In memory

VELINDA STEVENS
1952 – 2017

This edition of the KRH Nursing Annual Report is dedicated to Velinda Stevens.

Velinda was a true nursing advocate. She always felt that if we took great care of our patients, everything else would fall into place. Her vision enabled us to stretch our wings to soar to new heights on our journey to excellence.

She will be missed.

Photo courtesy of Jack Bell
A Message from the CNO

This report is a celebration of our success as a nursing organization. It represents nurses in all positions, settings, and roles throughout the KRH system. The quest for Magnet® designation is not a hospital or even a nursing initiative; it is a patient one. We have many accomplishments over the past year to be proud of. I am honored and thrilled to be working with all of you to build and shape our quality and nursing excellence infrastructure. I appreciate and respect each of you and am grateful to work with such engaged, professional nurses within our organization. This report showcases highlights from the past year we are excited about while moving closer to nursing excellence.

Our destination is nursing excellence…When will we get there? Can there really be an end point when creating a culture of ongoing nursing excellence? While on the journey, nursing has focused on putting together the structural elements of practice that are prerequisites to a culture of clinical excellence. Using structure, process, and outcomes, we have built a solid foundation which includes a shared governance structure, refining a professional practice model, a process to identify work environment issues at the unit level (RN satisfaction survey), and a method to analyze nurse sensitive data to improve patient outcomes (NDNQI).

The Magnet® designation is not about a prize, rather the pride that nursing has for what we do together, who we are day in and day out, and how we make the KRH system better for patients, family, and staff. It is an ongoing journey that is not solely about achieving Magnet® status; it is being an organization that puts clinical excellence, quality and safety, and evidence-based practices at the forefront of everything we do for our patients.

Studies show that Magnet® designated hospitals have a higher percentage of satisfied nurses, less nurse turnover and vacancy, improved clinical outcomes, greater nurse empowerment, and improved patient experiences. This requires commitment. We must have a long-term framework for quality-improvement efforts and a means for engaging and motivating nurses at all levels.

I am so very proud to serve alongside each of our nurses. I appreciate all of their hard work, going above and beyond, and want to thank each of them for their passion and commitment to our patients and their families. I also thank our patients, families, and community members for the trust they place in us to provide excellent care, for every patient, every time.

Sincerely,

Karen Lee, MHA, BSN, RN
Chief Nursing Officer
Congratulations to Kalispell Regional Healthcare’s
Nurse of the Year 2016

Christina Armstrong, BSN, RN, CCRN

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Pictured on the front cover:
Charlie Hoving, BSN, RN

2016 Nursing Annual Report
What nursing excellence means to me...

“offering comfort to those experiencing life-changing events”

Christine Miller, BSN, RN
Magnet® Model

The Magnet® Model guides the transition of Magnet® principles to focus healthcare organizations on achieving superior performance as evidenced by outcomes. Evidence-based practice, innovation, evolving technology, and patient partnerships are core foundations in the Magnet® Model. It provides the framework to achieve excellence in nursing practice.

The Magnet® Vision is one where “organizations serve as the fount of knowledge and expertise for the delivery of nursing care globally. Grounded in core Magnet® principles, they will be flexible and constantly strive for discovery and innovation. They will lead the reformation of healthcare, the discipline of nursing, and care of the patient, family, and community.” 2014 Magnet® Application Manual.
Transformational Leadership
Nurse leaders must demonstrate advocacy and support on behalf of staff and patients to transform values, beliefs, and behaviors. Nursing's mission, vision, values, and strategic plan must align with the organization's priorities to improve performance, wherever nursing is practiced. Mechanisms must be implemented for evidence-based practice to evolve and for innovation to flourish. As a result, nurses throughout the organization should perceive their voices are heard, and their input is valued, and their practice is supported.
- Strategic planning
- Advocacy and influence
- Visibility, accessibility, communication

Structural Empowerment
Nurses are involved in shared governance and decision making structures and processes to establish standards of practice and address opportunities for improvement. Nurse leaders serve on decision making bodies that address excellence in patient care and the safe, efficient, and effective operation of the organization. The flow of information is multidirectional among professional nurses at the bedside, leadership, interprofessional teams, and the chief nursing officer. Nurses and nurse leaders develop strong partnerships with community organizations to improve patient outcomes and advance the health of the communities they serve. This is accomplished through the organization's strategic plan, structure, systems, policies and programs.
- Professional development
- Teaching and role development
- Commitment to community involvement
- Recognition of nurses

Exemplary Professional Practice
Exemplary professional practice is evidenced by effective and efficient care services, interprofessional collaboration, and high-quality patient outcomes. Nurses partner with patients, families, support systems, and interprofessional teams to positively impact patient care and outcomes. The achievement of exemplary professional practice is grounded in a culture of safety, quality monitoring, and quality improvement. Nurses at all levels analyze data and use national benchmarks to gain a comparative perspective about their performance and the care patients receive.
- Professional Practice Model
- Care delivery system
- Staffing, scheduling, and budgeting process
- Interprofessional care
- Accountability; competence and autonomy
- Ethics, privacy, security and confidentiality
- Culture of safety
- Quality care monitoring and improvement

New Knowledge, Innovation and Improvements
Evidence-based practice and research is integrated into clinical and operational processes. Nurses are educated about evidence-based practice and research, enabling them to appropriately explore the safest and best practices for their patients and practice environment and to generate new knowledge.
- Research
- Evidence-based practice
- Innovation

Empirical Outcomes
The Empirical measurement of quality outcomes related to nursing leadership and clinical practice in Magnet-recognized organizations is imperative.
- Five key outcomes
  - SE3EO – Nursing certification
  - EP3EO – RN education
  - EP22EO – RN sensitive indicators
  - EP23EO – Patient satisfaction
  - NK1EO – Research

Note: Throughout this publication, you may see color coded squares next to articles. These color squares indicate the component represented.
The Intensive Care Unit (ICU) has undergone a complete transformation in 2016. We began the year with the design and construction of an 18 bed Intensive Care Unit with input from ICU leadership and staff.

The Intensive Care Unit has an elegant design that features beautiful mountain views and ample space for patients, patient families, and the multidisciplinary care team. This design creates a welcoming, healing environment for patients and family during a time when they may be the most vulnerable.

