OhioHealth Chief Nurse Council

The OhioHealth Chief Nurse Council is a shared governance group of highest ranking nurse leaders who represent OhioHealth nurses from all aspects of and areas across the health system.

Seated, from left: Sharon Neenan, MBA, BSN, RN; Lisa Gossett, MSN, RN, CENP; chief nursing executive; Lindsey Osting, MS, BSN, RN, NE-BC; and Kanesha Moss, MSN, RN; standing, from left, are: Kelly Vierling, MSN, RN, NE-BC, ACC; Joy Bischoff, MSN, RN, NE-BC; Beth Steele, MSN, RN, CPAN, FACHE; Le-Ann Harris, DNP, RN, NEA-BC; and Rhonda Dixon, MBA, BSN, RN, NE-BC. Unable to be in the photo are: Carmela Hartline, MS, RN, NEA-BC, CNS; Elizabeth Steger, MSN, RN, NEA-BC, FACHE; and Gina Terrell, MSN, RN, NEA-BC.

Published annually, the OhioHealth Nursing Annual Report is a record of nursing innovations and accomplishments across our health system for Fiscal Year 2018 (July 2017 through June 2018). For more information about this publication, please contact Kim Boggs, MSN, MBA, RN-BC, director, OhioHealth Nursing Excellence, at (614) 788.3640 or Kim.Boggs@OhioHealth.com.

On our cover: Elizabeth Appiah, BSN, RN

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Dear Colleague,

I am very pleased to present the 2018 OhioHealth Nursing Annual Report — an opportunity for us to showcase nurses across our health system who are living up to our vision, “every nurse will be a leader in improving the health of those we serve.”

I am so proud of all that we have accomplished, especially in the midst of so much change. In healthcare, change is the only constant and leadership is key as we navigate. Our responsibility as nurse leaders, regardless of role, is to continue to advocate for and support our patients and their families. By growing and cultivating leadership from within our organization, we are able to preserve our culture and continuity of care for our patients. To this end, nurses across our organization continue to lead in new ways.

Our Nursing Strategic Priorities have also evolved to include a set of belief statements that, together with our strategic priorities, serve as the “true north” for nurses at OhioHealth. All of this is exemplified in the stories you’ll read in this year’s nursing annual report. Stories, such as:
- Nurses across OhioHealth are testing the leadership waters in the new role of Clinical Leader — an advocate for clinical nurses who is ensuring a safe and positive patient experience by being visible, available and providing consistent leadership on the front lines.
- Nurses who are keeping each other and the caregiving environment safe by marshalling an effort to ensure that controlled substances are wasted safely and changing the culture from distrust to support and accountability.
- More nurses of color are serving in senior leadership roles through a new program that pairs 20 high-potential minority candidates with sponsors who support their development and advancement by coaching and advocating for them.
- Infusion and catheterization lab nurses have made it possible for patients in southeast Ohio requiring treatment for neurological conditions to receive care close to home.

As OhioHealth’s new chief nursing executive, I am honored to represent the breadth of talent and dedication demonstrated by OhioHealth nurses across our health system. Thank you for an impressive and exciting year of nursing at OhioHealth.

Sincerely,

Lisa Gossett, MSN, RN, CENP
Senior Vice President
Chief Nursing Executive
OhioHealth

OhioHealth is the largest health system in central Ohio with more than 9,000 nurses serving patients in the inpatient and ambulatory care setting, and as leaders across our health system.

The OhioHealth Nursing Strategic Priorities serve as our roadmap for achieving our goals of driving value for patients and the community. We updated these this past year to keep them aligned with the goals set by OhioHealth. Our Belief Statements grew out of discussion about the OhioHealth nursing philosophy and vision. Together, the OhioHealth Strategic Priorities and Belief Statements work together to serve as the “true north” for nurses.

**OUR VISION**

Every nurse will be a leader in improving the health of those we serve.

**WE BELIEVE**

- The patient is the reason we exist.
- The essence of caring occurs in human connection.
- Nursing practice is evidence-based and requires lifelong learning.
- Nurses will be exceptional partners in all OhioHealth achievements.
- Problem-solving is best closest to and with the patient.
- Shared governance is the basis for decision-making and transformational leadership.

**WE BELIEVE**

- Quality, Safety and Service: Deliver a consistent, safe experience upholding exceptional quality and service standards.
- Workforce Innovation: Ensure the right resources with the right competencies at the right time to deliver an exceptional experience.
- Diversity and Inclusion: Create a nursing team that reflects the diversity of the communities we serve and makes all feel that they belong.
- Deploy Lean Thinking: Assume ownership of continuous improvement skills among all associates.
- Advance and Expand Leadership Development Efforts: Expand leadership talent in nurses at all levels of the organization.
- Care Management: Develop structure and processes that leverage the registered nurse’s scope of practice to coordinate care.
Turning to nurse intuition and ingenuity to reduce falls

When nurses on the Surgical Trauma Intermediate Care Unit (STICU) at OhioHealth Riverside Methodist Hospital found that the fall risk assessment tool they were using wasn’t satisfactorily addressing their concerns, they created their own system — one that puts trust in the expertise and intuition of clinical nurses and uses very clever signage.

The STICU is a 16-bed step-down unit for trauma and surgical patients who will be in the hospital for a long time and are not intubated. Typically, patients are on medications that make them lightheaded or they’re connected to IVs and other equipment, and because of this, they don’t fully appreciate how prone to falls they may be.

“We have a culture on the unit of answering each other’s call lights and saw an opportunity to better inform each other of each patient’s fall risks,” says STICU nurse manager Jessica Heidorn, BSN, BS, RN.

That opportunity presented itself in January 2018, when a patient fell. In debriefing on the matter, nurses discussed the incident and the broader issue of preventing patient falls, finding that the Schmid Fall Risk Assessment tool didn’t factor in a nurse’s intuition and observations about a patient — for example, impulsivity.

“The nurse who answered the call light had no way of knowing the patient was impulsive based on the Schmid score,” says Heidorn. “We saw an opportunity to go beyond the information the Schmid tool was providing about patients.”

