortage, increasing complexity of care, shifts in payment models and an aging patient population. Mission Hospital nurses are uniquely poised to meet the demands of healthcare reform and help create the future state for the patients and families we serve. We have an exciting opportunity to create a more patient-centered, healing environment. I welcome you to engage on this journey of excellence with me!

Karen Olsen, MBA, BSN, RN, NE-BC
Vice President and Chief Nursing Officer
Mission Hospital
EMPOWERMENT

Councilor Model

Bedside nurses and nurse leader mentors compose the hospital-wide shared decision-making councils. The councils provide a voice and involvement for nurses at the point of direct patient contact. In 2012, the Nursing Informatics Council became the first hospital-wide shared decision-making council to expand system-wide across all five hospitals of Mission Health.
HOSPITAL-WIDE COUNCILS

Nursing Informatics Council

Chair:
Karen Payne Ward, MSN, RN, Nursing Informatics Specialist (January-May)
Karen Moseman, RN, MSN, CNML, Interim Manager, Nursing Informatics (June-December)

Co-chair:
Heather Martin, BSN, RN, Cardiology Intensive Care Unit

Leadership Mentor:
Rhonda Robinson, RN-BC, ONC, CNML, Director, Orthopedics, Neuroscience, and Spine Unit (April-May)
Jill Jones, MHA, BSN, RN, NE-BC, Director, Medical/Surgical Critical Care (June-December)

From May to October 2012, the Nursing Informatics Council (NIC) worked to streamline the IView nursing computer documentation. Members of NIC, which comprised bedside nurses from all five hospitals of Mission Health, met weekly with informatics staff for three hours over 12 weeks to gather information, review necessary changes and serve as the clinical decision maker in the redesign.

The average number of IView documentation bands was reduced from 19 to 14, making it easier for staff to find specific charting categories. Documentation workflow improved for the Emergency Department triage area; Obstetrics triage and Mother/Baby; Neonatal Intensive Care Unit; PeriAnesthesia Care Units; and Pediatrics. There was also improved Interdisciplinary Plan of Care (IPOC) integration with IView documentation.

The project work teams improved nursing documentation and nursing satisfaction with charting. Several bedside nurses commented that the redesign made documentation “easier,” “more efficient,” and gave them “more time at the bedside with my patients” (as much as one hour). Another nurse said, “It changed my life!”
**Nursing Night Council**

*Chair:*
Deborah Taylor, BSN, RN, Staffing Pool (January - March)
Liz Allen, RN, CCRN, Cardiovascular Recovery Unit/Intensive Care Unit (April - December)

*Co-chair:*
Liz Allen, RN, CCRN, Cardiovascular Recovery Unit/Intensive Care Unit (January - March)
Hannalie Lindsey, RN, PCCN, Cardiovascular Progressive Care (April - December)

*Leadership Mentor:*
Mary Harmon, BSN, RN-BC, NE-BC, Director, PeriAnesthesia Care Units

*Facilitator:*
Tina Barnes, MSN, RN, NEA-BC, Manager, Professional Nursing Practice

The Nursing Night Council (NNC) made a difference in 2012 for their patients and co-workers. The council requested and obtained 460 illuminated computer keyboards for 30 units across the hospital. This allows nurses to chart at night without turning on lights that disturb their patients.

Other projects the NNC completed were the extension of cafeteria hours at night by one hour to allow night staff longer access to hot foods; the request of box lunches for patients after regular hours; implementation of consistent on-call flexing guidelines across the hospital and the policy for floating guidelines.

**Nursing Practice Council**

*Chair:*
Melanie Goodwin, RN, CCRN, Coli Intensive Care Unit (January - August)
Christi Britt, BSN, RN, CCRN, Cardiovascular Intensive Care Unit (September - December)

*Co-chair:*
Sarah Rambo, BSN, RN, CMSRN, Women’s Surgical Unit (January - August)
Ann Marie Hammond, BSN, RN, Cath Lab (September - December)

*Leadership Mentor:*
Jill Jones, MHA, BSN, RN, NE-BC, Director, Medical/Surgical Critical Care (April - June)
Rhonda Robinson, RN-BC, ONC, CNML, Director, Orthopedics, Neuroscience and Spine Unit (July - December)