The rooms are fully functional with the necessary equipment for caring for the critically ill patient. The rooms are equipped with patient lifts, monitors, computers, suction equipment, medical gasses, and much more. With the diligent work and countless hours of teamwork, the new unit opened its door to patients on September 10, 2016. Since that time, we have expanded our services to include care of patients post trans-catheter aortic valve replacement (TAVR), and continue to provide and expand high quality services to Northwest Montana.
Development of a Pediatric Acute Care Unit

By Corrie Casey, BSN, RN, CCRN

Pediatrics has always had a place at KRMC whether it was a one room ward on the medical floor of the old patient tower, or the five beds designated as pediatric rooms on the medical floor of the new patient tower. Census of pediatric patients fluctuated greatly and nurses trained in pediatric care spent the majority of their time caring for adult patients.

In 2015, pediatric services began to grow with the addition of pediatric gastroenterology and oncology. In early 2016, other pediatric specialties were added to KRH such as cardiology and surgery. Upon the formation of these pediatric specialties, the hospital decided to create a separate pediatric and pediatric intensive care unit (PICU).

The new unit is located in what used to be the adult ICU and took nearly six months to complete.

Since the unit opened its doors on October 1, 2016, there has been an average daily census of two PICU patients and four to six pediatric patients.

Accomplishments of note:

- Nurse-led rounds occur every day at 9:00 a.m. and include the pediatric hospitalists, the PICU intensivist, pediatric social work, pediatric dietitian, pharmacy, bedside nurse, charge nurse, consulting services and respiratory therapy.

- Achieving great successes with patients, whether they receive treatment here in Kalispell and return home with good outcomes or the team recognizes a patient may need advanced care, involving transportation outside of Montana.

- The unit has been able to recruit nurses, physicians and support staff that are passionate about their work and are very loyal to each other. A successful team has formed who advocates together to achieve the best outcomes for patients and their families.
Ambulatory Surgery Centers (ASC) create a service for patients to receive same day surgery in a cost and care efficient manner. Polson Health Outpatient Center is designated as a multi-specialty ASC and provides a variety of same day services. Its patient community is the smallest in the state of Montana to support an ASC.

Since the center was created, it has operated as an extension of providers’ offices and has been seeing endoscopy patients as well as providing pain procedures since the summer 2015. Both KRMC and The HealthCenter provided support by sending teams down while the onsite staff learned to incorporate these procedures at the center.

By November 2015, we set off on our journey to ASC certification. A major change along the way came the following spring, when the Outpatient Center took on its own operations and became its own entity within the KRH system.

Shortly after this change, the state surveyors arrived onsite for their first evaluation. Impressed with the physical space, the staff knowledge, and the patient care provided, they cited zero deficiencies.

A week later, however, the State Life Safety Surveyor appeared and pointed out several details that had previously been missed. Thankfully, his exit interview provided clear direction and we were able to submit a plan of correction within a few hours.

On August 25, 2016, we reached our goal when the State of Montana granted us Ambulatory Surgery Center certification. We continue to offer endoscopy and pain interventions, in addition to general surgery, orthopedic hand surgery, plastic surgery, cataract surgery, and pediatric endoscopy.
What nursing excellence means to me...

“advocating for patient wellness in thought, word and deed, every time”

Robin Robinson, BSN, RN, CCRN and Annemarie Kramer, BSN, RN
DAISY Award for Nursing Excellence 2016

By Bev Dowling, BSN, RN

This international award began as a way for one family, Bonnie and Mark Barnes, to say thank you to all nurses for the care and compassion they received. The Barnes family lost their 33 year old son to complications of an autoimmune disease. During Patrick's hospitalization, the Barnes family trusted they would receive excellent clinical care; what they didn’t expect was the empathy and compassion with which that care was delivered.

As a way to honor Patrick and give meaning to his death, the Barnes families choose to create the DAISY foundation, which is an acronym for “Diseases Attacking the Immune System.” One branch of the foundation is the DAISY Award for extraordinary nurses. KRMC became affiliated with the DAISY Foundation in 2005. At that time, KRMC was one of only 400 participating hospitals involved. Today there are more than 2,400 hospitals, in 50 states and 15 countries working to recognize excellence in nursing. Nurses are nominated for the DAISY Award by patients, family members, and members of the healthcare team for their compassion and excellent clinical skills. Nominations outline the nominee’s demonstration of attributes, such as empathy and compassion in all situations, excellent communication and clinical skills, and all tell stories of extraordinary nursing care.

Each quarter a deserving nurse is recognized with a DAISY Award. In 2016, the following nurses were recognized for their ability to display excellence of care in nursing.

Molly Briggeman, BSN, RN

Molly is one of the most caring and compassionate nurses. She consistently communicates her concerns about patients to her charge nurse. Molly is very thoughtful in her care of her patients. She finds time to offer “Healing Touch” to her patients that are anxious or having pain. Molly is a team player always willing to help. She is a pleasure to work with.

Shanti Lackey, BSN, RN, CMS

Shanti is always willing to come help or put in a PICC line no matter what time of day. She is a pleasure to work with and has a very up-beat and positive attitude. Shanti’s clinical and communication skills are excellent. She is consistently focused on patient and family goals.

Kim Bergey, RN

Kim is a ray of sunshine in the unit. She has a gentle supportive attitude and works well with everyone. Kim is very skilled in labor/delivery and post-partum. She offers wonderful support to patients and families. Kim is active in our journey towards excellence, is a preceptor, and is training to be a transport nurse for the department.

Joyce Stevens, BSN, RN, CMS

Joyce embodies the core values at KRMC. She demonstrates excellence in every way every day at this facility. The level of her integrity is a shining example to all team members that have the privilege to work with her. The level of respect, kindness, compassion and caring Joyce demonstrates when providing care to our customers and their families is admired by her co-workers and sets the bar to the highest level for all team members fortunate enough to work with her.

Recognizing extraordinary nurses
What nursing excellence means to me...

“Nurses are the cornerstones of the healthcare community. They provide knowledge, service, and hope to patients during the joys and hardships of life. They selflessly dedicate themselves to the wellbeing and comfort of others, day after day, patient after patient.”

Chris Kleiv, Surgical Tech
The operating room is a unique area of nursing. So what is it exactly that one does as an OR nurse? In January 2016, a group of nurses began a journey to learn and experience the answer to this question.

Due to increased services in our growing organization and lack of qualified applicants, it was decided to offer another Peri-Op 101 course in surgical services and “grow our own” OR nurses. This course is offered by the national organization AORN (Association of PeriOperative Registered Nurses). The surgical services educator Lisa Saito, RN, is the administrator of the course. For eight to twelve months she guides the students through a combination of computer classes and hands on training. They learn all aspects of what it takes to become an operating room nurse.

The following two stories are from nurses that recently completed this course and gives insight to their journey.