On February 1, the STICU started posting banana illustrations on the hospital door of every patient who scores an M (medium) fall risk or higher. In addition, Heidorn and clinical nurse Annette Jenkins, BSN, RN, created their own STICU Fall Risk Assessment tool, capturing risk factors beyond what’s requested by the Schmid tool after a month of tracking them on a KPI board.

“We tracked this for about a month and got almost 1,000 responses,” says Heidorn. “We decided that if the Schmid tool isn’t working for us, we needed to make it work. Using our own tool, we found that nurses, factoring in their own observations and intuition, were scoring patients higher for fall risk than the Schmid tool 100 percent of the time.”

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In the STICU, a score of L+ or higher requires that a nurse or patient services assistant remain in the room with the patient while they use the restroom. “We agreed as a team not to question why a nurse has added a plus sign to the score,” says Heidorn. “We just need to know that our co-workers have given us a visual clue to pay close attention and treat the patient as a higher fall risk.”

Training involved primarily spreading the word in associate and shared governance meetings, as well as one-on-one coaching by clinical nurse leads and charge nurses who are responsible for auditing the fall scores. “The team on the unit has incredibly bought in to our process and keeping patients safe,” says Heidorn. “Prior to this renewed focus, it was rare to go more than 30 days without a fall on the unit, but we have had several extended periods lasting more than 100 days.”
Improving physician and staff satisfaction by keeping an open mind

A new scheduling model in the perioperative area of the Surgical department at OhioHealth Marion General Hospital is demonstrating how physician and staff satisfaction can improve immeasurably when everyone takes time to listen to one another and come up with a solution together.

The change is part of much larger work OhioHealth has been doing to transition the caregiving model from a focus on volume to a focus on value. The health system is doing this as part of much larger work OhioHealth has been doing focused on workforce innovation. “Staff have control of their own destiny. They’re able to have input into what affects their jobs.”

At Marion General, a changing healthcare model coupled with a longstanding culture, had led to tensions in the Surgical department. Historically, call-in surgeries began at 3:15 p.m., requiring all other scheduled surgeries to be completed no later than 2:30 or 3 p.m. With more surgeons working at multiple locations or participating in outreach services, they sometimes can’t start a surgery before 2 p.m. and complex cases can take until 5 p.m. or later.

“Physicians were frustrated with being unable to schedule patients later in the day, call teams were frustrated having to work overtime, and no one had work-life balance or any predictability of their schedule,” says interim surgical director Kimilyn Queen-Weis, MSM, MBA, CNA, FAHRA, RT(R)(CT) MB. “It was a model that was in place for decades. We had to change the way we always did things and look for new ways to be efficient and effective to meet the needs of our patients, providers and staff.”

Led by Queen-Weis, nurses and physicians applied A3 Problem Solving, embracing quite a bit of trial and error, to achieve:

• More efficient and effective scheduling
• More productive use of staff and physician time.
• Improved job satisfaction and morale.

Sarah Clevenger, BSN, RN, clinical nurse manager of Outpatient and Inpatient Surgery was charge nurse at the time. She says nurses and surgeons volunteered to participate on various work groups, including hours of operation. The chief of surgery participated in all groups.

“We brought in food and tried to make it a fun environment. It was an open forum, and people were hesitant at first. It was the first time staff members had been asked to be part of a solution to a problem this big, but they quickly engaged,” says Clevenger. “Data helped steer the conversation. They were very upfront about having to work until 2 a.m. and then having to be back the next morning, and the surgeons agreed they didn’t want someone in their room who had just worked 18 hours. It really helped to show both sides of the situation.”

The team evaluated the pros and cons of a number of different scheduling options until they hit on one that worked for everyone:

• First Iteration: The staff was divided into two teams — one that stayed until 5 p.m. and the other until 7 p.m. — so that physicians could schedule cases late in the day and associates would have more predictable schedules. But after piloting it for a while, it didn’t prove to be very efficient and the team went back to the drawing board.
• Second Iteration: The team tried 10-hour days, keeping four rooms open until 5 p.m. and giving the call team the next day off. The problem was the department wasn’t using all four rooms that late in the day. The team reconvened, and staff members presented how many cases were being scheduled between 3 and 5 p.m., how many cases ran past 5 p.m., and cost reductions in overtime, call stay and on-call pay because people were starting later in the day.
• Third and Current Iteration: The team settled on three days of the week with two rooms available until 5 p.m. While some staff members stayed on four 10-hour shifts, others went back to five eight-hour shifts. On slower days, only one room is open until 5 p.m.

The overall staff feeling going into the project was skepticism that anything would change, but once nurses noticed call-back hours being reduced, attitudes started to change, says charge nurse Jakob Scalfoss, BSN, RN. “I think it’s definitely helped with morale,” he says. “Nurses realize the surgeons are trying not to make us work after hours, and the new shifts are giving people the ability to get done what they need to get done. It’s really helped mend relationships.”

Queen-Weis agrees, saying, “Yes, we saved money and gained some efficiencies, but I feel like the bigger story here is how the group came together to come up with solutions. They were willing to be flexible to determine what was the right mix, all to meet our goal of doing the right thing to address the needs of our patients.”
Kicked off in July 2018, members of the cohort meet with their sponsors at least one hour a month to discuss their professional development, personal development and what’s required to fulfill a role in leadership. They divvy up time however they choose, sharing tools and resources designed to coach and inspire, and talking about their goals and challenges.

The group also gathers four times a year for events that include a presentation by OhioHealth chief nursing executive Lisa Gossett, MSN, RN, CENP, about the importance of diversity in healthcare, panel discussions with diverse OhioHealth leaders, and activities to help them understand more about themselves as they’re pursuing advancement or preparing for an interview.

The candidates were nominated by OhioHealth nursing leaders from across the system who sought African American, Latino and Asian nurses who have demonstrated an aptitude for leadership, and are interested in advancement. From these nominees, 20 nurses were selected for the first cohort.

Sponsors are nursing directors who, because of their influence in the organization, can advocate for minority candidates. Not all of the sponsors are minorities, Moss says, and before anyone is selected for the role, they must successfully complete unconscious bias training to make sure they’re comfortable with the process.

