2017 Nursing Annual Report
Pride in our Profession

KALISPELL REGIONAL HEALTHCARE
EXCELLENCE IN CARE, EVERY PATIENT, EVERY TIME.

Nursing Mission: To provide collaborative, evidence-based care that is patient centered.

Isaac Rajkowski, BSN, RN

My all-time favorite basketball coach is John Wooden. With ten national championships during his twelve year coaching career at UCLA, including a seven-year streak, he says, "Big things are accomplished only through the perfection of minor details." He goes on to say that his secret to success is the power of many little things done well. In the note that I received from KRH Chief Nursing Officer Karen Lee, she says, "…it's the small things that make this place great!"

I believe that my contributions, as small as they may seem at times, combined with the positive attitudes and contributions of every employee at KRH, are what make this a great organization. I believe my influence and presence on the floor improves patient safety, contributes to nurses doing the right thing every time, and improves job satisfaction. I believe this is true because of my daily contributions to a culture of safety and professionalism. It is not only the extra work I have accomplished this last year, but also the attitude I seek to consistently bring to my patients and coworkers every day.

I seek to know the names and stories of our housekeeping and kitchen staff because I believe that we are more likely to support each other if we know our coworkers by name and have listened to their story. This makes us stronger, safer, and ultimately an organization that I would want my family members to receive care from. If we continue to be diligent in doing the little things well, we will continue to improve our personal practice, our organization and the nursing profession as a whole. I am thankful for an opportunity to contribute every day at KRH to doing the small things well. Let's continue to commit to doing the right thing with every patient, every time because these are the small things that make us great.

The following letter is an example of one of the small things Isaac does for patients:

As I walked through the entrance of the hospital today, a melodious sound filled the air. An older gentleman, donned in a hospital gown and oxygen tubing, was playing the piano. His eyes had a sparkle which words cannot express. Beside him was a wheelchair and his nurse, Isaac Rajkowski. Isaac's action brought delight to this patient. The gentleman said he has played the piano for more than 50 years, but has not played it over the past several years. This simple act of kindness truly brought joy to this patient. Thank you, Isaac, for being such a compassionate team member.

-Karen Pilgrim, MSN, RN, director of nursing, KRH Physician Network
Advocacy – Being on the “A Team”

Cary Heskett, MSN, RN

I called him Mr. A because I could not pronounce his long Polish last name. We joked I was on his “A Team.” Over five months, I coordinated Mr. A’s care as his home health nurse.

Once a week, I visited Mr. A to evaluate his response to cancer treatments, as well as change his dressings. However, I needed to increase my visits to three times per week after Mr. A was hospitalized with complications. When Mr. A became weaker, I instructed his friend how to provide care. If she was out of town, I made an extra visit to cover for her.

Mr. A shared about his life. He cried; he knew the remainder of his life was short. Mr. A was appropriate for hospice but he wasn’t ready to give up on his cancer treatments, so I provided his care through home health.

At Mr. A’s last hospitalization, I visited him and met his children from out of town. His doctors informed him that his options for cancer treatment were expended. Therefore, I began a discussion about long-term care with his family. Mr. A chose to return home rather than transfer to a nursing home.

Two days later, I visited Mr. A at home and discovered that he had fallen several times and was too frail to care for himself. I gathered his children together and we discussed home safety, finances, and in-home care versus moving him into a nursing home. Mr. A was resistant to leave his home for financial fears. I connected his children to a social worker at the nursing home.

Ultimately, Mr. A decided to move into the nursing home. Within a few days, his nurse called requesting instruction on the care of his tube. Mr. A had told her, “Just call Cary, she will know what to do.”

I collected a few dressings from the home health supply closet, even though Mr. A was no longer receiving home health services. I felt it was the right thing to do. After work, I headed over to the nursing home and taught the second shift nurse how to use the dressing.

When I entered Mr. A’s room, his eyes lit up and he said, “I knew you would come.” He expressed his satisfaction with moving into the nursing home and asked about hospice. We shared some emotional moments. A week later, Mr. A died.

I was Mr. A’s advocate. My care went beyond providing medical treatment and I felt called to offer extra time, attention, and emotional support to both Mr. A and his family. I had completed my time on the “A Team.”
CNO Reflections of 2017

Karen Lee, MHA, BSN, RN, Chief Nursing Officer

As I reflect on our accomplishments of 2017, it is a bittersweet moment. I will be retiring at the end of this year, and I want each of you to know what an honor and privilege it has been for me to serve you and this organization as your Chief Nursing Officer. You have heard me say many times, “This is the best nursing team I have ever worked with.” It is truer now than ever.

When we began our journey to nursing excellence, we recognized it would be a marathon and not a sprint. Over the past years, we have continued moving forward with improving systems and processes that ultimately improve patient outcomes. Our shared governance and unit based councils have expanded our ability to change our culture. It gives nurses a voice throughout the organization. Nurses working together can accomplish anything, and 2017 was no exception.

Our nurse residency program was accredited with distinction by the American Nurses Credentialing Center this year. It is the first, and currently the only, accredited program in the state of Montana. Nurses worked to revise both the shared governance and professional practice models to better reflect our commitment to our patients and community.

Our first Charge Nurse Academy, developed by nurses for nurses, allowed us to better prepare young leaders in their role as charge nurse. Clinical nurses became more active participants in identifying opportunities to improve care by participating in data collection and work groups, and then making changes on their units that resulted in improved patient outcomes. Through collaboration with departments throughout the organization, we have improved the quality of care that we provide to patients.

It is my sincere hope that our journey to nursing excellence will result in Magnet® designation. The nursing profession is one of the most honored and trusted professions in the world and each of us have the honor and responsibility to change lives every day. Never forget that! Our voice in health care advocating for patients is a gift that each of us should remember we have. It has been very rewarding to watch our nursing increase departmental collaboration, become actively involved with medical staff colleagues, and always ask the question, “What's the best thing for this patient?” I am proud to have been a part of this organization for the past 19 years; ten of those as your CNO. Thank you for your commitment to patients, families and to our community. You all are truly the best!
Congratulations to Kalispell Regional Healthcare’s
NURSE OF THE YEAR 2017
Sandra Giroux, LPN

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Glacier National Park images generously supplied by Jack Bell Photography.
“I’m proud to be able to comfort and advocate for patients in difficult times, and make a difference in the lives of my patients and their families.”
- Maren Erpelding, RN, third floor medical
In 2015, A.L.E.R.T. celebrated its 40th anniversary as a helicopter air ambulance service. Our Bell 407 helicopter, tail number N407KH, had been a part of that history for the previous 16 years and logged in excess of 6,500 flight hours during that time. Though safe and generally reliable, that service had taken its toll as we began to experience longer, more frequent and costly maintenance downtime. As a result, in September 2016, the executive director of aviation operations, Carson Coryell, and I proposed a plan to replace N407KH with a new Bell 407GXP to the A.L.E.R.T. board members.