The Operating Room (OR) has been called many things from Operating Theaters, Surgical Suites, to more recently “the Bat Cave.” For me it has always been a place that I knew I wanted to work, and thanks to being accepted into the Peri-Op 101 program I finally have the opportunity.

The Peri-Op 101 program has been a whirlwind experience. At first, it was overwhelming trying to learn all the information and acquire the skills necessary to succeed in this one-of-a-kind environment, but after a while it became easier to process the vast amount of knowledge I received and incorporate what I learned into my work flow. The nurse educator, Lisa Saito, was instrumental in breaking down the overall OR requirements and explained them in a way that made sense. She was always available and helped me to navigate the various challenges that occurred. I don’t think I would have been able to adapt to the challenges of the OR without her.

The surgical nurses and scrub techs are a diverse group of individuals that made integrating into the OR a complex endeavor. While this is not an issue exclusive to the OR, it was an added stressor. Initially it was hard to see how I could possibly fit into this group of people, but once I spent more time with them I discovered that we shared an appreciation for detail, have strong work ethics, are goal-oriented, and are dedicated to providing the best care possible for our patient population.

The OR environment can be stressful and frustrating. It demands that all those working within it give a hundred percent all the time and function as a cohesive unit. There is always something new to learn and no two cases are the same, but even with all the challenges and uncertainty there is no other place I would rather work.

- Jennifer Watts, BSN, RN
In January 2016, four other nurses and I started the Peri-Op 101 program with Lisa Saito as our educator and mentor. The program is offered by AORN (Association of PeriOperative Registered Nurses) to safely integrate experienced nurses into the operating room as circulators.

Little different scenario for myself, I started with two months in Same Day Surgery to brush up on assessment skills. All the nurses in the program spent two days each with the surgical aides and sterile processing. After completing the computer modules, we passed the test required by AORN and moved onto the “hands on” portion of the program by going into rooms with another circulator to guide us and act as a preceptor.

After a year I can now begin to answer the question… “What does a nurse do in the OR?” What DON’T we do?! Safety is paramount and most of the training is centered on keeping your patient, yourself and your coworkers safe. The circulator establishes a rapport with the patient during the pre-surgical interview, helps anesthesia get the patient off to sleep, assists with positioning, counts, passes off medications, helps the scrub techs and surgeons with anything they need, troubleshoots equipment/technology and completes documentation all the while ensuring that sterility is intact and the patient is safe. Keep in mind that our patients are at their most vulnerable during surgery and it is the nurse’s job to make sure that all the others in the room remember that as well. There are real risks of harm from any number of sources associated with surgery.

As a person who has been in health care in one way or another since 1996, I can honestly say that this is the most challenged I have ever been. I continue to feel supported in my learning and encouragement to grow as a professional.

- Martha Overbeek, BSN, RN
Wherever the art of medicine is loved, there is also a love of humanity

It began with a simple request from KRH’s Kid Kare teacher to one of the hospitalists. Would this physician explain to her class of three year olds what it is exactly that she does? The answer, of course, was yes. The physician then contacted me to see about setting up a pediatric hospital room to be used for about thirty minutes. As they talked about this project, it grew into a much bigger project – the children’s medical fair or Kid’s Fair.

Within a short while and with quick planning a day was picked. For four hours on that day the Buffalo Hill Conference Center was divided into stations for the children to experience. This ranged from seeing a mock hospital room and all its equipment to donning hats and masks and playing the game Operation.

At the end of the day, it was determined to be a success and the goal to familiarize young children with the different aspects of health care from clinic visits to being a patient in the hospital was met. By having this experience when they are healthy, it may ease some of the anxiety if they become ill or are in need of the services offered by the health care industry.

After a successful inaugural fair, the organization plans to continue the event for years to come.
KRH hosted the first annual Career Development Expo on Friday, April 29, 2016. It was a big success! We had more than 200 attendees, both employees and non-employees, visit the 22 tables with schools and programs from around the area. Special thanks to the internal programs represented including HR, HealthCenter HR, Lab, Foundation, Brendan House, Nurses Help Nurses, Nurse Residency Program, and Professional Development Council. The feedback was positive and we hope all who attended were able to get information they needed on how to begin or advance their medical career.

The representative from Salish Kootenai College said,

“It was a superb day, I made so many contacts and it was a great professional networking event as well!”

KRH Human Resources department said,

“It was a great time to connect with not only potential outside candidates but educate current employees about other career paths in healthcare.”

Thank you to all who came out to support this event, work a table, donate a basket, or just come for some goodies. Plans are in place for another event in 2017.
Nursing Grand Rounds is a growing venue for Kalispell Regional Healthcare (KRH) nurses to showcase and disseminate their best evidence-based practice (EBP) and performance improvement (PI) initiatives. It is a place to recognize the hard work and dedication that KRH nurses show and give to our organization and our patients every day. Mid-year of 2016, the Evidence Based Practice and Research Council (EBPRC) assumed an active role in continuing and growing this venue.

The EBPRC members not only took this role, but also raised the bar! Using this established venue as a springboard, the council identified opportunities to incorporate more traditional elements of Grand Rounds, such as the presentation of case studies. The council has established objectives for Nursing Grand Rounds and is making great strides to meet them.

I. Integrate best practice initiatives to promote nursing excellence, professional development and staff engagement.
   a. Inspire excellence in patient outcomes through nursing research, EBP and PI within Kalispell Regional Healthcare.
   b. Promote nursing excellence through the presentation of clinical case studies.
   c. Connect the concepts of Kalispell Regional Healthcare’s Professional Practice Model to the daily practice of nursing.

In 2016 there were three separate Nursing Grand Round offerings showcasing the work of 16 individuals or teams from across the organization:

Nursing Grand Rounds 2016

Creating a Spirit of Inquiry
Emily Hutchins, MSN, RN

Reducing Alarm Fatigue on IMC
Julia Tikka, BSN, RN, PCCN

Hands on Handoff: SBAR Bedside Report
Shawn J. Chouinard, RN & Jocelyn Jakeway, BSN, RN

Floating as a Newly Licensed Nurse: Perception vs. Reality
Kayla Tenney, BSN, RN & Kara Leukuma, BSN, RN

Sepsis Protocol
Meridith Gargas, BSN, RN & Paula French, BSN, RN, CCRN

Research Study and IRB
Carla Genovese MSN, RN, CCRN & Laura Bermel, BSN, RN, CIC

Fall Reduction in the Inpatient Rehabilitation Patient Population at The HealthCenter
Rhonda Jellison, BSN, RN, CMSRN, Kari Carter, BA, RN, CRRN & Ellen Wesolowski, BSN, RN, CRRN