The goal is for someone to be placed in a leadership position by the end of the cohort,” says Moss. “So far, 50 percent of our candidates have been placed.”

From left: Elizabeth Appiah, BSN, RN; and Rhonda Dixon, MBA, BSN, RN, NE-BC

Setting — and achieving — diversity and inclusion goals

To better reflect the growing diversity of the communities it serves, OhioHealth is successfully placing more nurses of color in leadership roles through a Diverse Nurse Pipeline program that pairs 20 high-potential minority candidates with sponsors who support their development and advancement by coaching and advocating for them.

“We received a lot of support from OhioHealth’s Diversity and Inclusion department in creating a program that has an intense focus on the candidates,” says Kanesha Moss, MSN, RN, chief nursing officer at OhioHealth Dublin Methodist Hospital and OhioHealth Grady Memorial Hospital, and executive sponsor of the program. “Their sponsors understand their strengths and weaknesses, and are advocating for them when they’re not in the room. The program is designed to be very proactive, and we’ve seen some great success.”

The OhioHealth Diverse Nurse Pipeline is on track to reach its goal of placing 50 percent of the 2018 cohort in roles with more responsibility.

Diversity and Inclusion
Seeing the benefits of lean management beyond safety, quality and affordability

The collaborative use of lean management tools by Nursing, Radiology and Patient Transport at OhioHealth Doctors Hospital is improving the safety and quality of heart patients requiring continuous telemetry, and in the process, building confidence and trust among the three departments.

The Cardiovascular Step-Down Unit is a 26-bed telemetry unit, where almost every patient at one point or another is transported to Radiology for testing. Patients can be off the unit as long as two-and-a-half hours for certain nuclear medicine exams or five minutes for CT scans and other diagnostic procedures.

As part of the ongoing process to improve quality, safety and affordability of care, nurses on the unit realized that when a patient went to Radiology, no one was watching their monitors. The monitors were wired to transmit information to the unit where a patient was admitted, rather than where they were at any given time. Radiology, in the meantime, had no way of reading the monitors and was under the assumption patients were continuously monitored from the unit.

“No event ever occurred, but the situation was putting everyone at risk – especially the patient,” says Holly Lawyer, MBA, BSN, RN, NE-BC, nurse manager of the Cardiovascular Step-down Unit. “If a patient was in distress, setting off the alarm, nurses would go to the patient’s assigned room and they may not be there. It could take several minutes to figure out where the patient was and then call for that department to check the patient. We realized that this could delay emergency care and was not safe for the patient or the staff.”

“The perception on our end was that nurses were watching the monitors while patients were here in radiology,” says Mark Ferguson, RT(R)(ARRT), manager of Radiology. “Our technicians didn’t have any official training on how to read them. If there was any physical change we noticed in the patient, our first response was to call a radiology nurse on our unit.”

Nuclear medicine technologist Lyric Hanson, RT(N)(ARRT), CNMT, explains that the portable telemonitor has different modes — either showing the patient’s rhythms or not showing them. “It wasn’t that we thought Radiology wasn’t physically looking at the patient, they were just watching for a physical change rather than being able to monitor the alarms to prewarn someone,” says Lawyer. “We realized connection problems existed between nursing and radiology because we weren’t on the same page. It was an ‘aha!’ moment for us.”

“Patient transporters, in the meantime, were trained to respond, but only to notify someone if a red alarm goes off.”

Working closely together, the Cardiovascular Step-down Unit, Radiology and Patient Transport identified root causes and developed action plans using A3 Problem Solving and KPI boards. Their solution, which has been in operation for approximately a year, works this way:

- Transporters notify the unit that they’re on their way and have to be met by the patient’s clinical nurse or a charge nurse so that the nurse knows when the patient is off the unit.
- Before releasing the patient for transport to Radiology, the clinical nurse or charge nurse must switch the monitoring mode so that radiology technologists are able to see the monitoring lines. This step, Lawyer notes, also prevents sending patients who may be a little unstable to a department that isn’t the best place for them at the time.
- Radiology confirms the monitor is in the correct mode so that they can see the rhythm all the time, and if it’s not, switch the mode and contact the nurse on the unit to verify the patient’s rhythms are still visible before sending them on for their exam. “If we don’t see the monitor properly, we do some troubleshooting,” says Hanson.

Approximately 35 radiology technicians also completed a four-hour telemetry training class developed by unit educators and OhioHealth Learning, where they learned to distinguish between a patient’s normal heart rhythms and deadly heart rhythms, such as atrial fibrillation and ventricular tachycardia. If a patient is experiencing an event, Radiology contacts the hospital’s Rapid Response team rather than the radiology nurse.

“The transporter notifies the unit once the patient is back in the room so that a nurse can switch the monitor back to its original mode. Transporters were also trained on the new standard of work.

“All three departments had this on their KPI boards, and we followed up in real time when there were misses,” says Lawyer.

Beyond safety and quality of care enhancements, the new process has been a huge boost to morale in all three departments, particularly in terms of confidence and trust. Radiology technicians are now equipped and prepared if a patient experiences a change in condition while under their care, and nurses have the assurance that patients are being monitored when they’re off the unit.

“It was kind of a touchy issue when we all came together at first, but the project has really helped build relationships among the departments,” says Lawyer. “No one is afraid to raise a red flag now if they see something a patient needs.”
Succession planning is also an essential part of the model, enabling clinical nurses to test the waters of leadership and prepare them for advancement, particularly to the role of clinical nurse manager. While it is formally designed as a leadership role, it is not an official management position.

“This is an opportunity for nurses to step into leadership and see if it's the direction they want to go,” says Judy Brewer, BSN, RN, manager of Learning for OhioHealth Nursing Excellence. “We look for people who have the desire and the potential to become managers. We've had a few people who decided it wasn’t for them and opted out, and that’s okay too.”

The patient-centered leadership model and clinical leader role grew out of root-cause analysis identifying several trends negatively impacting nursing sensitive indicators, such as patient satisfaction, quality and associate engagement. These trends included inadequate visibility or support, poor communication, lack of accountability for the patient experience, complexity of care, and span of control.