*Facilitator:*
Tina Barnes, MSN, RN, NEA-BC, Manager, Professional Nursing Practice

The Nursing Practice Council (NPC) worked to improve and standardize nursing practice across the hospital in 2012. The council projects included standardization of clinical practices and safety measures for small volume intermittent infusions to ensure complete volume delivery of antibiotics to the patient; for suction canister and tubing changes to ensure better patient outcomes and decrease costs; and for improvement in visibility and tracking of dermal medication patches. The council provided support to departmental and unit best-practice committees and assisted new committees with development and recruitment in their effort to improve communication and dissemination of best practices hospital-wide.
Liz Allen, Tina Barnes and Hannalie Lindsey (left to right) of the Nursing Night Council pause while evaluating the new illuminated keyboards.
Nursing Professional Development Council

Chair:
Lisa Clark, MSN, RN, CPAN, Nurse Educator, Nursing Professional Development (NPD)

Co-chair:
Joy Brooks, BSN, RN, CEN, CBIS, Nurse Educator, NPD (January-December)
Lucy Beard, BSN, RN, CMSRN, General Surgery (July-December)

Leadership Mentors:
Carol Jackson, MHS, BSN, RN, Director, Nursing Support Services (January-December)
Regina Phelps, PhD, RN-BC, NEA-BC, Executive Director, Nursing Education and Research, Mission Health (January-July)
Suzanne Beyea, PhD, RN, FAAN, Director, Center for Nursing Excellence, Mission Hospital (August-December)

Facilitator:
Darlene Schleider, MSN, RN, CCRN, Nursing Education Specialist, NPD (August-October)
Karen Lundberg, MSN, RN, Nursing Education Specialist, NPD (November-December)

The council organized the Celebrating Nursing Excellence through Certification event held on March 19. An oasis station for massages, yoga, tai chi, biofeedback, Healing Touch and music therapy, plus door prizes, posters, gifts and personalized letters of appreciation from President and CEO Dr. Ronald Paulus, President and COO Jill Hoggard Green, PhD, RN, and VP and CNO Kathleen Culhane Guyette, MSN, RN, NEA-BC, were included as part of celebrating our certified nurses.

On September 18, the group sponsored an Education Fair open to all Mission Health staff. Representatives from more than 15 universities and colleges provided information about nursing and non-nursing programs, including LPN to RN, CNA to RN, accelerated BSN, RN to MSN, RN to DNP, health information tech, dialysis tech, surgical tech, CNA and phlebotomy. Human Resources gave resource information, and Integrative Healthcare staff were available for Healing Touch and seated massages. The College Foundation of NC and The College Network presented funding information.

The group continued to sponsor the Clinical Ladder program for professional development of registered nurses that recognizes and rewards nurses for clinical excellence. The work of the nurses who advanced in the program helps achieve a high standard of care delivery in pursuit of our B1G(GER) Aim.
**Advanced Practice Nursing Council**

*Chair:*
Jodi Yaver, PNP-BC, Mission Children’s Specialist

*Leadership Mentor:*
Ginny Raviotta, MN, RN, NE-BC, Director, Women’s and Children’s Services

Cindy Benton, FNP, Neurology Services, a member of the Advanced Practice Nursing Council (APNC) and previous chair of the council, served as an elected non-physician provider representative for the Mission Medical Associates Physician Leadership Council (PLC). She also served as the advanced practice nurse representative on the Medical Administrative Committee (MAC) of Mission Hospital.

Representation of advanced nurses in physician groups fosters a more collaborative practice and emphasizes the contributions that advanced practice registered nurses can make in primary and tertiary care.

**Nursing Research Council**

*Chair:*
Kristy Stewart, MS (N), RN, ONC, Orthopedics (January-September)
Cheryl Postlewaite, MSN, RN, CWOCN, Wound Therapy (October-December)

*Co-chair:*
Kathleen Genito-Tamaray, MSN, RN, CCRN, Cardiovascular Intensive Care Unit (January-August)
Christine Conrad, BSN, RNC-OB, Labor and Delivery (October-December)

*Leadership Mentor:*
Karen Olsen, MBA, BSN, RN, NE-BC, Vice President and Chief Nursing Officer (January-July)
Jodie Becker, MHA, MSN, RN, CCRN, NE-BC, Director of Cardiovascular Surgical Services (August-December)

The Nursing Research Council (NRC) approved nine nursing research studies in 2012, including issues related to noise reduction, care delivery model change, a revised case-management orientation program, progressive mobilization, and post-operative nausea and vomiting. In addition, nurses in the Women’s and Children’s Services launched nine research studies, participated with Mountain Area Health Education Center (MAHEC) physicians in two large multicenter studies, and had a continuation of four national registries for research.