At a cost of $4 million, the new helicopter was purchased and arrived on June 22, 2017. It is the same make and model as the previous helicopter, but the newest model. This was important due to existing inventory of replacement parts and pilot familiarity, as well as having the same lead and backup helicopter operations. A special gifts initiative was started to raise the $4 million needed. Thanks to our amazing community, employees, friends and board members, the $4 million check was presented to KRH leadership in April 2018.

The Bell 407GXP integrates reliability, speed, performance and excellent maneuverability into the very familiar Bell 407 platform. The upgraded Rolls-Royce 250-C47B/8 turbine engine delivers more power (notably during hot and high conditions) and the ability to cruise at 133 knots/hr; a 10 knot increase over our legacy Bell 407.

From a pilot’s perspective, the most significant improvements are directly in front of us. The 407GXP is equipped with the Garmin G1000H™ flight deck, a system which provides critical flight information at a glance for greater situational awareness and safety. This system includes integrated flight instruments, engine instruments with power situation indicator, Traffic Information System, Helicopter Terrain Avoidance Warning System, moving map, pathway-in-the-sky and Garmin’s Helicopter Synthetic Vision Technology. Equipped with a two-axis autopilot, safety is further enhanced by reducing pilot workload and again, increasing overall situational awareness.

For the medical team, the added safety, reliability and speed provided by our new aircraft has been well received. The LifePort medical interior and loading system are quite similar and familiar to the team as it is nearly identical to the system installed in N407KH. This cross-compatibility has allowed us to minimize duplication and unnecessary equipment redundancies.

The Bell 407GXP was given a new tail number: N407VS. The ’VS’ was chosen in memory of former KRH CEO Velinda Stevens, her service to KRH, and unwavering commitment to the A.L.E.R.T. program.

As of late September 2017, N407VS has flown more than 100 flight hours and transported 85 patients since becoming our primary medical response aircraft. We look forward to many years of safe, efficient and reliable service from her.
Transfer Center Streamlines Communications

Erik Browne, BSN, RN

Kalispell Regional Healthcare (KRH) has grown to truly become a health care destination in Montana. With this growth, physicians and administration decided our organization needed to streamline how patients were directed into our organization from outlying facilities.

We sought to simplify how providers around Montana could connect with the appropriate physician at KRH for patient consult and/or transfer. This job was tasked to the staffing office/house supervisor team as they are already directly involved with admissions. This team worked through late 2016 and early 2017 to study and understand how other hospitals successfully implemented a transfer center in their organizations.

We used University of Washington/Harborview Medical Center in Seattle as our primary role model for our process and guidelines, gaining much of our understanding through a site visit in December of 2016. Our team of house supervisors and nursing care coordinators initiated the Transfer Center at KRH on June 1, 2017. We now have a registered nurse available 24 hours a day, seven days a week, dedicated to connecting outlying providers with KRH physicians, arranging both incoming and outgoing transfers, and assisting the house supervisors with bed assignments and staffing related to inbound patients.

Since inception, the Transfer Center has coordinated more than 100 patient transfers from two dozen different Montana hospitals per month, and connected nearly as many providers in consultation. It continues to be our goal to improve the transfer process for our organization in order to expedite care for patients and efficiently utilize the resources KRH has to offer.

Greg Louden, BSN, RN, and Erik Browne, BSN, RN
“I’m proud to be a nurse at KRH because I get to work with a highly skilled team to improve the lives of my fellow community members.”

- Brian Dahl, BSN, RN, Brendan House
Acute Care Core Competencies

Debra Goodrum, BSN, RN

Competency: what does it mean? Webster’s dictionary states, “competency is the ability to do something successfully or efficiently or performance of the normal function.” Nursing defines competency as possessing specific knowledge, skills and abilities to perform your duties as a nurse. Do patients care about your ability? Does the hospital care? Do the doctors or providers care? Does the insurance company care? The bigger question; do you care?

During the “performance of the normal function” as a nurse, the reason we all care is for the sake of the patient and their families who are stressed, sick, confused, scared and overwhelmed, and in need of a competent nurse. Being a nurse is hard. Being incompetent is harder, as you’ll have to find time to redo things you did incorrectly the first time. Everyone wants an expert nurse to care for them, to work for them, or wants to be one of them. The time, effort and ownership of becoming an expert nurse lies within one's self. These factors were the impetus for creating our acute care competency program to develop excellence in skills, knowledge and abilities while fostering an attitude of ownership with peer accountability.

Our program grew from within the medical/surgical unit-based councils in an effort to advance nursing to the optimum level of competence referred to as excellence. The knowledge and skills measured in this year’s new program include blood administration, management of chest tubes, use of new Linet beds, wound care management and managing the first five minutes of a patient emergency. These skills were chosen by the councils in conjunction with unit managers and our data. These skills were chosen by the councils in conjunction with unit managers and nurse sensitive indicators. As patient acuity increases, our resources decrease. Being competent is now more relevant than ever before. What we did yesterday will be outdated tomorrow as research uncovers the new truths to many of our practices.

In addition to the new competency program, a nursing lecture series is taking shape. The series includes on the unit in-servicing during staffing huddles and meetings as well as just-in-time training in an effort stay up to date with what’s new. Grateful to our speakers, we are receiving formal lectures on timely topics such as spinal hematomas, complications of a “whipple” pancreaticoduodenectomy, care of wounds and ostomies, and hyperthermic intraperitoneal chemotherapy; all with patient case reviews to enhance at-the-bedside knowledge, skills and abilities of our excellent nurses.

In 2018, we have 365 days of opportunities to improve our “performance of the normal function” and provide our patients, co-workers and ourselves with expert nurse care. Are you ready for the challenge?

“If you don’t have time to do it right, when will you have the time to do it over?”  
- John Wooden
In October 2016, a workgroup was established to review registered nurse (RN) job descriptions at KRH. This team included representatives from the KRH human resources department, two clinical educators, a clinical director, and a clinical manager. The goal for this team was to develop an RN job description that identified and defined core competencies for all newly hired RNs that align with ANA Standards of Practice and Professional Performance.

The proposed KRH RN job description identifies 11 basic core competencies for RNs that address the six American Nurses Association (ANA) Standards of Nursing Practice of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation and also aligns with the seven ANA Standards of Professional Practice. Nurses at KRH must display professional behaviors, follow KRH policies and procedures, and demonstrate proper communication. Methods of validation for successful completion of these competencies and adherence to Standards of Professional Practice are: (a) direct observation by a charge nurse, supervisor, or member of the nursing leadership team, and (b) participation in peer evaluation. The KRH nurse must also complete all mandatory training.

Assessment of the KRH RN core competencies uses Benner’s model of novice to expert. The basic core competencies are introduced at nursing general orientation attended by all newly hired KRH nurses. Competency is then determined by the unit specific clinical educator and manager. In addition, unit clinical educators and clinical managers from this work team identify and define unit specific core competencies.