Each clinical leader has 12 to 18 designated staff members or constituents. Use of the clinical leader role is unique to each unit, depending on factors such as complexity and needs of patients, staffing and patient census. On some units, clinical leaders have patient assignments and on others, they do not.

At Grady Memorial, for example, four clinical leaders — three who work days and one who works nights — share responsibility on 3 East and 4 North, which encompass the medical-surgical telemetry and observation units, as well as the ICU. Each of the three who work days have a full patient assignment on one of those days.

“Having a patient assignment was something we all felt strongly about,” says clinical leader Amy Davidson, RN. “It was important to us that as the resource to frontline nurses, we know first-hand their daily struggles and not lose our engagement. These trends included inadequate visibility or support, poor communication, lack of accountability for the patient experience, complexity of care, and span of control. And it kept us in close contact with the ED,” says Counts. “They know who their go-to person is now on the inpatient unit.”

Counts says the clinical leaders advocate for staff nurses, bringing ideas and requests to management, such as participating in continuing education for a procedure they don’t do very often. They’ve also increased staff recognition on the units, entering points in real time on Inspire, OhioHealth’s recognition platform, whenever clinical nurses go above and beyond.

“They get a lot of raw information from staff that, as a manager, I would not necessarily hear,” says Counts. “When we got the results from our Associate Engagement Survey, we took this as an opportunity to let them lead the feedback sessions. They pulled their constituencies together, brought in snacks, and really gathered a lot of useful feedback on what our scores mean.”

The clinical leaders at Grady Memorial have responsibility for bed management, including morning huddles with the nurse administrator, surgical nurse practitioner, chaplain, and clinical leaders from other units to review the status of beds and new patients. They had the opportunity to shadow nurses at OhioHealth Grant Medical Center in preparation for the recent reopening of the hospital’s observation unit. And they attended Critical Care Fellowship classes.

“We look for people who have the desire and the potential to become managers. We've had a few people who decided it wasn’t for them and opted out, and that’s okay too.”

The Grady Memorial clinical leader on night shift works closely with counterparts in the emergency department (ED), sharing ideas and addressing issues brought forward by clinical nurses on the inpatient unit that have improved workflow and resolved typical tensions between the departments. “The structure has improved our relationship with the ED,” says Counts. “They know who their go-to person is now on the inpatient unit.”

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The OhioHealth Care Management Team partnered with physicians, nurses, physical and occupational therapists, and dieticians to come up with a model called, “Why Not Home.”

The team’s work began in October 2017, when the concept was piloted for approximately three months and then rolled out across the health system in June 2018.

Among the campuses piloting the initiative was OhioHealth Doctors Hospital, which is now using the approach throughout the hospital. “It’s about getting away from cookie-cutter discharge planning and doing the due diligence necessary to getting patients the support they need at home,” says Kate Coffield, LISW-S, manager of Care Management at Doctors Hospital.

Under the guidance of social worker Julie Kachic, MSW, LSW, and case manager Yvonne Kristofeld, RN, the process relies on multidisciplinary teams working together at optimum consistency and effectiveness. Their focus is on patients with AM-PAC scores ranging from 16 to 19 who are candidates for discharge to home versus a SNF. (The acronym for Activity Measure for Post-Acute Care, AM-PAC is an assessment tool used by physical therapists to evaluate a patient’s functional mobility, with a range from zero for patients who are fully dependent to 24 for patients who are most independent.)

When patients with AM-PAC scores of 16 to 19 are identified as “Why Not Home” candidates, care management immediately gets involved, coordinating with physicians, the physical therapist, dietician and other team members. “We have to look at the total patient. We’re not just focused on therapy, we also have to take into consideration a patient’s needs for nursing skills,” says Kristofeld. “Some patients may have an AM-PAC of 16 to 19, but comorbidities — depending on how involved they are — may make them a better candidate for a SNF.”

A classic “Why Not Home” case was one Kachic and Kristofeld presented to OhioHealth’s Accountable Care Organization Board of Directors: An 83-year-old woman with a history of coronary artery bypass grafting, COPD, myotonic dystrophy and hypertension was admitted to Doctors Hospital for heating-pad burns, shingles, urinary tract infection and falls.

Upon admission, social workers received a referral for the woman to a SNF, but the physical therapist on the unit had given her an AM-PAC score of 16. In discussing her case, the multidisciplinary rounding team identified her as a possible “Why Not Home” candidate.

Kachic met with the patient and her son, who she lived with and was her caregiver, about discharge to home with support from home health. This hinged upon the patient’s ability to walk short distances and the son’s ability to help manage her wound care. “She had some pretty involved wound care needs, which was one of our concerns,” says Kristofeld. “We reached out to one of our wound care nurses, who evaluated and treated her, working closely with the woman’s son and bedside nurse.”

She was also seen by a physical therapist daily and consulted by a dietician, while Kachic worked closely with the woman’s primary care physician and Humana to assure a smooth handoff. “Everyone on the team played a role in the case, which is why it worked so well,” says Kachic. “They really wanted to go home, and everyone, including the family, worked with us, which made it so successful.”

Making discharge to home a viable alternative to skilled nursing facilities

Nurses who are part of multidisciplinary Care Management teams across OhioHealth are working together to successfully improve outcomes and reduce costs by discharging more patients to home instead of a skilled nursing facility (SNF).

Evidence shows that patients discharged to SNFs are at higher risk for readmission, acquired infection, depression and other difficulties. Outcomes are better when patients are discharged to home as long as the right care and support system are in place.

“We know that patients prefer to go home. They want to be with the people they love in the environment where they’re most comfortable,” says Abigail Hartung, MSW, LISW-S, system director of Care Management at OhioHealth. “This especially applies to patients in a ‘gray zone,’ who, with additional support, are able to go home.”
We believe the patient is the reason we exist.

Going above and beyond to care for patients in the home

Seeing patients get better over time and knowing they’re making a difference for a grateful patient base is attracting OhioHealth Home Health nurses to this growing organization and increasingly needed role.