The group organized the Research Fiesta on May 8. Nurses presented poster and podium reviews of their research studies and evidence-based practice projects. Throughout the year, more than 15 posters were accepted and displayed at national conferences, such as the American Organization of Nurse Executives (AONE), Nursing Teaching Institute (NTI), Society of Gynecologic Nurse Oncologists (SGNO), and the Association of Women’s Health Obstetric and Neonatal Nurses (AWOHNN).
NRC began work to expand the policy for presentation and publication of evidence-based practice and research projects to broaden the scope to system-wide with guidelines for responsible and ethical actions and delineation of the approval process. The policy, to be completed in 2013, will provide information and requirements related to authorship, appropriate credit and recognition for active participants, steps in the approval process, and upholding of professional integrity.

**Nursing Administrative Council**

*Chair:*  
Kathleen Culhane Guyette, MSN, RN, NEA-BC, SVP and CNO (January-July)  
Karen Olsen, MBA, BSN, RN, NE-BC, VP and CNO (August-December)

The Nursing Administrative Council (NAC), comprising directors, managers, other nurse leaders and other departmental leaders, met monthly as a communication strategy to disseminate and discuss information related to ongoing initiatives and change implementations.

Environmental services, laboratory, pharmacy and Biomedical Engineering, who partner with nurses in providing healthcare, brought suggestions, questions and issues to NAC. In addition to nursing quality initiatives, such as prevention of infections, falls and pressure ulcers, other topics that were reported and discussed included patient record documentation, IV infusion pumps, stocking medications in Pyxis, cleaning rooms on patient discharge and value stream mapping.

**Nursing Quality Council**

*Chair:*  
Lindsey Moon, RN, General Surgery (January)  
Kristy Stewart, MS(N), RN, ONC, Orthopedics (March-December)  
*Co-Chair:*  
Kristy Stewart, MS(N), RN, ONC, Orthopedics (January-February)  
Kathleen McGowan, RN, Neurotrauma Intensive Care Unit (August-December)  
*Leadership Mentor:*  
Linda Anderson, MSN, RN, Director, Adult Medical Surgical Units  
*Facilitator:*  
Monica Ridgeway, MHA, BSN, RN, CPHQ, Nursing Quality

The Nursing Quality Council (NQC) worked to improve the quality of care provided to our patients. Council members collaborated with Information Technology regarding two important computer documentation processes to decrease the workload of lab test order entries and reduce missed labs and improve communication and safety in patient handoffs. The resulting
documentation changes automatically defaulted blood collections to lab or nurse draws based on the patient’s unit location and added essential elements about the patient’s condition to the Nursing Communication Page.

In the interest of reducing waste, the council’s work on a nursing productivity/non-value added time project changed from active development to review with the advent of value stream mapping projects that would include their topics. They reviewed quarterly National Database of Nursing Quality Indicators (NDNQI) reports to learn and share areas of needed improvement with their colleagues.

**Nursing Governance Board**

*Chair:*
Kathleen Culhane Guyette, MSN, RN, NEA-BC, SVP and CNO (January-July)
Karen Olsen, MBA, BSN, RN, NE-BC, VP and CNO (August-December)

*Co-chair:*
Jeanie Bollinger, BSN, CCRN-CSC, Cardiovascular ICU (January-July)
Rosemary Rice, BSN, RN, CAPA, Asheville Surgery Center (August-December)

*Facilitator:*
Ginny Raviotta, MN, RN, NE-BC, Director, Women’s and Children’s Services