Avasure Telesitter Program
Jill Zempke, MHA, MSN, RN, Kristi Streitmatter, BSN, RN-BG, Patricia Davey, RN, CMSRN & Addi Eastman, RN

DVT Prophylaxis
Ally Wilson, BSN, RN, CMSRN & Kathleen Anderson, BSN, RN-C

Using EPB to put the cows to pasture
Kari Hagler, BSN, RN

Inpatient Intravenous Chemotherapy Administration: Nursing Competence and Confidence
Kristi Andersen, MN, RN-BG, CNL Student

Emergency Room IV Stop Time Reimbursement
Debbie Mulcahy, BAN, RN, CEN, SANE-A, SANE-P

Creating a Culture of Rest and Healing
Alie Gwinn, BSN, RN & Emma Goosens, BSN, RN

Hands on Aids for Patient Education
Michelle Reimnitz, RN

NICView System
Karen Rupp, BSN, RN, NREMT-P, Jessie Cady-Kauffman, BSN, RN & Ashley Roth, BSN, RN

Offering Naturopathic Medicine to Breast Cancer Patients in Northwest Montana (January 2017)
Kim Grindrod, BSN, RN, OCN, CBCN & Melissa Vornbrock, BSN, RN, CBCN
Promoting a Culture of Rest and Healing

By Alie Gwinn, BSN, RN and Emma Goosens, BSN, RN

A Grand Rounds presentation

The objectives of this project were to:

- Promote rest and healing in the acute care setting using non-chemical interventions.
- Increase staff awareness of the noise levels in correlation to patient’s perception of rest.
- Provide staff with alternative interventions to enhance patient rest and healing.

The proposed question of the project was, “For patients on the first floor, how will the implementation of non-chemical interventions affect their perception of rest?” Pre-data collection was done using patient and staff surveys.

Prior to implementation the first floor staff was educated on the aspects of the project including establishing a specific time designated as the quiet hour. Utilization of ear plugs for patients and the Continuous Ambient Relaxation Environment (C.A.R.E.) Channel, a channel that has soothing background music and calming photography, was initiated.

Implementation started with posting a sign at the entry of the unit designating the quiet time, a laminated handout was placed in each room that explained the quiet time.

Doors were closed and lights were dimmed to signify the quiet hours. Care by other healthcare team members was coordinated to allow for the established quiet time.

In summary, some of the limitations that were encountered were the lack of understanding of how to use the C.A.R.E. Channel and its limit to just a few rooms.

Based on the data and positive response, however, staff felt that this project had many beneficial components and has been adopted by two other units with the support of nursing leadership. Due to the favorable response when the C.A.R.E. Channel was used, a proposal for the funds was submitted and granted by the Employee Philanthropy Club allowing for the C.A.R.E. Channel to be available for our patients in each room beginning in February 2017.

How Quiet was it Last Night?

<table>
<thead>
<tr>
<th>% of Patients</th>
<th>Predata; Last night was</th>
<th>Postdata; Last night was</th>
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<tbody>
<tr>
<td>Very Quiet</td>
<td>43%</td>
<td>64%</td>
</tr>
<tr>
<td>Somewhat Quiet</td>
<td>28%</td>
<td>31%</td>
</tr>
<tr>
<td>Somewhat Noisy</td>
<td>26%</td>
<td>3%</td>
</tr>
<tr>
<td>Very Noisy</td>
<td>3%</td>
<td>2%</td>
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</table>

Patient Survey...

<table>
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<tr>
<th>% of Patients</th>
<th>The afternoon &quot;Quiet Time&quot; successfully provided a time for uninterrupted sleep and rest</th>
<th>The use of the C.A.R.E. channel helped my environment of healing</th>
</tr>
</thead>
<tbody>
<tr>
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<td>35%</td>
<td>33%</td>
</tr>
<tr>
<td>Agree</td>
<td>31%</td>
<td>31%</td>
</tr>
<tr>
<td>Neutral</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Disagree</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Did Not Use</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

By Alie Gwinn, BSN, RN and Emma Goosens, BSN, RN
For many staff at KRH, differentiating between research, evidence-based practice (EBP), and performance improvement (PI) remains challenging. In October, 2016, members of the Evidence Based Practice Research Council delivered a presentation at Nursing Grand Rounds to further explain these terms.

When conducting research, one asks “What is the best thing to do?” A research study is implemented when the literature search reveals little to no information about the topic. Research tests a hypothesis and generates new knowledge.

When implementing evidence-based practice, one asks “Are we doing the right thing?” The literature is searched for best practice. New knowledge is implemented through a practice change, and the outcomes are measured.

When one is conducting performance improvement, “Are we doing the best thing... correctly and continuously?” is asked.

Performance improvement generates internal evidence about processes and outcomes. Performance improvement ensures that existing policies and procedures are followed precisely and consistently.

During the presentation, the Evidence Based Practice Research Council member further described each definition as it would relate to feeding cats. Adding humorous examples facilitated staff understanding of these confusing terms.
Developing a Sepsis Protocol

By Meridith Gargasz, BSN, RN and Paula French, RN, BSN, CCRN

A Grand Rounds presentation

Why the need for a sepsis protocol?

- Sepsis is responsible for more deaths than cancer, AMI, and strokes.
- Sepsis is overlooked, under treated, and has a high mortality rate.
- Sepsis is responsible for more than one million hospital admissions a year.
- The cost for treating sepsis is over one billion dollars.
- Nationwide one patient presents to ER every minute with severe sepsis.

Benefits of developing a protocol

- Physicians and nurses can prevent sepsis and its devastating effects.
- Early identification of sepsis and improved patient outcomes.

What was done at KRMC

- A organization-wide protocol was developed to be easy to read and understood by all medical staff. All are encouraged to carry this protocol on a business card for guidance.
- A screening tool was developed for all inpatients which helps to alert the nurse of the risk or presence of sepsis. This also helps guide the nurse towards initiating the protocol.
- The policy was rewritten to a nurse-driven protocol that allows the nurse to initiate the protocol after proper screening.
- An order set was developed for ease, accuracy, and consistency of correct treatment by the physicians.
- Organization-wide education/training was provided to all nursing staff by several offered lectures. Training for acute care nurses included a written education module on the sepsis screening process, the sepsis protocol, and the new policy.