“This is the future of healthcare — people want to receive care in their home and as we continue to look at cost, the home is where we need to continue to focus,” says Katie Toopes, MSN, RN, system director of OhioHealth Home Health. “Home health nurses truly get to see the patients’ improvement over time. You see them taking ownership of their own health and medical care or being able to function again in their home or the community. Those successes stay with you for a long time.”

For example:

+ A man with diabetes and an A1C of 12 was about to lose a limb, but through support and education from his interdisciplinary care team and the trust they built with the patient, his A1C is now at an appropriate level and limb function has been restored. “This is a true win when it comes to building trust between the nurse and the patient, and a good outcome results from that,” says Toopes.

+ A woman with a below-the-knee amputation is living with a nephew who uses drugs and is verbally abusive to her and her caregivers. OhioHealth Home Health nurses are working with social workers, the OhioHealth Foundation and potentially local police to relocate her safely from the house to a more secure and caring environment with another relative.

OhioHealth Home Health has more than 180 nurses serving an average 1,900 patients who live in 19 counties in the greater central Ohio region. The business line has grown significantly in the past year. These nurses provide total comprehensive care to patients referred and/or discharged from the hospital — from monitoring patients and providing education throughout the healing process, to coordinating physical, occupational and speech therapy, and addressing psycho-social support needs. On average, they’re in each patient’s home three times a week.

“We truly work as an interdisciplinary team to care for these patients,” says Toopes. “The relationships we hold with each other and other disciplines (therapy and social work, particularly) are very important because we don’t actually see each other day to day. The way we work together can be a true bar to an environment, and we want to make sure the patient is at the center of care.”

Still, much of their work is autonomous and, from their perspective, an opportunity to be creative and a challenge to improve. “In a hospital or doctor’s office, you’re working in an environment you can control,” says Megan Sebar, BSN, RN, clinical nurse manager. “You don’t have that kind of control in a patient’s home so you have to improvise and be creative. You have to create the sterile area, for example, you would otherwise have in a healthcare facility.”

“There’s a level of autonomy here that doesn’t exist even in Critical Care, the emergency department or operating room. Our nurses have to have incredible critical thinking skills and confidence,” says Toopes. “There’s not someone down the hall who can help in a situation — you’re navigating out on your own. Someone is always a phone call away, but we don’t have that second set of hands or eyes.”

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Social determinants of health are a huge focus for Home Health nurses, who partner with social workers, the OhioHealth Foundation and local community organizations and businesses to resolve issues — mostly socioeconomic — that may be preventing patients from returning to their best health. On any given day, they may encounter biting dogs, bedbugs, homes in disrepair, several feet of snow and, worst of all, a patient or family member struggling with abuse and addiction.

“When we get into a patient’s home, we encounter all sorts of things that play into their ability to take care of themselves,” says Toopes. “If they have a gaping hole in their roof and need money to fix that hole, they’re going to spend their money fixing it rather than on medications that are important to them. Or, they may have very little income and can’t afford the medications or healthy foods needed to manage their disease properly.”

Beyond travel, this is a key reason OhioHealth Home Health works to keep nurses as close to their own home as possible; they have relationships with local community organizations and businesses who serve as the support system for those in need in their communities. “One nurse was able to get an air conditioner donated to a patient by a local retailer,” says Kristie Keir, PTA, clinical manager. The demands elevate the relationships home health nurses have with their patients to an entirely different dimension — one built on strong bonds between the caregiver and the patient and their family members. “These patients are homebound or not getting out of the house much, if ever,” says Susan Kaufman, RN, clinical nurse manager. “The Home Health nurse may be the only bright spot in their day — the only thing they have to look forward to — and that really builds a strong bond with the caregiver, the patient and their family.”

"From left: Brandi Eddy, BSN, RN, WCC; Susan Kaufman, RN; Megan Sebar, BSN, RN, and Kristie Keir, PTA, MHA"
To date, she’s collected and distributed more than 15,000 pairs. She believes many more people in the area could benefit if more OhioHealth hospitals start doing the same. “I don’t care who they go to, as long as there’s a need,” she says. “The more word gets out about what we’re doing, the better.”

Francis came up with the idea nine years ago, not as a nurse, but as a patient at Dublin Methodist. “I was a patient here, and when I was leaving, I asked someone what to do with my socks,” she says. “They told me I could keep them or throw them away in the garbage. It seemed like a waste to throw them away, so I took them home.”

A couple of years later, when she was hired to work in Dublin Methodist’s recovery area, she pitched and got approval for her sock idea, placed a plastic bag in the utility room for collection, and spread the word to fellow staff members on the unit to ask patients when they’re being discharged if they want to keep their socks or donate them.

“We say to patients, ‘You’re welcome to keep these, but if you don’t need or want them, we donate them to the homeless,’” says Francis. “I would estimate 9 out of 10 people, when they hear what we’re doing, donate their socks. It makes my heart happy.”

A clinical nurse at OhioHealth Dublin Methodist Hospital who saw discarded hospital socks going to waste has turned them into an act of kindness and generosity that’s benefiting central Ohio’s neediest.

Kathy Francis, BSN, RN, a clinical nurse in Dublin Methodist’s Preoperative, Postoperative and Preadmission Testing Unit, collects, launders and donates discarded hospital socks and donates them to local homeless shelters and food kitchens.

Socks are among the most-needed items donated to shelters for the homeless, and an average 7,200 surgical patients a year at Dublin Methodist receive them as an important fall prevention measure.

Once a week, for the past six to seven years, Francis brings home a bag full of the thick, yellow, double-grip socks, launders and folds them, and neatly packs them up in carryout bags for delivery to Deacon Tony Bonacci of St. Joseph Catholic Church in Plain City, Ohio. “When I first started, I was collecting 25 to 30 pairs of socks a week,” she says. “I’m now bringing home 50 to 60 pairs for donating.”

In addition to shelters for the homeless, Deacon Tony takes the socks to the Faith Mission and soup kitchens in downtown Columbus. “He told us that some of the people who use the shelters a lot watch for him and hold the door open when he arrives, knowing they’re going to get socks,” says Francis.