The Nursing Governance Board (NGB), consisting of direct care nurses, chairs of the hospital-wide shared decision-making councils and other nurse leaders, met monthly to communicate and discuss the work projects of each council. This central council afforded bedside nurse leaders direct collaboration with the chief nurse leader. The group gave the NGB Nursing Excellence Award to seven nursing and non-nursing staff members throughout the year for their work’s contribution to nursing excellence at Mission Hospital.
Janet Ray, RN-BC, and Anita Camaron, LPN (standing left to right), involve a patient and family member in bedside report.
PROFESSIONAL PRACTICE

Bedside Report at Shift Change

In the summer of 2012, nurses across the hospital moved shift change report from the nurses’ station to the patient’s bedside. Patient safety and greater patient involvement in their plan of care was the goal of implementing a structured approach to communicating important information. The manager, staff and nursing unit supervisors of 8 North played a key role in the hospital-wide rollout. Their successful pilot and previous adoption of bedside report gave them the experience to provide education to other units at staff and shared decision making meetings.

Bedside report promotes a culture of safety to reduce patient harm and supports sharing of information, questions and suggestions. A patient’s involvement can lead to less anxiety, better compliance with their plan of care and overall increased satisfaction with their care. Several patients and their family members provided positive feedback about bedside report, including “Bedside reporting makes me feel like I am involved with my mom’s care,” “I love seeing both of my nurses at the same time,” “Looking up at the goals on the whiteboard helps keep me on track,” and “It (bedside reporting) shows good teamwork.”

Institute for Healthcare Improvement Intensive Care Work Team

Mission Hospital collaborated with Institute for Healthcare Improvement (IHI) in quality initiatives to improve clinical outcomes, patient safety and patient satisfaction. One IHI team focused on patient care in the Adult Intensive Care Units (ICU) and worked toward full implementation of the ABCDE bundle of critical care that minimizes use of sedation, resulting in reduced ventilator days as well as decreased ICU and overall hospital length of stay. The ABCDE acronym refers to:

A = Spontaneous Awakening Trials [sedation holiday];

B = Spontaneous Breathing Trials;

C = Coordination [multidisciplinary rounds] and Choice of Medications;

D = Delirium Assessment;

E = Early Mobilization

Improvements were introduced in rapid Plan-Do-Study-Act (PDSA) cycles with feedback from staff to guide further changes. Patient care process standardization across the ICUs contributed to the statistically significant decline in ventilator days and ICU length of stay in all five ICUs. Such outcomes translate to quicker recovery times for our patients, a faster return to their families and communities, and a decrease in costs.
Teamwork and the Nursing Care Model

Over the past two years, Mission Hospital’s nursing care delivery model evolved to include more certified nursing assistants (CNAs). This initiative allowed nurses to spend more time with the patient providing care as regulated by their licensure. More CNAs were hired to collaborate with nurses in performing care and tasks that could be delegated.

Classes were developed and implemented throughout the year to enhance the skills and confidence of CNAs within the new model. Teamwork, communication and quality patient care were emphasized. Possible barriers to effective teamwork were discussed, and a positive, friendly attitude was encouraged. Mutual respect, trust and courteous appropriate delegation were identified as integral elements in the success of the care delivery model.

The orthopedics floor adoption of the new model required adjustments by all nursing staff. The changes and implementation process to fill vacated RN positions with CNAs was discussed with the nurses. In the beginning, nurses were hesitant about the model and whether they could manage all their responsibilities with an increased patient load.

As CNAs were hired, the unit’s shared decision-making team met and developed a staffing plan that helped both nurses and CNAs. The decision was made to assign RNs four to five patients on day shift and five patients on nights. Each CNA was assigned to work with two RNs, giving them a workload of eight to 10 patients. The assignments proved manageable.

The change proved effective, and nurses reported being extremely happy with the CNA support. The RNs, who initially felt the increased assignment would be too much, recognized the value of the CNAs’ help. Having extra caring and competent staff to meet patient needs provided more timely care and improved the patient and family experience.

ACE Geriatric Unit

The Acute Care of the Elders (ACE) innovations unit opened in March 2012 on 8 North, St. Joseph campus. ACE is a model of care designed to address the specific needs of hospitalized older adults, to improve clinical outcomes by preventing functional decline and other complications prevalent in hospitalized elderly patients. The care of patients on the unit focused on functional independence, an interdisciplinary team approach, patient- and family-centered care, and discharge planning to the least restrictive environment. The dedicated staff who have geriatric expertise concentrate on the patient’s level of functioning, specific treatment of diagnoses common to older adults and an integrated planning of discharge to maximize clinical outcomes.