**Implementation plan**

Basic core competencies are currently introduced in general nursing orientation. Revised job descriptions identifying core competencies for newly hired KRH RNs are developed and will be utilized beginning in 2018. Core competency assessment modules using the KRH learning management system are being developed for all newly hired RNs to KRH acute and critical care units and will be fully implemented by August 2018. Once implemented, all newly hired KRH RNs will complete core competencies upon hire and then again annually.
OB Department Introduces the Baby Box Program
Angele Romero, BSN, RN

Last year, a pediatrician noted that babies were routinely found co-bedding or in an unsafe sleep environment upon her visits out to newborns. The Kalispell Regional Medical Center (KRMC) OB Department took this feedback seriously and began extensive research to help change this culture. A vision focused on safe sleep practices began to form.

One of the guidelines for safe sleep practices set forth by the American Academy of Pediatrics (AAP) is to have the newborn infant sleep in the same room, but not in the same bed as the parents for at least the first six months. For many of our families, purchasing a bassinet as well as a crib to put in their bedroom for their newborn was not attainable. Upon the arrival of a new baby, families now have the option to get a Baby Box; a simple, hard-sided box with a mattress and fitted sheet that can be used as a bassinet. Even better, the box comes filled with newborn essentials like a SleepSack, diapers, a thermometer, a bulb syringe and a goodie bag for the new mom.

Created by The Baby Box Company, these boxes are currently being used in many areas of the United States and Canada. KRMC is the only hospital in Montana to provide this for our families.

To receive their free Baby Box, families must complete a series of online videos through Baby Box University. There are 19 videos, each about 30 minutes in length on various educational topics pertaining to baby care and care of a new mother. The videos were recorded right here at KRMC with our own pediatricians, obstetricians and nurses to provide familiar faces for our families.

With almost 80 Baby Boxes distributed so far, this is just the beginning of The Baby Box program at KRMC. We are thrilled to be able to offer this option to our patients as they welcome a newborn to the family.
“We’re proud to be a part of the journey to the new Montana Children’s Medical Center and part of the new PEDS/PICU team for the kids of Montana.”
- Lori Sagona, RN, CPN, and Dani Hineman, BSN, RN, CPN, PICU

An Integrative Approach to Pain Management
Doreen Hart, RN, HN-BC
The Montana Center for Wellness & Pain Management
serves patients with chronic pain and addiction.
Right now, two of the biggest health concerns in this country are chronic pain and opioid addiction. Chronic pain affects 100 million Americans each year, while the next two most common concerns, diabetes and cancer, affect 25.8 million and 11.9 million per year, respectively. The opioid crisis is rapidly growing in the United States, as the number of deaths only increase each year.

When utilizing the traditional approach to pain management, patients were not engaged and not progressing in their care. They were often stuck in a cycle of pain, depression, and then possible medication reliance, despite directives from providers. To try and break this cycle, we developed the EMPOWER program at The Montana Center.

The program is a patient-centered care model which encourages patients to become active agents in their own care. With EMPOWER, patients create personally relevant goals. Patients meet with a psychologist and patient navigator, and together, create attainable and measurable goals to address life with chronic pain. Active patient-provider partnerships help integrate medical, alternative and counseling therapies throughout the program. Combined with the elements of ongoing education and group support, EMPOWER is dedicated to each patient's personal commitment to change.

The continuum of care is a vital part of the program. Through provider follow up, check in calls and patient education classes and groups, our staff is committed to helping patients reach their goals. Program participants also receive an EMPOWER workbook to bring to each appointment as a major tool in their forward movement of care.

From May 1 to October 21, 2017, 26 percent of new patients have initiated the EMPOWER program, and eight percent of established patients have initiated the EMPOWER program. Our goal is to establish 100 percent of new patients and more than 50 percent of established patients in the EMPOWER program.

To reach our goal, we have included our addiction patients to initially participate in the EMPOWER program, and then adapt the process to support these patients in their recovery to autonomy and self-reliance. Our next step is gathering data and formally documenting all that we have discovered throughout this journey.
Inaugural Charge Nurse Academy Prepares Leaders

Katie Neff, MN, RN, CNL

KRH welcomed the addition of Charge Nurse Academy in 2017. Developed by charge nurses, staff nurses and clinical managers, Charge Nurse Academy is designed to meet the needs of the charge nurse leadership position in our organization. Charge nurses lead their teams every shift and often work with a variety of personalities, unique patient situations and demands outside their own department. During this three-part training series, charge nurses cover topics in communication, unit management and fiscal considerations.

Communication

As role-models, charge nurses participate in a “Would you buy your brand?” training activity. Whether through work-related activities, personal activities, social media platforms, or others, we each send messages that create our brand. Would YOU buy your brand? DISC training, a simple tool that uses individual assessment data to provide information about your workplace priorities and preferences, help our charge nurses identify different ways of communicating with their coworkers. Some people need bullet points, some need a personal connection before talking business while others need detailed steps and data to best work and communicate effectively. Regardless of the person’s tendencies, charge nurses realize the importance of flexing to others’ styles to optimize communication on their units during this training.

Unit management

As the "air traffic controller" of the unit, charge nurses learn more on managing their unit as part two of the series. Helping mentor staff to become knowledge workers rather than task-based workers is a key component in nursing excellence. Staffing needs of the unit can be a complex puzzle. During this training, the staffing office/house supervisor team provides tips on staffing needs assessment. Human resources leads a discussion on the expectations of our charge nurses as it relates to policy compliance. This session closes with welcoming the director of risk and medical staff services to share risk management considerations for staff documentation, handling tough situations, and more.

Fiscal considerations

Lastly, the charge nurses learn the breadth of impact they can have on their units from creating awareness around patient’s length of stay related to diagnosis, utilizing data to drive patient care, or to do the little things such as ensuring their staff takes a lunch break on each shift. While our charge nurses may not be routinely looking at profit and loss statements, there are many aspects of fiscal stewardship they can help drive.
The nurse residency program at KRH is leading the way for new nurse development in Montana. As the first program of its kind in the state, participation has been steadily growing since its official start in July 2015. Newly licensed nurses from all over the country apply to receive 12 months of training and support to help transition to clinical practice. The most recent cohort includes nearly a dozen nurses who have been placed in medical, surgical, oncology, transitional and intermediate care units, and the program is expanding further to other specialty areas like critical care, psychiatry and maternal newborn care. All residents undergo an intensive clinical orientation, bi-weekly trainings, leadership development, and complete the program with a formal evidence-based practice project.

Mandy Pokorny, MHA, BSN, RN, KRH nurse residency program coordinator, says her team has worked hard to formalize the program and provide a solid foundation for nurses joining the workforce. “The program aims to help establish clinically sound, professionally engaged, and emotionally resilient nurses at the bedside, and really grow the KRH team from the ground up.” Pokorny said. She went on to co-publish her findings from the program’s development in the Practice Transitions section of Core Curriculum for Nursing Professional Development (5th ed.).