She’s also receiving sock “orders” — so many, in fact, that when she recently purchased a new car, she and her husband took into consideration the number of bags of socks that could fit in the back.

Nurses in Dublin Methodist’s emergency department are collecting the socks too now, and from the recent publicity she’s received for what she’s doing, she’d like to see more hospital socks collected in more units across OhioHealth.

“There are so few good-news stories anymore,” she says. “If we can all come together, more people would benefit; fewer socks would wind up in landfills, and it’s a good feeling too, knowing we’re helping others.”
We believe nursing practice is evidence-based and requires lifelong learning.

Connecting nurses with resources and experiences to help them learn and grow

OhioHealth is encouraging nurses to grow beyond clinical competency to become knowledgeable, professional leaders in the practice of nursing. By participating in Nurse Leadership Academy’s Lifelong Learning—an approach to professional development—nurses are connected with resources and experiences to support their continuous learning in whatever direction they choose.

“Professional development is something OhioHealth nurses both need and want, and we know through research that opportunity to network with experts in the organization and explore new experiences delivers the greatest return,” says Judy Brewer, BSN, RN, manager of Learning for OhioHealth Nursing Excellence. “This is a shift from the familiar, one-size-fits-all, traditional classroom approach. Whether you are a nurse just starting your career or a nurse with years of experience, the Academy connects all OhioHealth nurses with resources to help them continue to learn and grow.”

Among the many resources available to all nurses under Lifelong Learning is a self-directed module available through OhioHealth Learning (Course OD3457). Key components of this module are resource maps, which guide nurses in the areas of:

- Intentional networking.
- Individual mentoring and coaching.
- Self-directed, independent study.
- Experiences that stretch beyond routine responsibilities.
- Professional organization participation.
- Traditional classroom learning programs.

The resource maps are available for download from the course, along with a “123-IDP” form that is used to create an individual development plan that works this way:

1. Nurses describe their interest and goal, for example, delivery of direct care, clinical informatics, community health or management.
2. Nurses select two learning activities to support these goals, or they can create their own learning activity with input from their manager.
3. Nurses set three checkpoints along the way, with input from their manager.

The IDP helps nurses determine their own timeline and set reasonable checkpoints for each activity in moving toward completion. The timeline for one activity, for example, could take six weeks to complete and the timeline for another, six months. “The purpose of setting checkpoints is to stay on track, not rush to finish,” say guidelines in the Lifelong Learning managers toolkit.

One nurse leading the way is Tamra Kennedy, BS, RN, clinical leader on the Clinical Decision Unit at OhioHealth Doctors Hospital, who spreads the word about the Lifelong Learning module and resource maps at the Doctors Hospital Nursing Congress and OhioHealth Nurse Practice Advisory Council meetings. She’s also sharing her experiences with other clinical leaders so that they can support constituents who are interested in professional development.

“The Lifelong Learning module is such an amazing way to grow professionally and see the bigger picture of nursing,” says Kennedy.

Kennedy was first introduced to Lifelong Learning in January 2018, when her manager asked if she was interested in helping pilot the program with other clinical nurses. Since then, she’s completed three IDPs based on the resource maps:

- Community Health: “I chose this because Doctors Hospital is a very community-based hospital, and I live in that community,” she says. “I would always see the OhioHealth Wellness on Wheels primary care mobile clinic in the area, and I wanted to connect with and learn about it.”
- Clinical Informatics: “I thought this sounded boring and wanted to be over and done with it, but I was so pleasantly surprised,” she says. “We live in a world in which technology is used in so many different ways, and it really opened my mind up to how a nurse at every level is supported by technology.”
- Management: “In the role of clinical leader, you have one foot in as a clinical nurse and the other in leadership,” she says. “It coincides well with my position and other leadership classes I’ve taken, and it’s a way to see if management is something I want to pursue.”

“Professional development is something I want to pursue,” Kennedy says. “It coincides well with my position and other leadership classes I’ve taken, and it’s a way to see if management is something I want to pursue.”

She also likes the flexibility of the overall process—from the range of resources available to the time it may take to complete an activity. “I share my ideas with my manager, and she gives suggestions,” says Kennedy. “When I did my informatics map, I reached out to our nurse informaticist and one of my activities was helping patients sign up for OhioHealth MyChart using their own smart phones and tablets.”

Kennedy is now in the throes of an IDP to follow the nursing research resource map and contemplating her fifth IDP. “You don’t have to do all of the maps, but that’s my personal goal,” she says. “Nursing is such a broad career that if you’re burned out or have lost your passion in one area, there are still so many other possibilities. There is always a way to have an impact on people, and Lifelong Learning highlights all those things.”
Launched in January 2018, the Heart Failure Rounding team defines high risk as heart failure patients with an ejection fraction less than 40 percent or who are repeat readmissions. The multidisciplinary team, which includes a cardiologist or nurse practitioner, hospitalist, inpatient cardiac rehabilitation educator, dietician, pharmacist, case manager and social worker, sees these patients as a group at least once during their stay. Individual team members meet one-on-one with patients as often as needed.

Education plays a key role in the team’s interaction with patients and their families, as well as the clinical nurses and hospitalists providing care to heart failure patients. “Especially when they’re newly diagnosed, heart failure is and sounds scary,” says Dalton. “We spend a lot of time explaining to patients and their family members what’s happening when someone has heart failure, what they need to do to manage it and how this can contribute to their quality of life. Otherwise, people leave the hospital scared and without knowing what to do.”

Dalton says the Heart Failure Rounding team spends a lot of its time addressing social determinants and getting patients to see the value of resources available to them, such as the OhioHealth Heart Failure Clinic. She adds that proper medication management is among the team’s most common concerns. “Many times, patients’ medications are changed while they’re in the hospital, and they don’t fully understand what they should be taking, when and how much,” says Dalton. “Our pharmacist alleviates their confusion by reviewing with them their total medical list, including what they should stop taking when they go home.”