Criteria for admission require each patient to be 70 years old or older, community-dwelling and ambulatory prior to illness and hospitalization. The goals of the ACE unit are to prevent, identify
and manage geriatric syndromes; involve the patient and family in goals of care; discharge back home; coordinate hospital and transitional care from the day of admission; and round at the bedside every day with the interdisciplinary team. Among the expected patient outcomes are improved functional performance and an increase in discharges home with fewer readmissions and less mortality. Less delirium, a reduction in the use of inappropriate medications, less time spent in the hospital, and decreased healthcare costs are also expected benefits.
Micah Sedillos, Child Life Specialist, engages a young patient with a medical puppet.
NEW KNOWLEDGE, INNOVATIONS AND IMPROVEMENTS

Research studies and evidence-based practice are the foundation of nursing’s pursuit of new knowledge and best practices to facilitate high-quality patient care. Development of improved and innovative ways to provide excellent care leads to increased efficiency and better outcomes for patients and their families. Here are some examples of research, innovations and evidence-based projects at Mission Hospital during 2012.

Medical Puppets—Mission Children’s Hospital

Interdisciplinary teams at Mission Children’s Hospital started two research studies in 2012 that involve the use of medical puppets for therapeutic play. Since play is the primary language of children, medical puppets give them the opportunity to act out their feelings as they face unknown tests and treatments in an unfamiliar environment. They can examine organs and practice starting IVs on the puppets, plus have their family members participate in pretend procedures. A grant from the DAISY Foundation provided for the purchase of four therapeutic play puppets.

The study focused on the inclusion of siblings in therapeutic play for children with cancer or autoimmune diseases and included children in our hematology/oncology service in both the inpatient and outpatient areas. The children were prepared and offered the opportunity to do medical play with the puppet before having their port accessed or during dressing changes. If siblings were present, they were included in the play.

The study explored whether having a sibling present in the play had any effect on the anxiety levels of the patient. Data collection will continue in 2013. The research team includes Kim Delk, BSN, RN, CPN, Manager of Pediatrics, the Child Life Specialist Team and Mary Ellen Wright, MSN, APRN, CPNP, Nurse Researcher, Women’s and Children’s Health, Mission Hospital.

The second study was funded by the Association for Medical Imaging Management and Toshiba’s Putting Patients First Program grant and focused on pediatric imaging and therapeutic play. The data collection phase will extend into 2013 and includes children undergoing magnetic resonance imaging (MRI) and the use of therapeutic play with puppets and video goggles to decrease the need for sedation and lessen the time of the procedure. The study uses the Pediatric Perioperative Anxiety Scale to measure anxiety levels of the children undergoing MRI.

The research team is a collaborative effort among Pediatric Radiologist Dr. Burdette Sleight, Certified Child Life Specialists Amy Fisher and Amy Waters of the Reuter Outpatient Center of Mission Children’s Hospital, and Mary Ellen Wright, MSN, APRN, CPNP, Nurse Researcher, Women’s and Children’s Health, Mission Hospital.
Research Study—Postoperative Delirium

“The Effect of Postoperative Delirium on Outcomes after Cardiac Surgery” was the research study by Ralph Francis Mangusan, MSN, RN, RN-BC, PCCN, CWCN, Cardiovascular Progressive Care, and Vallire Hooper, PhD, RN, CPAN, FAAN, Manager, Nursing Research, Mission Health. This study assessed the relationship between the development of postoperative delirium after cardiac surgery and the following outcomes: length of stay after surgery, occurrence of falls, discharge to a skilled nursing facility/rehabilitation center/long-term acute care, discharge to home with home healthcare, and utilization of inpatient physical therapy. Electronic medical records of 656 cardiac surgery patients were reviewed retrospectively. Postoperative delirium was identified among nearly 25 percent of the participants.

Those without delirium experienced significant outcomes: shorter length of stay after surgery, decreased occurrence of falls, fewer discharges to a skilled nursing facility/long-term acute care/rehabilitation center, fewer discharges home with home healthcare, and fewer needs for inpatient physical therapy.