Support and guidance during the first year of nursing is critical. Nationwide, nursing turnover in the first year of hire can be as high as 60 percent, with half of those nurses leaving the profession altogether. Nurse residency programs are key to combating this statistic. Most of the nurses who complete the KRH program not only remain employed with KRH, but train into specialty areas and/or become preceptors and clinical experts on their units, adding to the strong team of skilled nurses who share their expertise with future residency groups.

The nurse residency team’s effort has not gone unnoticed. In November 2017, the KRH nurse residency program was awarded accreditation with distinction by the American Nurses Credentialing Center’s (ANCC) practice transition accreditation program, the highest recognition awarded by the ANCC program. KRH is the first health care system in the state of Montana to be awarded this distinction and one of only 30 ANCC accredited programs in the nation. The ANCC appraiser team commended the program on its robustness, especially considering the small size of the hospital and limited resources.

Pokorny describes the program’s success as an absolute team effort. “This process has been a lot of work and a true pleasure to be a part of. It takes a village to create a successful environment for our nurses transitioning into the profession, and I am proud to see that we are heading in the right direction. Collaboration is key and I can’t speak highly enough of the good work and support from our executive leadership team, nursing directors and managers, expert clinical nursing staff, clinical educators, preceptors, interdisciplinary teams, human resource partners, and academic partners. We look forward to continuing to grow and refine our program in the upcoming years.”
Education is key to the success of the stroke program. A new hire stroke nurse curriculum was recently built and annual education is provided based on the assessed needs. Education and support are provided to outreach hospitals through the telestroke program. There is also a continued focus on physician education promoting stroke best practice. “We are better equipped and trained to consistently provide our stroke patients with quality care.” - April Gunderson, RN, third floor surgical

Performance improvement
Data is collected at the patient and program level and reported to the Centers for Medicare & Medicaid Services (CMS), AHA/ASA Get with the Guidelines (GWTG) Stroke, and to the staff. The data is analyzed by the interdisciplinary stroke committee and quality department from which performance improvement plans are developed to drive change and improve care.

Continuing the journey
To be fully recognized for our commitment to providing quality, evidence-based stroke care, KRH hopes to obtain the stamp of certification as a primary stroke center. The Joint Commission survey for this certification is planned for spring of 2018. “I was able to play cribbage with one of my stroke patients. It was one of his favorite games. Although everyone’s road to recovery is not as successful, I am encouraged by our effort to give each patient the best chance at recovery and quality of life.” - Isaac Rajkowski, BSN, RN, third floor medical

KRH received the highest honor for exemplary performance at reducing stroke-related death and disability. We also received the Target: Stroke Honor Roll award for commitment to rapid treatment with alteplase.

“I’m proud to be a nurse because I have the opportunity to make a difference each day and give a lasting impression. They may not remember my name, but they will remember how I made them feel.” - Sadie Fuller, BSN, RN, first floor
The Institute of Medicine (2007) recommends that 90 percent of clinical decisions be evidence-based by 2020. In addition, hospitals recognized with the American Nurses Credentialing Center’s Magnet® status are expected to foster and utilize evidence-based practice (EBP) as part of the four evidence-derived Magnet® components: transformational leadership, structural empowerment, exemplary professional practice, and new knowledge, innovations, and improvements (Kaplan, 2014). How is KRH advancing EBP in the nursing profession? It starts with nurse residents.

In a recent Journal of PeriAnesthesia Nursing, co-author Hosking notes that, “EBP content and project development within nurse residency programs have influenced nursing practice and enhanced the culture of the hospitals in which residents provide care. The completion of EBP projects was identified as one of the five instrumental structures or processes with potential for promoting transformational change within an organization” (2016, p. 260-1). With the goal of transformational change, EBP education in KRH’s nurse residency program underwent a total transformation. Today, the fundamentals of making an evidence-based practice change are taught as a five-part series. The series is incorporated into the nurse residency program, and includes experienced staff seeking interest in EBP.

During the KRH EBP Course, learners will:

- Learn the case for EBP in nursing
- Determine an inquiry for change and transform their question into a search strategy
- Search the literature for evidence to support the change
- Appraise the evidence to determine reliability, validity and applicability
- Make an evidence-based practice change recommendation

In 2017, Mandy Pokorny and Kari Hagler submitted an abstract to the Helene Fuld Trust National Institute for Evidence-based Practice first national EBP challenge. Their series titled, “Igniting a Spirit of Inquiry in a Nurse Residency Program” described how nurses at KRH embody evidence-based nursing through the nurse residency program. Since then, the series has been opened to both nurse residents and experienced nurses.

References
This year, a small group of nurses started a workgroup called nurse preceptor support and advancement (NPSA). Reporting to the professional development council, the workgroup is committed to supporting the professional practice and development of KRH nurse preceptors. In doing this, we are also committing to support onboarding practices for new and experienced nurses joining our teams. This workgroup has been created by preceptors, for preceptors.

One of four initiatives this year was to create a way to honor and recognize preceptors at KRH. Nursing staff was asked to nominate a preceptor who personally had precepted them when they joined KRH, or a preceptor on their team who had exemplified the role.

The first Nurse Preceptor of the Year recipient was nominated by her peers and selected by the workgroup as the preceptor who most closely exemplified the five foundational roles of a preceptor: educator, evaluator, protector, socializer and role model.

Anne Martin-Giblin from first floor medical/oncology was selected as the 2017 Outstanding Preceptor. Ann received a $500 scholarship sponsored by the education department.

Anne, nurse preceptor program instructor, and Mandy, NPSA member
Annual Montana Diabetes Education Conference

Colleen Karper, BSN, RN, CDE

As a labor of love, the volunteer committee plans, promotes and hosts this conference each year. Committee members come from across the state of Montana and include Committee Chair Deb Bjorsness, RD, CDE, BC ADM, State Treasurer Leslie Coates, MS, RD, CDE, Lisa Ranes, RD, CDE, Registration Lead Kris Kilen, RD, CDE, Laura Del Guerra, RD, CDE, Marci Butcher, RD, CDE, and Continuing Education Coordinator Colleen Karper, RN, CDE.

Registered nurses and dieticians attended this year’s conference along with pharmacists and medical professionals from a variety of other areas. The overwhelming feedback from the group was that the conference was excellent in quality of speakers and content.

We look forward to the next annual diabetes education conference which is scheduled for October 25, 2018 at Fairmont Hot Springs in Anaconda, Montana.

On October 5, 2017, the Montana Diabetes Education Conference was held in Bozeman, Montana, and included the following learning objectives:

- Describe and explore the core defects of type 2 diabetes
- Explore popular fad diets
- Discuss the positive and negative aspects of the newer medications for Type 2 diabetes
- Discuss the expansion of the diabetes prevention program in Montana and in the U.S.
Expanding Telehealth at KRH

Nicole Perisho, BA, BSN, RN

Telemedicine is the use of secure interactive audio-video equipment to link providers and patients located in different geographical areas. Telemedicine started at KRMC in 2010 due to the scarcity of stroke neurologists in rural critical access hospitals (CAH). Neurologists were seeing a trend of the arrival of ischemic stroke patients outside the window of treatment for alteplase (tPA). It was discovered that a large amount of these patients were arriving at their rural CAH within the window to receive tPA, but since those hospitals didn’t have access to a stroke specialist, they would transfer the patient to a larger facility, without treating them with tPA first, causing them to be outside of the window for tPA on arrival. At KRH, we are innovatively working with other large health systems and academic health centers internationally to bring specialty providers and care to people living in rural, underserved areas.