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While patient education is her focus, Dalton also makes sure clinical nurses fully understand the importance of taking standing daily weights and strictly monitoring intake and output of heart failure patients, using rewards and incentives to ensure nurse compliance. And she works with hospitalists to help them understand how the Heart Failure Rounding team works and when they should be consulted.

Beyond bedside rounding, the Heart Failure Rounding team meets three times a week to discuss all high-risk heart failure patients in-house, their discharge plans and, with that, the support they may need once they’re home. “It gets everyone on the same page in terms of a plan to move forward and what issues need to be resolved for patients,” says Dalton. “We address everything and anything that might factor into readmission, including social and financial support needs.”

The team also stays up to date on services benefiting heart failure patients, inviting representatives to speak on such topics as community resources, improving referrals to the heart failure clinic, and palliative care.

Of the 145 high-risk heart failure patients the Heart Failure Rounding team saw in Calendar Year 2018, 11 percent – or 16 patients – were recorded as a 30-day all-cause readmission, outperforming the national goal of 16 percent or less.

Dalton emphasizes that the group of high-risk heart failure patients tracked by the team in the first year were hand selected and, therefore, did not include hemodialysis or nursing home patients. But because readmissions for the control group were lower than heart failure patients at-large, the team has hopes of expanding the program to those with an ejection fraction of less than 40 percent.

“This is a huge population and the cases are much more complex,” says Dalton. “They’re dealing with hypertension or obesity or they are of low socioeconomic means. The treatment of this group is different, and we hope to make a difference for them too.”

Taking a team approach to reducing heart failure readmissions

A new Heart Failure Rounding team at OhioHealth Mansfield Hospital has had so much success reducing 30-day readmissions of high-risk heart failure patients that they’re now exploring how to expand the program even further.

“We were looking at how to reduce readmissions of heart failure patients, and one of our new nurse practitioners shared with us how multidisciplinary rounding has successfully been used,” says Alecia Dalton, BSN, RN, CCRN-K, CHFN, an inpatient cardiac rehabilitation educator at Mansfield Hospital. “We were already doing this on our ICUs, and we adapted this approach to heart failure patients who are high risk for readmission.”

“We were looking at how to reduce readmissions of heart failure patients, and one of our new nurse practitioners shared with us how multidisciplinary rounding has successfully been used,” says Alecia Dalton, BSN, RN, CCRN-K, CHFN, an inpatient cardiac rehabilitation educator at Mansfield Hospital. “We were already doing this on our ICUs, and we adapted this approach to heart failure patients who are high risk for readmission.”
Nurses in our infusion center and catheterization lab not only stepped up to learn these new procedures, they helped get neurological care services at O'Bleness Hospital up and running.”

Nurses worked with Dr. Woo and specialists from the OhioHealth Neuroscience Center at Riverside Methodist Hospital to build end-to-end processes for patients receiving Ocrevus™, a new infusion drug that’s slowing the progression of MS in patients, and electroencephalogram (EEG) monitoring.

Because O'Bleness Hospital is not yet on CareConnect, OhioHealth's electronic health record system, these processes had to include a number of manual steps, not to mention the fact that each process came with its own set of complexities.

“MS infusions
Shelly McClintock, RN, and Savannah Hopstetter, RN, are among the infusion nurses at O'Bleness Hospital who were recruited to help establish the process for Ocrevus infusion treatments. “At the time, this area was brand new to my role,” says Jarvis. “These nurses had experience with high-risk infusions and were a great resource. I was really able to lean on them for help.”

Providing Ocrevus infusions is a process that involves close coordination with the physician, drug representatives, pharmacy, lab, procurement, billing and insurance, and revenue cycle. McClintock explains that managing risk with Ocrevus involves a lot of checks and balances with regard to the medication supply, as well as specific lab tests that aren’t common for most nursing disciplines.

For example, she says, “Until we started giving these infusions here at O’Bleness Hospital, people were having to drive to Columbus just for lab draws and to complete a pretty in-depth questionnaire before the pharmacy would even release the medication.”

It took about three months to get everything up and running, and patients have been getting their Ocrevus infusions close to home for about a year now. Demand has exceeded all expectations as well. While the infusion center originally anticipated only a few patients each year, they now treat around 15 patients.

“It’s been exciting for all of us because it’s such a positive experience for each person,” says Hopstetter. “A lot of people are young when they’re newly diagnosed with MS — it’s a scary deal — so it’s nice to watch them adjust and receive positive reports.”

Seizure monitoring
Similarly, a game plan had to be established for EEG monitoring, which is done in a dedicated area of the catheterization lab at O'Bleness Hospital.

Because the lab had capacity, Jarvis asked for volunteers from the department to learn how to perform EEGs and, like the infusion nurses, work with Dr. Woo and OhioHealth Neuroscience specialists in Columbus to build the service with the added complexity that images would be read in Columbus. Among them were Julie Tritipo, BSN, RN and Diane Detty, RN.

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I thought, it’s never a bad idea to have an extra skill,” says Tritipo. Detty agrees, saying it’s been a great experience and that she likes the variation of the work and the patients they serve. “Putting leads on someone’s head was a little terrifying a first, but we’ve been doing about three EEGs a week now for the past 18 months,” she says. “It’s interesting, and patients like not having to travel a long way to get the care they need.”

Keeping neurological care close to home
Nurses in the infusion center and catheterization laboratory at OhioHealth O’Bleness Hospital have made it possible for patients in southeast Ohio requiring treatment for neurological conditions to receive care close to home.

For a long time, O’Bleness Hospital was without a neurologist, and patients had to travel as far as 80 miles each way for epilepsy seizure monitoring or multiple sclerosis (MS) drug infusions. That changed when Douglas Woo, MD, joined OhioHealth Neurological Physicians in Athens in fall 2017.

“We already had an existing population in this area who needed neurological care, but there was a lot we had to have in place to make it happen beyond learning the procedures.”

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They’re now sharing their work across OhioHealth, with plans to help each hospital implement the new process. They’ve also presented their work at the 2018 American Nurses Credentialing Center National Magnet Conference® and have plans to publish. “About one in seven to 10 people in the United States have a substance use disorder requiring treatment, and that number includes healthcare professionals,” says Kobelt. “These are our peers and friends who have increased access to opioids at work, job-related stress and may not fully understand substance use disorder as a chronic medical condition.”