Patients who develop postoperative delirium after cardiac surgery are more likely to develop poorer outcomes. To improve the postoperative course of those at risk for and those who develop postoperative delirium, the development and implementation of an extensive care plan to address this condition is necessary.

Research Study—Patient Education and Warfarin Therapy

Rebecca L. Barber, MSN, RN, BSAH, PCCN, Patient Educator, conducted a research study, “Patient Education and Warfarin Therapy: Readmission Rates Pre/Post Warfarin Team Initiation.” A Warfarin Team was formed at Mission Hospital in response to the 2011 National Patient Safety Goals (NPSG). The team, consisting of a physician chair, pharmacists and registered nurses, focused on international normalized ratio (INR) testing, Warfarin dosing and patient education. The goal of this team was to identify and eliminate barriers that prevent the stabilization of INRs within the prescribed goal range and to ensure that all patients receive education from a registered nurse about Warfarin therapy in order to prevent harm and reduce readmission rates related to Warfarin therapy.

The purpose of this study was to compare 90-day readmission rates within the same timeframe in consecutive years, before and after the Warfarin Team was initiated, to determine if the team’s measures had been an effective avenue to reaching the 2011 NPSG. In a retrospective chart review, 556 patients with active Warfarin orders for the month of July 2010 were compared to 417 patients with active Warfarin orders during July 2011.

Research results confirmed that in 2010, Warfarin related readmissions occurred at a rate of 7.2 percent of the total patient group, while in 2011, Warfarin related readmission occurred at a reduced rate of 1.4 percent of the total patient group.
**Value Stream Mapping in the Emergency Department**

For one week in July 2012, staff in the Emergency Department (ED) participated in value stream mapping (VSM), surrounding three streams of patient flow, patients being discharged from the ED, patients being admitted to the hospital, and behavioral health patients being admitted, discharged or transferred.

The goals of the VSM evaluation were to improve the patients’ experience, throughput and safety, as well as staff experience, in the busy 61-bed ED averaging 285-300 patients daily. Areas for improvement were identified, and the most crucial needs were addressed.

Over the next five months, many changes were implemented. Among those were the review and adjustments of staff schedules to provide better coverage at peak hours; on-boarding of new graduate nurses; and the September opening of the five-bed Behavioral Health Unit. A hospital surge plan team was created to develop processes to handle occasions when the patient volume is more than the bed capacity, resources or staff could effectively or safely manage.

An emergency medical technician (EMT) was stationed in the waiting room during peak hours to assist with rounding, vital signs and customer-service needs. A patient experience initiative was implemented that included handouts, electronic displays, signage, waiting-room enhancements, essential oils and holistic initiatives.

A paramedic served as “air traffic controller,” talking by radio with incoming ambulances, directing their traffic and updating nursing staff, allowing the nursing team to provide more quality care and to decrease the wait for bed placement. A behavioral health intake clinician started screening patients at time of triage for suicidal and homicidal ideations and assessing sitter needs.

Significant improvements were noted as changes were made. Patient capacity improved by nearly 32 percent. The “left without being seen” rate dropped from 5.5 percent in September to slightly more than 1 percent in December. Patient satisfaction increased from 42 percent to 55 percent (goal of 61.6 percent or the 90th percentile) in mid-December, with patients saying their care was “excellent.” The Behavioral Health Unit provided closer observation for patients at the highest risk. Patient time from the ED door to being seen by the ED physician decreased from 64 minutes to 29 minutes in December. In addition, the staff vacancy rate decreased from 28 percent in May to 8 percent in September and stabilized the remainder of the calendar year.
**Pain Target© Project**

The Pain Target© program is an innovation in pain assessment that uses a bull’s-eye pain target sign to assist the patient and healthcare team in establishing a pain target, or comfort-function goal. The “pain target” is a pain score goal that will enable patients to meet their recovery goals with a minimal level of discomfort. Initiated on the Women’s Surgical Unit, the Pain Target sign was copyrighted by Mission Health in 2011.