Nursing plays a role in telehealth by providing the distant site clinic and CAH resources in addition to education and competency training their nursing staff might not otherwise have access to.

Acute telemedicine services

KRH’s acute telehealth services program provides patients and CAHs in the northwest region 24/7 access to specialty providers in neurology, neonatology and emergency care providers. These services provide many benefits to patients, as well as health systems overall. For example, a patient might be able to stay and be treated in their community: avoiding an unnecessary transfer. Not only does the patient benefit by remaining in their home community, but the local hospital benefits from the revenue of caring for and treating that patient.

Telestroke

KRH’s telestroke program partners with eight CAHs in Montana: Chester, Conrad, Cut Bank, Libby, Plains, Ronan, Shelby and Whitefish. Since the inception of the telestroke program, there have been 174 telestroke consults which resulted in tPA being administered to 55 patients, 49 patients have been transferred to KRMC, 17 patients were treated in our emergency department using the telestroke robot, and nine patients were transferred to hospitals elsewhere in the state. The telestroke program is run by KRH neurologists, and was initially funded through grants from United States Department of Agriculture Rural Development, the Montana Department of Public Health and Human Services, and through KRH support.

Teleneonatology

KRH’s neonatologists cover 24/7/365 a year via telemedicine to the communities of Cut Bank, Libby, Ronan, Whitefish and Shelby. This service has been up and running since fall 2015, and has had 13 consults; six transfers to KRH’s NICU and the remaining seven babies were able to stay in their home community.
1. An interprofessional workgroup established together the area of clinical quality improvement. The workgroup’s goal was to support the organizational goal of reducing patient falls as well as a decrease in patient falls with injury.

See pages 36 and 37 of this report for current NDNQI falls with injury costs an organization $14,000.

In a Sentinel Event Alert, the Joint Commission states the average fall injury resulting from a patient falling on or against some other surface (e.g., a counter), on another floor, on or against some other surface (e.g., a counter), on another floor, or on a bed. What is a patient fall? According to the National Database of Nursing Quality Indicators, it is a “sudden, unintentional descent, with or without rashes, coughs, colds, and sniffles, through integrated care. KRH Care Anywhere extends primary care services to Canadian patients via telemedicine to provide the initial consult for services like orthopedics, neurology, neurological surgery and psychology.

vEPC

KRH emergency department doctors provide virtual emergency physician consult (vEPC) to provide support to CAH doctors, physician assistants (PA) and nurse practitioners (NP) staffing rural emergency departments. vEPC is currently supporting CAHs in Cut Bank and Conrad.

TeleHospitalist

KRH telehospitalist program provides KRH hospitalists supervision for KRH NPs practicing at Cabinet Peaks in Libby, Montana. The NP cares for the patient in Libby, and then NPs and the hospitalist located in Kalispell “round” via telemedicine once a day and consult on an as-needed basis throughout the day and night.

International telemedicine

The medical tourism department has been working with Canadian patients via telemedicine to provide the initial consult for services like orthopedics, neurology, neurological surgery and psychology.

KRH Care Anywhere

KRH Care Anywhere extends primary care services to patients with low-acuity complaints such as pink eye, rashes, coughs, colds, and sniffles, through integrated 24/7 virtual care clinics. Patients can access this type of care over the internet on your phone, tablet, laptop or personal computer. KRH Care Anywhere is available to the public residing in the state of Montana and other states where providers are licensed. This service is available to the public for a $45 flat fee per visit and to employees on KRH’s health plan for a $24 fee per visit.

Scheduled telemedicine consults

Specialty providers have embraced telemedicine by providing patients excellent care while allowing them to stay in their home communities. This means saving patients money and time, along with decreasing stress and anxiety. Sometimes these patients face a 60-500 mile commute one way to see their physician, possibly taking off work, taking children out of school and paying for food, gas and possibly lodging in the event of an overnight stay.

Educational offerings via telehealth

KRH currently offers a number of educational programs to providers and medical staff in house, regionally, and for CAHs across the state including but not limited to Monday’s Noon Conference Series and Nursing Grand Rounds.
The KRH nursing professional practice model is comprised of six core components that offer structures and processes to provide care to every patient we are privileged to serve. Patient-centered care is efficiently provided in a safe, high-quality manner based on evidence in practice. The model is a schematic representation of how nurses communicate, practice, collaborate and develop professionally at KRH. It is also used to guide and evaluate the professional practice of nursing, leading to exemplary outcomes for our organization, our community, and beyond.

The **soil** is our mission, from which our purpose exists.

The **roots** provide the foundation in our practice including the ANA Code of Ethics for Nurses, the Montana Board of Nursing Statutes and Administrative Rules, and the KRH core values.

The **tree trunk** represents our patients, staff and community, built on the theory of caring, represented by a heart.

The **leaves** represent how the profession flourishes with shared governance, professional relationships, professional development, recognition, and care delivery.

The **mountains** recognize the geography of northwest Montana and build on the KRH logo and awareness of the work that nursing practice goes beyond the walls of our buildings.

The **sun** builds on our local geography of “Going to the Sun Road,” representing where we aspire to be.
Nursing Professional Practice Model
Excellence in care, every patient, every time.

Mission: To provide collaborative, evidence-based care that is patient centered.
Together the workgroup established its purpose as:

1. An interprofessional workgroup focused on ensuring patient and employee safety as it relates to patient fall and injury prevention.

2. Utilizing evidence-based practice, the workgroup will evaluate falls and organizational fall prevention processes for improving performance in the area of clinical quality, patient and staff safety, staff responsiveness, and documentation as it pertains to falls.

What is a patient fall? According to the National Database of Nursing Quality Indicators, it is a “sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can).” Patient injury resulting from a fall ranges from none, to minor, to moderate, to major, and even death. In a Sentinel Event Alert, the Joint Commission states the average fall with injury costs an organization $14,000. Engaged caregivers are the heart of every fall prevention program and must recognize they are the primary line of defense for patients against a fall.

In July of 2017, a short-term falls workgroup was created as a branch of the Nursing Shared Governance Quality and Safety Council. The workgroup convened for a total of eight meetings with an average attendance of 20 people. Attendees represented the NICU, OB, Pathways Treatment Center, Brendan House, quality and safety, pharmacy, as well as intensive care, intermediate care, third floor medical, third floor surgical, first floor oncology, physical and occupational therapies, and physician and nursing excellence teams.