Results after a sepsis protocol was implemented

- A steady incline in compliance with initiating treatment within the set parameters for CMS.
- KRMC remains above the national average in compliance of early management of sepsis.
- Successful implementation of a sepsis protocol has increased staff ability to rapidly identify sepsis.
- Protocol implementation also helps to evaluate the ongoing need to educate all staff (including physicians) on early identification and treatment of sepsis. This will in turn improve survivability for patients with sepsis and decrease related healthcare costs.
Sepsis Protocol (3 hour bundle)

2 or more of SIRS criteria met plus a suspected infection
- RR > 20
- HR > 90
- Temp > 38.0 or < 36.0 C
- WBC > 12 or < 4, 10% bands
- Altered mental status

Obtain cultures and lab work (STAT)
- CBC with differential
- Lactic acid #1
- CMP (evaluates organ dysfunction)

Establish sepsis severity
- Severe sepsis: 2 or more SIRS criteria and 1 or more organ dysfunction
- Septic shock: severe sepsis and persistent hypoperfusion after initial fluid boluses

Administer IVF and Antibiotics (within 1st hour)
- NS or LR at 30cc/kg/hr (4-6 liters/2hr)
- Broad spectrum antibiotic, organ specific coverage

Stabilize patient and consider:
- Intubation
- Central line especially if pressors are in use
- Start pressors only if hypotension is not corrected by IVF boluses
- X-ray/CT/US as indicated
  Aim for MAP 60-65

Transfer to ICU (optimal in 2 hours or less)

Sepsis Protocol (6 hour bundle)

Severe sepsis
- 2 or more SIRS criteria
- 1 or more signs of organ dysfunction
- Lactic acid > 4
- Hypotension
- Creatinine > 2.0
- Urine output < 0.5 ml/kg/hr x 2 hrs
- PLT < 100,000
- INR > 1.5
- aPTT > 60

Septic shock: present when both are met
- Pt has met severe sepsis criteria
- 1 or more of the following
  - Lactic acid level > 4
  - Persistent hypotension
    (MAP < 65, SBP < 90, or 40-point drop in baseline BP by 2 or more constant readings)

Draw lactic acid #2 (within 6 hours of presentation)
Consider repeat of other labs

Repeat focused examination within 6 hours/Physician documentation
- VS
- Chest examination
- Cardiac examination
- Capillary refill
- Skin examination
- Pulses

IV Fluid
- NS or LR (consider albumin or blood) 30 cc/kg/hr
- Limit pressors-use IVF boluses to keep MAP > 60

Medical management
- Ventilation (low volume)
- DVT prophylaxis
- GI prophylaxis
- Sedation schedule-sedation holiday
- Continue and reassess antibiotics

Highlighted RED-CMS required
Highlighted in RED-CMS required
Naturopathic medicine is a practice of diagnosis, treatment, and prevention of illness. It is based on the assumption that when one part of your body or mind is not working properly it affects your entire well-being. Restoring the health and well-being of our cancer patients, while providing much needed emotional support make a naturopathic physician a crucial part of our oncology team.

Our objective was to develop a sustainable business model for offering naturopathic therapies alongside conventional medical treatments. These therapies support normal metabolism, decrease side effects of treatment, boost the body’s immune system, and improve energy. Our top priority is to honor our patients’ beliefs and preferences for holistic care, with their well-being and overall quality of life in mind.

Methods
Anyone with a diagnosis of breast cancer can be referred to naturopathic services at Northwest Oncology and Hematology (NWOH). Our naturopathic physician Lynn Troy, ND, offers appointments four days per week. This entails a detailed interview, dietary analysis, nutrient and supplement review, physical examination and individualized treatment plan. Patient’s insurance is billed and if not covered we offer patient assistance. A dispensary at NWOH helps offset the cost of this program while providing quality assurance with professional grade supplements.

Results
In 2015, 27 breast cancer patients had an initial consultation with Lynn Troy, ND. Many of these patients continue to see her on a regular basis even after their immediate treatment or need has ended. The patient demand continues to grow.

We estimate 35 percent of patients have insurance to pay for these visits; Blue Cross and Allegiance currently provide coverage. We work with local non-profit organizations to provide a nutritional/supplement grant program and utilize a voucher system to pay for supplements to qualified candidates.

Conclusions
“Naturopathic medicine, with its emphasis on empowering the individual and identifying the underlying causes of symptoms that result in chronic health conditions including cancer, can and should be a major component of any new approach to redefining The War on Cancer.” (Alschuler, L. Written Testimony Presented to the Senate Committee on Health, Education, Labor and Pensions: May 8, 2008). We have embraced this philosophy and found a way to deliver naturopathic care in an accessible way, recovering costs either directly or in downstream benefit.
What nursing excellence means to me...

“delivering the level of service we promise to our patients”

Addi Eastman, RN
Injury Falls Per 1,000 Patient Days
(compared by bed size of 100-199)
(Source: NDNQI)

Percent of Surveyed Patients with Hospital Acquired Pressure Ulcers (Injuries) Stage II and Above
(compared by bed size of 100-199)
(Source: NDNQI)
Central Line Associated Blood Stream Infections (CLABSI)
Per 1,000 Central Line Days
(compared by bed size of 100-199)
Source: NDNQI

Catheter Associated Urinary Tract Infections (CAUTI)
Per 1,000 Catheter Days
(compared by bed size of 100-199)
Source: NDNQI
From September 12 to October 2, 2016, KRH RNs and advanced practice RNs (APRNs) participated in their third RN satisfaction survey.

The survey includes RNs and APRNs that hold direct patient care responsibilities 50 percent of the time or greater. Voluntary participation is offered and includes RNs and APRNs from across KRH: KRMC, Pathways, Brendan House, HealthCenter and the clinics. Of the 659 invited to participate in 2016, 451 chose to participate. The average unit response rate reached 75 percent!

Results have been widely shared at Nursing Excellence Open Forums, with leadership and with staff from across the organization. Although a large number of units exceed the national benchmark on many of the categories, there is still room for improvement. Literature supports a correlation between RN satisfaction and improved patient outcomes.

Leaders from across KRH are working with their staff to identify opportunities for improvement and to create action plans to drive this work.
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**Legend**

- **Legend**
  - **2014 - Exceeded benchmark**
  - **2015 - Exceeded benchmark**
  - **2016 - Exceeded benchmark**
  - **No benchmarking or data**
  - **Highest scoring category**
  - **Did not exceed benchmark**
  - **Trending up**
  - **Trending down**
  - **NC - No change**
  - **Exceeded benchmark in 3/4 categories**

Kalispell Regional Healthcare
Kalispell Regional Medical Center, compared to the NRC Health Database average, performs above average in 9 of 10 dimensions on the hospital patient experience survey.

So where should the focus be for improving patient experience in 2017? Most persons reviewing this information would be drawn to the areas where we are performing below the database average.