The second phase of the National Database of Nursing Quality Indicators (NDNQI) Pain Measure study was completed in the spring of 2012. This project included a successful expansion of the Pain Target© program to the Orthopedics Unit. While the final NDNQI data collection point did not show any significant differences in patient outcomes, further evaluation will continue in 2013.

Hospital wide roll-out of the Pain Target© program was initiated in December 2012 with a Learning Management System module and dissemination of signs to all units that electively decided to participate. Institutional Review Board (IRB) approval for a research study to examine outcomes related to this roll-out was also received in late 2012 and data collection will be ongoing in 2013.

Oral and poster presentations for the Pain Target© program were presented at the Society of Gynecologic Nurse Oncologists (SGNO) Conference in Nashville in April 2012 and at the Association of Women’s Health Obstetric and Neonatal Nurses (AWOHN) in Washington, D.C., in June.

**Integrative Healthcare**

In 2012, the Integrative Healthcare Department grew, with new offerings in music therapy and acupuncture. Music therapy consults for inpatients and outpatients were made available at the hospital campuses and the SECU Cancer Center to help address physical, emotional, cognitive and social needs. Outpatient acupuncture treatments were added for the treatment of chronic back pain, headaches, knee osteoarthritis, nausea and vomiting associated with cancer treatment, and smoking cessation.

Integrative Healthcare continued their focus on the safe and compassionate integration of complementary and conventional medicine through research, evidence-based practice, clinical services and community partnerships. Their family-centered and culturally sensitive approach is implemented by staff members who include an integrative medicine physician and nurse practitioner, holistic nurse specialists, movement instructors specializing in tai chi, qigong and yoga, pet therapy coordinators, an education coordinator, an acupuncturist, a music therapist and administrative staff.
Nurses (left to right) Tracy Hannah, BSN, RN, CMSN, Melissa Wilson, BSN, RN, CMSN, Nurse Educator, and Nancy Mastrantonio, BSN, RN, CMSN, Nursing Unit Supervisor, created the Pain Target© bull’s eye sign and the Pain Target© program.
EMPIRICAL OUTCOMES

Patient Satisfaction

Mission Hospital finished the 2012 calendar year with an Overall Quality of Care ranking of 89.4 compared to others in the Professional Research Consultants (PRC) national database. This also means that 69 percent of our patients rated the organization as excellent.

Twelve nursing areas at Mission Hospital were nationally recognized by PRC for top 10 percent performance in patient experience during 2012:

- 6 North
- Cardiovascular Progressive Care
- Heart Failure Unit
- Maternal Fetal Medicine
- Medical Cardiology Step-down
- Oncology
- Orthopedics
- Pulmonary Medical Care
- Trauma Care
- Mission Cancer Center
- Pediatric Hematology/Oncology
- Radiation Therapy

This designation is given annually to healthcare facilities, providers, outpatient service line and inpatient units that score in the top 10 percent (i.e., at or above the 90th percentile) of PRC’s national client database for the prior calendar year. These awards are based on the percentage of patients who rate the facility, provider, outpatient service line, or inpatient unit “excellent” for the “overall quality of care” question.

Award winners were celebrated at the June 2013 PRC Excellence in Healthcare Conference in Orlando, Florida, and Mission Health hosted a Service Award Banquet in July to celebrate the achievements of each unit.

During the two events, Mission Hospital received the Four-star Excellence Award, an annual designation given to healthcare facilities that score in the top 25 percent of PRC’s national client database for the prior calendar year. The award is based on the percentage of patients who rate the facility “excellent” for the “overall quality of care” question.

Our ongoing initiatives, including Leadership Quality Rounds, Communication in Healthcare training, Relationship Centered Leadership training, and quality improvement and service excellence projects, promote excellence in the care of our patients and their families. Our BIG(GER) Aim is the inspirational force in our journey to excellence.
Central Line-Associated Bloodstream Infection

The rates of central line-associated bloodstream infection (CLABSI) at Mission Hospital markedly improved in June 2012. The diligence of nurse clinicians in following protocols to prevent infection afforded better outcomes for our patients.

From July through December 2012, our overall average CLABSI rate of 0.38 placed us in the top 10% of hospitals in our benchmark group.
Mission Health has been named one of the nation’s Top 15 Health Systems by Truven Health Analytics for the second year in a row.