Kobelt began digging into the issue when nursing director Shelly Hall, MSN, RN, brought her concerns to the attention of the hospital’s Medication Safety Council. An administrative nurse manager at the time, Hall noticed that nurses on her unit were accidentally taking medications home in their pockets, talking about signing for wastes they did not witness, and administering medications and wasting later.

The issue was escalated to the Quality and Patient Safety Department, and because of her role, Kobelt was tapped to lead the work necessary to addressing the problem. The hospital’s primary focus was on opioid controlled substances, such as morphine, Dilaudid®, hydrocodone and oxycodone.

To get a complete and accurate picture of controlled substance wasting at Grant, Kobelt met with the hospital’s administrative nurse managers, who openly shared similar stories and concerns. She then pulled together a multidisciplinary team that used A3 Problem Solving to identify root causes and develop a solution.

The team used the hospital’s Shared Governance Councils as an avenue for connecting with more than 100 clinical nurses who administer controlled substances. Grant’s Nursing Congress and four of the nursing councils — Nursing Practice, Nursing Service Excellence, Nursing Safety and Quality, and Nursing Evidence Based Practice, Innovation and Research — analyzed all processes involved in controlled substance wasting and contributed to the solution.

“We can’t stress enough the importance of involving the nurses on each of the units in the process. There was such a stigma, no one could talk about wasting in a positive way”

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The Nursing Safety and Quality Council went to each medical-surgical unit, asking nurses to describe the steps they take to waste controlled substances and observing them doing it. For each unit, they developed a visual map of all the steps, calling out common work-arounds, differing processes and broken connections. They also took inventory of each automated dispensing unit, finding that only two were located near a sink, which is an approved wasting receptacle.

Key themes that emerged from the nursing councils’ due diligence included:

- Delayed wasting
- Holding waste in pocket
- Not wasting with a witness
- Accidentally taking opioids home
- “Ghost rules” that aren’t backed up by policy, such as nurses having 20 to 30 minutes from the time they administer a controlled substance to when they waste what’s left
- Unavailable or inaccessible supplies for wasting
- Varying wasting environments unit to unit

Changing culture to ensure safe wasting of controlled substances

Nurses at OhioHealth Grant Medical Center have marshalled an effort to ensure that controlled substances are wasted safely, directly involving the nursing shared governance model and ultimately changing the culture from potential distrust to support and accountability.

Paula Kobelt, DNP, RN-BC, outcomes manager of Pain Management, Quality and Patient Safety, Hillary Gallo, BSN, RN, RN-BC, clinical nurse manager in the Rapid Diagnosis and Treatment Center, Chelsea Gall, BSN, RN, educator and staff nurse on the Medical-Surgical unit, and pharmacist Jena Whitcomb, PharmD, BCPS, led the planning and due diligence needed to establish a new standardized policy and protocol for controlled substance wasting, now known hospital-wide as “Waste With Me.”

The Nursing Service Excellence Council used SurveyMonkey® to anonymously poll nurses on current practices. “What we found was that nurses knew what to do but they weren’t doing it, which confirmed the need for a culture change,” says Gall. “Nurses said in the survey they always wasted with a witness, for example, but in small group discussions with them, we knew this wasn’t happening.”

continued on page 30
The Nursing Practice Council evaluated four to five policies pertaining to controlled substance wasting, finding that not one provided clear guidance for nurses and recommending that one be created.

The multidisciplinary team identified targets to improve controlled substance wasting, and Gallo and Gall conducted a unit roadshow, distributing “Waste With Me” signs and supplies and working directly with nurses in small groups on each of the units to set things up. “We can’t stress enough the importance of involving the nurses on each of the units in the process,” says Gallo and Gall. “There was such a stigma, no one could talk about wasting in a positive way. We just kept emphasizing, ‘We want to make this easy and to support you,’ and that’s what really made the difference.”

“People can get defensive or feel accused when you ask if they’ve wasted a medication,” explains Gall. “By having it come from the nurse instead of the witness, we were able to shift the culture from distrust to support and accountability.”

With nurse input, they also organized and secured supplies, including a new Cactus Smart Sink® that’s been installed by each automated dispensing unit. “We wanted to eliminate all barriers, even the smallest ones,” says Gallo. “The nurses chose what type of organizer would be the best, and what supplies they wanted in it.” Gall adds that staff were the ones who wanted “Waste With Me” signage right in front of them at the automated dispensing unit to keep wasting top of mind.

From January to November 2017, the average time from automated dispensing unit to waste on the Rapid Diagnostic and Treatment Center decreased from 17 minutes to four minutes and from eight to four minutes on the pilot medical-surgical unit.

The new policy and process has since been approved by the Nursing Congress and is gradually being rolled out throughout the rest of the hospital. Gallo and Gall conducted a unit roadshow, distributing “Waste With Me” signs and supplies and working directly with nurses in small groups on each of the units to set things up. “We can’t stress enough the importance of involving the nurses on each of the units in the process,” says Gallo and Gall. “There was such a stigma, no one could talk about wasting in a positive way. We just kept emphasizing, ‘We want to make this easy and to support you,’ and that’s what really made the difference.”

**WASTE WITH ME | NEW POLICY TARGETS**

- Nurses must waste controlled substances within five minutes of pulling them from the automated dispensing unit.
- A witness must be present when the controlled substance is wasted.
- Controlled substances must be wasted in a sink or approved waste disposal system.
- Medications must be administered immediately.
About OhioHealth

OhioHealth is a nationally recognized, not-for-profit, charitable, healthcare outreach of the United Methodist Church. Based in Columbus, Ohio, OhioHealth is currently recognized by FORTUNE Magazine as one of the “100 Best Companies to Work For.” Serving its communities since 1891, it is a family of 30,000 associates, physicians and volunteers, and a network of 12 hospitals, 60+ ambulatory sites, hospice, home-health, medical equipment and other health services spanning a 47-county area.

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