The workgroup’s goal was to support the organizational goal of reducing falls with injury to a rate of 0.55 falls with injury per 1,000 patient days. This was done by evaluating current organizational fall prevention strategies, ensuring fall prevention structures and processes are in place, increasing organizational fall prevention awareness, and by developing interprofessional educational strategies.

The workgroup summarized their findings and recommendations in the form of an action plan which was presented to the nursing shared governance quality and safety council in September 2017. The council approved the action plan and work began. Since September, fall prevention policies have been updated, Meditech fall prevention documentation has been improved, all status boards display fall risk, consistent signage to alert staff to high fall risk patients has been implemented, a consistent post fall huddle process has been established, a post fall review team has been created with a goal of identifying system opportunities, and interprofessional fall prevention education has been distributed. The group’s hard work is paying off by a decrease in total patient falls as well as a decrease in patient falls with injury.

See pages 36 and 37 of this report for current NDNQI falls with injury data and benchmarks.
Telemedicine is the use of secure interactive audio-video equipment to link providers and patients located in different geographical areas. Telemedicine started at KRMC in 2010 due to the scarcity of stroke neurologists in rural critical access hospitals (CAH). Neurologists were seeing a trend of the arrival of ischemic stroke patients outside the window of treatment for alteplase (tPA). It was discovered that a large amount of these patients were arriving at their rural CAH within the window to receive tPA, but since those hospitals didn’t have access to a stroke specialist, they would transfer the patient to a larger facility, without treating them with tPA first, causing them to be outside of the window for tPA on arrival. At KRH, we are innovatively working with other large health systems and academic health centers internationally to bring specialty providers and care to people living in rural, underserved areas.

Nursing plays a role in telehealth by providing the distant site clinic and CAH resources in addition to education and competency training their nursing staff might not otherwise have access to.

Acute telemedicine services
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Expanding Telehealth at KRH
Nicole Perisho, BA, BSN, RN
“When you’re a nurse, you know that everyday you will touch a life or a life will touch yours.”
- Amber Hewitt, RN, The HealthCenter surgical
Engaging Family in Bedside Report

Melissa Pliley, BSN, RN, CMSRN

The staff on third floor surgical recently had the privilege of having Deb Wilson, KRH chief operating officer, attending our staff meeting. Deb’s father, Mr. Haven, was hospitalized in Billings, Montana, after a complex surgery during this past year, and Deb shared the three different styles of nursing report handoffs she experienced.

First and worst was the handoffs that did not happen at the bedside, but outside the room in the hallway. The nursing staff informed Deb and her father that they would be giving report and would be unavailable for the next hour. Report would then commence in the hallway. This caused some anxiety for Deb and her father and led them to ask significantly more questions as they were unsure what information was being shared with the next shift. To say the least, this reporting style did not inspire confidence for Mr. Haven or Deb.

The second reporting style was performed at the bedside but the patient and family were not included in the discussion. Deb conveyed that at times, incorrect information was being passed on to the next shift and it was very awkward for Deb and her father to interrupt and interject with the correct information.

The best reporting style was when the nurses entered the room, introductions were made and Mr. Haven and Deb were included in the report.

Deb and her father were able to add their input, ask questions, and provide appropriate information about Mr. Haven’s care. They could rest assured that everyone was on the same page and that Mr. Haven would get the best care possible.

As Deb conveyed her message during our staff meeting of why she is such an advocate for good bedside nursing report, she was a little emotional. At one point, she even had to pause before continuing with her message. Seeing such raw emotion really drove the message home for me and has now changed my practice to not only perform report at the bedside, but to include the patient and family. Nurses often forget how much we impact patients and their families by what we do and how we interact with them. The question no longer is why do bedside nursing report, but why not do good bedside nursing report!
Physician/Nurse Manager Dyads Emphasize Teamwork

Doug Nelson, MD, vice president of medical affairs

Close collaboration between physicians and nurses is one of the bedrocks of excellent patient care. A team approach which utilizes the unique skills and perspectives of both nurses and physicians and emphasizing good communication is ideal. This team approach is widespread at KRH, and is well illustrated by the recent formation of physician/nurse manager dyads on many of our clinical units. Developed in part to assist our organization's “Journey to Nursing Excellence” effort, these dyads consist of a physician with an active clinical practice in the hospital paired with the nurse manager of the clinical unit where that physician most actively practices.

These physicians have agreed to work as partners with unit nurse managers to:

- Monitor quality of care metrics and creatively recommend and help implement improvement projects.
- Serve as liaisons to other physicians practicing in that area to improve overall physician-nurse communication.
- Provide educational programs for nurses and physicians.
- Work to improve patient safety, reduce medical errors and prevent “never events.”
- Serve as a sounding board for nurse manager proposals.
- As an ultimate goal, working together to improve patient care and patient experience.

We anticipate enhanced teamwork between nurses and physicians as these dyads continue patient care from a team approach.

Kaija Lockhart, ICU nurse manager, and Dr. Brent Pistoese
Success in the Stroke Program

Dani Walker, BSN, RN

From the moment a stroke occurs, 1.9 million neurons are lost every minute, only leaving a small window in which diagnosis and treatment may prevent lifelong complications. To recognize, evaluate, diagnose and treat stroke patients, infrastructure and organization is a necessity.

Infrastructure

The KRH stroke program is composed of many teams: from the clinical and consulting staff, to the interdisciplinary teams, to administration and the program development teams. The interdisciplinary stroke committee is one of those teams that provides oversight and leadership for the design, implementation and evaluation of the KRH stroke program. The core stroke team consists of the RN stroke program coordinator and stroke medical director, and drives process development and change.

To ensure the program consistently provides best practice stroke care, evidence-based recommendations from The American Heart/Stroke Association (AHA/ASA) were selected as our foundational clinical practice guidelines (CPGs). These CPGs are implemented into practice through stroke order sets, policies and algorithms.

Improving patient care

Critical components of our stroke program include the assessment, diagnosis and treatment of acute stroke. The evidence is undeniable: the earlier the treatment with alteplase (tPA), the better the patient outcomes. Benchmark goal times were established as shown below.

To facilitate this time-sensitive process, the stroke response team was developed and responds within the emergency department. KRMC and The HealthCenter.

The telestroke program provides the opportunity for immediate audiovisual neurology support at KRH and our regional critical access hospitals.

For patients who are candidates for endovascular stroke intervention, a transfer process is in place.

Designated stroke units were identified to allow for consistent monitoring and management of stroke patients. These units are the ICU, third floor medical and third floor surgical.
Education is key to the success of the stroke program. A new hire stroke nurse curriculum was recently built and annual education is provided based on the assessed needs. Education and support are provided to outreach hospitals through the telestroke program. There is also a continued focus on physician education promoting stroke best practice.

“We are better equipped and trained to consistently provide our stroke patients with quality care.”
- April Gunderson, RN, third floor surgical

Performance improvement

Data is collected at the patient and program level and reported to the Centers for Medicare & Medicaid Services (CMS), AHA/ASA Get with the Guidelines (GWTG) Stroke, and to the staff. The data is analyzed by the interdisciplinary stroke committee and quality department from which performance improvement plans are developed to drive change and improve care.