Perhaps focusing on improving communication about medication side effects or symptoms to look for after discharge, or creating a quiet environment would be good choices. Focusing improvement efforts in these areas would likely produce some positive improvement but would be missing a bigger opportunity to make sustained improvement in all areas of our patients’ experience.

Meaningful patient experience is about more than creating a quiet environment to optimize patients’ rest and comfort. It is even more than providing the medication information about side effects or symptoms to look for after discharge.

Optimizing patient experience in a hospital setting is all about communicating in ways patients can understand.

How will we know they didn’t understand if we do not verify and validate their understanding at the time we are delivering information?

Take note of the common question in the Communication with Doctors and Communication with Nurses dimensions: “How often did [doctors and nurses] explain things in a way you could understand?”

Our patients rated us lowest on both of these key questions under the respective HCAHPS dimension.

What would our patients’ experience be if they felt we always explained things in a way they could understand? Wouldn’t our patients’ perception of communication about medication side effects and symptoms to watch for after discharge also be perceived as always being conveyed in a way they understood?

Improving patient rating on these two questions has a global effect on the entire patient experience and correlates most highly with their overall perception of the hospital’s quality and care delivery.

Reviewing our performance over this past year reveals an important opportunity. How do we better convey information to improve understanding?

The evidence exists for application of simple tools that also make caregiver roles more engaging and enjoyable.

Starting encounters with the “Social 10” and using the “Teachback” method to confirm understanding are proven techniques. Focusing on these two actions and embedding them in the culture of our care delivery would make a significant impact in our patients’ perception of our quality and care.
# Adult Inpatient Hospital HCAHPS

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<tr>
<th>HCAHPS Dimensions</th>
<th>Kalispell Regional Medical Center</th>
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<td>Staff took preferences into account</td>
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<td>Understood managing of health</td>
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Below Database Average = Room for improvement
What nursing excellence means to me...

“working together with a multidisciplinary team to have the best outcome for our patients”

Anaka Fraser, BSN, RN, CEN
Evolution of Our Shared Governance Model

In May of 2016 we discovered that we had an opportunity to improve communication pathways, structure and decision making authority within our Shared Governance Model. The existing Shared Governance Model was not widely recognized by staff and nursing leadership.

Nursing Consulting Partners presented the concept of “Accountabilities for Shared Decision Making” (George & Haag-Heitman, 2010) at a workshop held for our facility. It delineated clinical practice accountabilities and management accountabilities with overlapping shared decision making. Keeping the “Accountabilities for Shared Decision Making” in mind, nurses explored how our current Shared Governance structure functioned and discussed ways that it could be improved.

A steering committee was formed in June of 2016 and organization-wide nursing open forums were held to educate staff on shared decision making and gather input regarding our existing model and potential new model structures. Revised models were formed from the ideas and comments. Two models were presented at open forums held in August 2016 and finalized for all KRH registered nurses to vote on via survey in September 2016.

Seven hundred and thirty-seven registered nurses received the email invitation to vote and 301 responded. The model selected is a uniquely colored circular kaleidoscope pictured here.

This model represents open, collaborative communication and transparency among councils. One nurse commented that the model chosen was a “better representation of collaboration between disciplines and the dance we do as we share ideas and responsibility.” The outer gears represent the nurse at the unit level through Unit Based Councils (UBC), both in the ambulatory care and inpatient care settings. Representation from each inpatient UBC come together to form the KRH Unit Council and representation from each clinical UBC form the KRHPN Ambulatory Council.

The KRH Unit Council previously did not exist. This council was created to give voice to each UBC facilitating communication with each other as well as with other councils within the Shared Governance structure.

Nursing also saw the opportunity to include Advanced Practice Nurses in our Shared Governance Model and have been diligently working to establish an Advanced Practice Professional Council.

Chairs from the existing Shared Governance Councils (Professional Development Council (PDC), Professional Practice Council (PPC), Evidence Based Practice and Research Council (EBPRC), Quality and Safety Council and Leadership Council joined together with the chairs of the newly created councils to establish the Coordinating Council. Much like the motion of a jellyfish, information flows into the Coordinating Council and then back to all the Shared Governance Councils, UBCs and the bedside nurse.
In 2016 our council worked to promote clinical inquiry and generate interest in evidence-based practice (EBP). We began this work by launching a Sacred Cow Contest. The contest was a replication of a published, creative strategy to promote clinical inquiry and generate interest in EBP. Nurses were encouraged to submit contest entries identifying a nursing practice that may not be based on best available evidence or established best practices.

The contest winners were announced at Nursing Grand Rounds and nursing staff were encouraged to reach out to the council for mentorship in finding answers to their clinical inquiries. The Evidence Based Practice and Research Council adopted the winning sacred cow and is currently searching the literature and developing an action plan to address the inquiry. This inquiry questioned our current practices for drawing blood cultures from a central line. The work of the council will be presented to staff at Nursing Grand Rounds in June 2017.

Our council has also assumed an active role in identifying presentations for Nursing Grand Rounds and mentoring groups or individuals with their presentations. One of our council’s goals is to provide assistance and guidance for dissemination of EBP and research findings internally and externally through these types of activities; journal clubs, Nursing Grand Rounds and poster presentations. We developed a tool called “EBP/Research Timeline – From Inquiry to Grand Rounds.” The tool gives an overview of a realistic timeframe one can expect from initial clinical inquiry to Nursing Grand Rounds presentation. It also provides for quarterly communication and mentorship between an individual or group and our council. This tool guides a person in obtaining necessary support and oversight of the EBP project or research study.

This is done by an individual or group obtaining a letter of support from a manager at the beginning stages of the inquiry and also by seeking Institutional Review Board review for either a non-research determination letter or approval of a research protocol. A person can use this tool as a guide even if they do not intend to present at Nursing Grand Rounds.

Another resource our council has developed to support EBP, research and performance improvement (PI) within the organization is the EBP at KRH site of the WIRE. This site can be used to find a tool to help in determine if a clinical inquiry is Research, EBP or PI. Tools can be found to guide work through the steps of EBP, to determining levels of evidence, critical appraisal tools, the EBP/research timeline – From inquiry to Grand Rounds, an EBP project tool, and an EBP step-by-step article series by the American Journal of Nursing.

As our council continues to develop, we are spending focused time educating ourselves to the principles of EBP and research. All council members have completed National Institute of Health (NIH) training on protecting...
human subject research participants. We have established goals for 2017 which include; continuing our education to, in return, be able to provide mentorship for individuals or groups; and to develop strategies to meet educational needs of staff with regards to EBP, Research and PI.