Continuing the journey

To be fully recognized for our commitment to providing quality, evidence-based stroke care, KRH hopes to obtain the stamp of certification as a primary stroke center. The Joint Commission survey for this certification is planned for spring of 2018.

“I was able to play cribbage with one of my stroke patients. It was one of his favorite games. Although everyone’s road to recovery is not as successful, I am encouraged by our effort to give each patient the best chance at recovery and quality of life.”
- Isaac Rajkowski, BSN, RN, third floor medical

KRH received the highest honor for exemplary performance at reducing stroke-related death and disability. We also received the Target: Stroke Honor Roll award for commitment to rapid treatment with alteplase.
Nurse Residency Program Gains Ground
Contributed article

The nurse residency program at KRH is leading the way for new nurse development in Montana. As the first program of its kind in the state, participation has been steadily growing since its official start in July 2015. Newly licensed nurses from all over the country apply to receive 12 months of training and support to help transition to clinical practice. The most recent cohort includes nearly a dozen nurses who have been placed in medical, surgical, oncology, transitional and intermediate care units, and the program is expanding further to other specialty areas like critical care, psychiatry and maternal newborn care. All residents undergo an intensive clinical orientation, bi-weekly trainings, leadership development, and complete the program with a formal evidence-based practice project.

Mandy Pokorny, MHA, BSN, RN, KRH nurse residency program coordinator, says her team has worked hard to formalize the program and provide a solid foundation for nurses joining the workforce. “The program aims to help establish clinically sound, professionally engaged, and emotionally resilient nurses at the bedside, and really grow the KRH team from the ground up,” Pokorny said. She went on to co-publish her findings from the program’s development in the Practice Transitions section of Core Curriculum for Nursing Professional Development (5th ed.).

Support and guidance during the first year of nursing is critical. Nationwide, nursing turnover in the first year of hire can be as high as 60 percent, with half of those nurses leaving the profession altogether. Nurse residency programs are key to combating this statistic. Most of the nurses who complete the KRH program not only remain employed with KRH, but train into specialty areas and/or become preceptors and clinical experts on their units, adding to the strong team of skilled nurses who share their expertise with future residency groups.

The nurse residency team’s effort has not gone unnoticed. In November 2017, the KRH nurse residency program was awarded accreditation with distinction by the American Nurses Credentialing Center's (ANCC) practice transition accreditation program, the highest recognition awarded by the ANCC program. KRH is the first health care system in the state of Montana to be awarded this distinction and one of only 30 ANCC accredited programs in the nation. The ANCC appraiser team commended the program on its robustness, especially considering the small size of the hospital and limited resources.

Pokorny describes the program’s success as an absolute team effort. “This process has been a lot of work and a true pleasure to be a part of. It takes a village to create a successful environment for our nurses transitioning into the profession, and I am proud to see that we are heading in the right direction. Collaboration is key and I can’t speak highly enough of the good work and support from our executive leadership team, nursing directors and managers, expert clinical nursing staff, clinical educators, preceptors, interdisciplinary teams, human resource partners, and academic partners. We look forward to continuing to grow and refine our program in the upcoming years.”

“I enjoy making a difference one person at a time.”
- Ryan Stolte, RN, The HealthCenter second floor
Volunteer Team Gives Peace and Comfort

Sara Dye, BSN, RN, CMSRN, and Melissa Thompson, RN

Nurses are well known for having a strong passion for excellent patient-centered care and do our best to provide care with compassion, dignity and kindness. You can see it as you walk through each unit, and hear it with every story as you pass through the halls. Whether it’s our thirty plus years of experience nurses or brand new nurses and nurses’ aides on the floor, the drive to provide genuine patient care is evident.

Last fall, Melissa Thompson, resident care manager, and I attended a leadership conference and the speaker talked at great length about compassionate care teams throughout the country. We both have a strong love for palliative and end-of-life care, so we decided we should create our own compassionate care team at Brendan House.

At that time, Melissa and I were both long-term care resident care managers at Brendan House (I have since become a clinical nurse manager for infusion/vascular access and resource pool). The Brendan House environment has a wide variety of patients and care needs. There are patients who range from 25-year-old endocarditis patients, to 50-year-old pancreatic cancer patients, to 75-year-old hip fractures and to 102-year-old geriatric patients who are residing here for the rest of their life.

The first official compassionate care team was started in 2001 by a woman named Sandra Clark, inspired by an incident she had with a patient in 1986. She was a busy RN on her unit and came to the room of one of her frail elderly male patients. He said to her in a barely audible voice, “will you stay with me?” She told him she had six other patients to attend to but would do the best she could to come back as soon as she was able. Of course, her team took much longer than expected, and by the time she came back to him, he had passed away. Alone.

This patient greatly affected Sandra, so she set out to create a program to ensure no patient would die alone. Finally in 2001, she was able to create a team of volunteers to fulfill her mission.

“No person is born alone, and in the best of circumstances, no one should die alone.”
-anonymous

Many hospitals throughout the country soon developed various forms of compassionate care teams. We as leaders were very inspired to create our own team, so we started the process in early March 2017. We both agreed that Brendan House already does the best they can to make our patients’ lives be lived to their fullest potential, so this will be an extension of our already exceptional care.

The team is entirely volunteer based. Any staff member, KRH employee or community member who goes through the KRH volunteer process, can be a part of the team. These volunteers will receive specific orientation to the program, and strictly be at the patient’s bedside, unencumbered, and no staff duties assigned. The program is a great equalizer: whether it’s your supervisor, the hospital administrator, the housekeeper, the kitchen staff or a family member, each person’s role is the same. The team members provide peace, comfort and dignity to those in their weakest moments.

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Melissa Thompson and Sara Dye
An Integrative Approach to Pain Management

Doreen Hart, RN, HN-BC

The Montana Center for Wellness & Pain Management serves patients with chronic pain and addiction.

Right now, two of the biggest health concerns in this country are chronic pain and opioid addiction. Chronic pain affects 100 million Americans each year, while the next two most common concerns, diabetes and cancer, affect 25.8 million and 11.9 million per year, respectively. The opioid crisis is rapidly growing in the United States, as the number of deaths only increase each year.

When utilizing the traditional approach to pain management, patients were not engaged and not progressing in their care. They were often stuck in a cycle of pain, depression, and then possible medication reliance, despite directives from providers. To try and break this cycle, we developed the EMPOWER program at The Montana Center.

The program is a patient-centered care model which encourages patients to become active agents in their own care. With EMPOWER, patients create personally relevant goals. Patients meet with a psychologist and patient navigator, and together, create attainable and measurable goals to address life with chronic pain. Active patient-provider partnerships help integrate medical, alternative and counseling therapies throughout the program. Combined with the elements of ongoing education and group support, EMPOWER is dedicated to each patient’s personal commitment to change.