2016 Summary of Quality and Safety Council Activities

The past year has been one of reorganization and exploring what our council’s role is in relation to the Shared Governance Model at Kalispell Regional Healthcare. We were a council focused on one goal in the previous years — reducing patient falls.

The start of 2016 found us focusing on the implementation of a post fall huddle. The process as designed was to help nursing caregivers review fall risk assessment for accuracy, plan effective interventions with the patient and their family to prevent falls; to reinforce the plan with the patient and their family members. The idea was that this action of consistent, systematic review of actual fall triggers within 15 minutes of the event would help to reveal trends not obvious in the patient’s record.

The council members identified the need for an electronic post-fall huddle process in February. HealthCenter Inpatient Unit and Inpatient Rehab Unit volunteered to test the electronic process.

In the meantime, Magnet® consultants advised our council to broaden the scope of improvement efforts and to make data accessible to unit staff.

In March, the council reviewed performance data on another nurse-driven quality indicator: catheter associated urinary tract infections (CAUTI). Our organization rates had been high in 2015. Foley insertion and care education by nursing and infection prevention staff were anticipated to improve CAUTI rates in 2016.

In April, HealthCenter had only one fall in a month. They recognized they couldn't adequately test the post fall huddle process. The decision to go organization-wide with a paper form for documenting a post-fall huddle was made. Further review of fall trends revealed that unassisted falls were increasing across hospital units.

Was this trend an indication that rounding or patient education about fall prevention interventions were an opportunity needing attention? Nursing education on patient education had been developed in the beginning of the year by the council. This education, with an emphasis on “health literacy” and use of “teachback” as a method to confirm understanding, became a priority. With the support of Karen Lee, the computer based lesson on patient communication was assigned to all nursing staff across the organization in the second trimester of 2016.

The council added new members during the next five months. We knew we needed to increase the number of nurses who provided direct patient care to accomplish the goals of disseminating data at a unit level and engaging frontline staff in the practice changes that would improve our performance on nurse driven indicators of quality. We also needed subject matter experts to support the improvement process. Representatives from infection prevention and patient safety were added.

During the remainder of 2016, we focused on rewriting the council by-laws and spent time digging into the NDNQI data base to build understanding of the data and the various ways it can be displayed.

As 2016 drew to a close, we continued to see rates of falls with injury trending above the benchmark for the hospital overall. While some units did measure short-term reductions in falls with injury, these gains were not sustained organization wide.
We also noted a small increase in pressure ulcer occurrence at the end of this year. With major changes to the definitions of the pressure ulcer indicator anticipated in 2017, there will be a period of relearning on this topic.

Catheter associated urinary tract infections saw a decline organization wide. Trends in central line associated bloodstream infections remains very low.

The Quality and Safety Council set goals for 2017:
• Develop expertise among council members regarding nurse driven quality indicators by reviewing definitions; evidence-based best practices and interpretation of unit performance. The goal is to have at least 50 percent of reporting units performing below NDNQI benchmark for at least 4 of 8 quarters.

Nurse driven indicators are:
- Falls with injury
- Hospital-acquired pressure ulcers stage 2 and above
- Central line associated bloodstream infection
- Catheter associated urinary tract infections
- Patient experience scores

• Build accountability for unit performance on nurse driven indicators among KRH clinical units by setting an expectation of bimonthly progress reports to the council; to include action planning, interventions implemented, and outcomes measured.

APRN Council
The Advanced Practice Council is in the formative stages. Membership will encompass the advanced practice providers within KRH.

Coordinating Council
As nursing staff worked on revising and improving our shared governance structure in June 2016, it became evident that communication throughout the councils needed much improvement. Chairs from the existing shared governance councils were brought together to form the Coordinating Council and began meeting monthly in August 2016.

The purpose of the Coordinating Council is to coordinate, communicate, and integrate the work of the nursing councils and conduct business that provides the necessary environment to promote excellence.

Kalispell Regional Healthcare Unit Council (KRHUC)
The KRHUC serves as the governing body for KRH’s collective unit based councils. Through the use of the American Nurses Association’s scope and standards of practice as guiding principles the KRHUC will uphold the standard of practice as it pertains to nursing excellence and care delivery to our patients. This council serves to act as a centralized clearing house and communicator between individual unit councils and the Coordinating Council which disseminates information to all councils.

KRHUC reports the evidence-based practice projects of each unit-based council to the Coordinating Council. Knowledge and outcomes of these projects is shared units, departments and other systems as indicated in order to coordinate system change organization wide.

This was a newly developed council in 2016 and has been working on establishing membership, electing officers and writing by-laws. Goals for the coming year are to develop the processes for disseminating the organization-wide unit council activities and provide all councils with a defined
algorithm of that process. Through education and promotion the council's goal is to achieve 100 percent representation of all the unit-based councils.

**KRHPN Ambulatory Council**

The Kalispell Regional Healthcare Physician Network (KRHPN) Ambulatory Council exists to provide a mechanism to create quality outcomes through standardization, collaboration, communication, coordination and a sense of community. The members participate in the development of a multi-faceted training program to provide the nursing staff with the knowledge, skills, and abilities to undertake evidence-based practice (EBP) or research. This council provides oversight and mentorship for the clinics. It provides a platform to discuss safety stories, clinic updates and clinical concerns.

The KRHPN Ambulatory Council supports incorporation of EBP and research into KRH ambulatory nursing policies and procedures and foster and facilitate interdisciplinary communication and collaboration across all clinics.

Our goal for last year was to educate and initiate the council on Shared Governance and unit councils. We did two presentations on Grady Porter’s Shared Governance and developing unit councils in the clinic setting. Education was offered on how to start a unit council in the clinical setting as a voice to fulfill the purpose of the KRH Ambulatory Council by-laws. Support was given to newly formed unit councils in the different clinics as a platform to disseminate, standardize, collaborate and communicate between the clinics.

**Leadership Council**

The Nursing Leadership Council exists within the Shared Governance Model for KRH. To pave the way on our journey to excellence, KRH has developed this council and includes nurse leaders from across the organization. This council has expanded from the Nurse Leadership Committee and is beginning to build momentum as we have come together. For example, each Shared Governance Council has a nursing director and clinical nurse manager representative. Each month when the leadership council comes together, a report of each council is shared. This is aligned with our Accountabilities for Shared Decision Making Model, which was adopted in July 2016.

As leaders we are to pave the way by breaking down the barriers for staff so they are able to professionally practice with autonomy ensuring excellence in care delivery that is provided with high quality and safety.

The Nursing Leadership Council has developed bylaws and goals. It is focused on ensuring:

- Action plans for the RN satisfaction results are in place for each area and reviewed monthly to ensure implementation and evaluation of plans.
- The Shared Decision Making Model is utilized to address barriers for other shared governance councils.
- A nursing strategic plan is developed that aligns with the organizational strategic plan.
Nursing Shared Governance Model Councils at KRH

focusing on the Patient Experience, Employee Experience, and Meditech 6.15 implementation.

The coming year will continue to be a time of transformation and growth as we strive for continued collaboration, transparent communication and celebration of staff accomplishments.

Professional Practice Council (PPC)

The Professional Practice Council reviews, guides and promotes the standards of clinical nursing practice and excellence in patient care through utilization of evidence-based practice and requirements of regulatory agencies.

This council addresses nursing practice issues, they are involved in policy review and revision of the nursing organization-wide policies. In the last year the PPC has been working on:

- Medication policy. Task force established to initially look into cosigning the IVP medication portion of the policy to ensure best practice is utilized and there is compliance within the organization. The entire policy will be looked at along with medication policies of other departments such as Pharmacy and Respiratory Therapy to combine into one multidisciplinary policy.
- A restraint work group was formed to look at the restraint policy and compliance.
- A coude catheter module and policy will be presented at the January meeting for feedback and approval.
- The council discussed nurse’s notes in nursing documentation and will take discussion to their unit level for feedback to the council.

Future goals for this council are:
- Nursing communication tool. A work group was formed with plans to attend demonstrations of several different vendors of communication devices and will have input into the selection process for the organization.
- To establish a process for continuous review of nursing organization-wide policies and then begin reviewing policies using this process.
- Participate in new product and equipment review through the organization-wide Products Committee.
- Advocate for standards of clinical nursing practice that utilize EBP and are congruent with regulatory requirements.

Professional Development Council (PDC)

2016 was a year of reorganization for PDC. We reviewed our bylaws and updated our purpose/mission statement to more closely align with our initial purpose and maturing shared governance model. Our new mission statement is: to promote and evaluate professional development and clinical competency of nurses by inspiring nurses to excel in professional growth through promoting educational opportunities, career advancement, advocacy and research to support the unique needs of the nursing profession.

We then gained structure by following “how to run an effective meeting” and using the standard templates for our meeting agenda and minutes. We also developed a communication grid that identified departments not represented on our committee and each council member is required to communicate with their assigned departments about the council take-aways.

We have changed members this past year and have taken this opportunity to re-evaluate members’ responsibility and increase accountability for their participation.

Projects have been numerous and exciting. They include:
- Awarding two $500 scholarships that were randomly drawn from names submitted via email. This money was left over from previous Jeans Day program is designated to be spent on an educational offering. This is usually a conference or on-line course. Specific
guidelines are in place for the recipients to share what they learned either by a formal presentation or writing an article for the *Grapevine* newsletter.

- We raised the bar for the 2016 Clinical Ladder and recognized those nurses who went above and beyond. We had 27 Level I, 20 Level II, 18 Level III, 8 Level IV and 2 Level V participants.
- With the revision of our Shared Governance Model, PDC took ownership of certification approval.
- Nurse preceptor support and advancement and career development workgroups now report to PDC.

- Charge nurse development taskforce is currently meeting and plans to recommend a detailed model in February 2017.
- Professional Development Portfolio (Clinical Ladder) work group is presenting a new plan for 2017-2018.
- PDC also participated in the first annual career fair for new resident nurses completing their first year and will be ready to participate in the 2nd annual coming soon.
A part of our nursing excellence journey is continued learning and discovering new knowledge. One way we achieve this is by attending the annual Magnet® Conference. This year’s theme was “Empowering Nurses to Transform Healthcare” and nine nurses attended. As the team prepared to attend, each member had a specific focus with questions they were bringing to the conference, with the goal to bring back the learnings to share as we continue our journey.

At the time the conference took place, there was much news surrounding a storm that would become a hurricane, and become a storm again, was headed towards the Florida coast. In the end, the storm became strong enough to be a hurricane and the conference was cut short. While disappointed, the team took the time they had to learn as much as possible. The opening session of conference included 9,832 nurses from around the world. There was celebration of successes, sharing new ways of thinking, and the coming together as nurses, with the common vision of being change agents in our profession. During the two days, the team spent time learning, networking, interviewing and sharing.

The team from KRH who attended, soaked in as much as they could in that short time and were energized to share. Information of what was learned was presented at the October Nursing Excellence Open Forums and highlighted preparing for the Magnet® appraisal, creating mindfulness practices, establishing peer review, evidenced-based practice, professional development and finding joy along the way. Shared Governance and Unit Based Councils are weaving in these learnings as we continue moving forward.

By Katie Dill, MA, BSN, RN
What nursing excellence means to me...

“creating a healing environment for all – patients, family, and peers”

Anthony Babb, BSN, MSE and Kaija Lockhart, BSN, RN
A journey begins with one step.

This year’s annual report is filled with the many steps of accomplishment we have taken to build on our journey of excellence. As an organization we have grown in knowledge, embraced change, questioned practice, and owned outcomes all while we deliver on our nursing mission of excellence in care: every patient, every time.

We held Nursing Excellence Open Forums where many learned and gave voice to the excellence journey we are on and creating together. Examples include learning about Shared Governance and providing input into the creation of the model and now evaluating our Professional Practice Model to ensure it speaks to practice occurring in each area. In addition, being reintroduced to the ANA Code of Ethics and Nursing Scope and Standards of Practice and understanding how these are foundational to our respective roles, has re-energized many staff to inform their practice.

Along the way, Shared Governance Councils have become stronger with frontline staff leadership who has learned how to effectively lead a meeting and disseminate information with “take aways” back to the areas they represent.

To watch staff this year have the courage to ask the difficult questions, have engaging dialogue, and ensure practice is based on the evidence has been a wonderful transformation to be a part of.

In addition, councils have been created to ensure all areas of nursing are represented across the continuum of care and practice. Communication has increased with the creation of the Coordinating Council and will continue to expand as we grow in services.

There is still much to do as we continue on this journey. The best part is we have the right team members to bring us to where we are headed. I hope you have enjoyed reading this year’s report. There is much to be proud of. Excited to be a part of this journey, where together we are making a difference for good and above all doing the right thing!

Sincerely,

Katie Dill, MA, BSN, RN – Caritas Coach
Regional Outreach CNO
Director of Nursing Excellence
Certificate Holder, Fundamentals of Magnet®
Excellence in care; 
every patient, every time.

Above all... 
do the right thing!