The continuum of care is a vital part of the program. Through provider follow up, check in calls and patient education classes and groups, our staff is committed to helping patients reach their goals. Program participants also receive an EMPOWER workbook to bring to each appointment as a major tool in their forward movement of care.

From May 1 to October 21, 2017, 26 percent of new patients have initiated the EMPOWER program, and eight percent of established patients have initiated the EMPOWER program. Our goal is to establish 100 percent of new patients and more than 50 percent of established patients in the EMPOWER program.

To reach our goal, we have included our addiction patients to initially participate in the EMPOWER program, and then adapt the process to support these patients in their recovery to autonomy and self-reliance.

Our next step is gathering data and formally documenting all that we have discovered throughout this journey.
10 2017 Nursing Annual Report

Kalispell Regional Healthcare

OB Department Introduces the Baby Box Program
Angele Romero, BSN, RN

Last year, a pediatrician noted that babies were routinely found co-bedding or in an unsafe sleep environment upon her visits out to newborns. The Kalispell Regional Medical Center (KRMC) OB Department took this feedback seriously and began extensive research to help change this culture. A vision focused on safe sleep practices began to form.

One of the guidelines for safe sleep practices set forth by the American Academy of Pediatrics (AAP) is to have the newborn infant sleep in the same room, but not in the same bed as the parents for at least the first six months. For many of our families, purchasing a bassinet as well as a crib to put in their bedroom for their newborn was not attainable. Upon the arrival of a new baby, families now have the option to get a Baby Box; a simple, hard-sided box with a mattress and fitted sheet that can be used as a bassinet. Even better, the box comes filled with newborn essentials like a SleepSack, diapers, a thermometer, a bulb syringe and a goodie bag for the new mom.

Created by The Baby Box Company, these boxes are currently being used in many areas of the United States and Canada. KRMC is the only hospital in Montana to provide this for our families.

To receive their free Baby Box, families must complete a series of online videos through Baby Box University. There are 19 videos, each about 30 minutes in length on various educational topics pertaining to baby care and care of a new mother. The videos were recorded right here at KRMC with our own pediatricians, obstetricians and nurses to provide familiar faces for our families.

With almost 80 Baby Boxes distributed so far, this is just the beginning of The Baby Box program at KRMC. We are thrilled to be able to offer this option to our patients as they welcome a newborn to the family.

The KRH care team is a multi-disciplinary group of KRH employees with the mission of:

Providing timely, specialized, and compassionate peer-driven support to staff and physicians. CARE stands for compassionate, accessible, responsive, encouraging.

The KRH care team has been working since 2014 on a critical incident stress management (CISM) program here at KRH.

CISM is a comprehensive, integrated, systematic and multi-component crisis intervention program that was developed by Jeffrey T. Mitchell, PhD, after serving as a firefighter/paramedic. The goal of a CISM program is to help people return to work and to reduce the potential long-term consequences of repeated exposure to traumatic stress. This program has been widely used in the pre-hospital setting for fire departments, emergency medical services and the police.

How it works
After a critical incident, any KRH employee or physician with a concern may request services.

Confidentiality
All support provided by clinicians and peer resources is confidential. Exceptions to confidentiality only occur if there are concerns that an individual may be at risk of harming himself or herself or others. All individuals attending debriefings will be requested to hold all information and feelings shared by peers in confidence. If supervisory personnel attend a debriefing because they were part of a critical incident, they will be requested not to use information learned in the debriefing as the basis for evaluation or corrective action.

Participation
An employee may elect to attend a debriefing or defusing. Managers and directors with concern about a particular employee who chooses not to attend a debriefing are encouraged to talk individually with the employee and consult with human resources and the employee assistance program (EAP) as needed. Performance issues or concerns will be addressed in accordance with existing human resources policies.

Training
The KRH care team assumes responsibility for selecting and training all clinicians and peer resources interested in performing defusings and debriefings. Assessment of competency, ongoing training, support and evaluation of services provided will also be the responsibility of the KRH care team.

Defusing
An employee personally affected by an incident is encouraged to seek out a peer resource. KRH care team members may also meet with small groups impacted by a particular incident, and in doing so, may determine the need for a formal debriefing. The nursing supervisor will receive a list of peer resources with contact information.

Debriefing
A physician, or an employee in consultation with his or her manager, may make a request for a formal debriefing by calling the nursing supervisor. If an incident occurs after hours or on the weekend, the nursing supervisor will use the list of peer resources to contact a team member.
In October 2016, a workgroup was established to review registered nurse (RN) job descriptions at KRH. This team included representatives from the KRH human resources department, two clinical educators, a clinical director, and a clinical manager. The goal for this team was to develop an RN job description that identified and defined core competencies for all newly hired RNs that align with ANA Standards of Practice and Professional Performance.

The proposed KRH RN job description identifies 11 basic core competencies for RNs that address the six American Nurses Association (ANA) Standards of Nursing Practice of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation and also aligns with the seven ANA Standards of Professional Practice. Nurses at KRH must display professional behaviors, follow KRH policies and procedures, and demonstrate proper communication. Methods of validation for successful completion of these competencies and adherence to Standards of Professional Practice are: (a) direct observation by a charge nurse, supervisor, or member of the nursing leadership team, and (b) participation in peer evaluation. The KRH nurse must also complete all mandatory training.

Assessment of the KRH RN core competencies uses Benner’s model of novice to expert. The basic core competencies are introduced at nursing general orientation attended by all newly hired KRH nurses. Competency is then determined by the unit specific clinical educator and manager. In addition, unit clinical educators and clinical managers from this work team identify and define unit specific core competencies.

Implementation plan
Basic core competencies are currently introduced in general nursing orientation. Revised job descriptions identifying core competencies for newly hired KRH RNs are developed and will be utilized beginning in 2018. Core competency assessment modules using the KRH learning management system are being developed for all newly hired RNs to KRH acute and critical care units and will be fully implemented by August 2018. Once implemented, all newly hired KRH RNs will complete core competencies upon hire and then again annually.

“I am proud to be a nurse here at KRH because it feels like home. I love taking care of the beautiful people here in the Flathead Valley. We are fortunate to have high quality health care at our fingertips.”
- Jamie Phillips, RN, CMSRN, third floor surgical
On January 1, 2017, KRH initiated a new position called manager of patient and family experience. Within a few short months, the KRH 2017 strategic initiatives were announced and included employee experience, patient experience and Meditech 6.15.

Clearly our leadership sent the message that patient experience matters.

The patient experience committee went to work. In January 2017, they established a goal to review all patient comments and use them to inform us of where we need to focus efforts. Every month, patient comments are compiled and sent to unit managers for review. Positive comments are shared with staff. They inspire us by describing the way to do things right. Patient comments tell us how caregivers have connected with them and provided the care they needed when they needed it.

“The locals call KRMC ‘Hilton Hospital’ - a very appropriate name. I was a terrible patient, but Melissa and April on third floor surgical were angels. They acted as if I was the perfect patient, instead of the frightened, pain-ridden women I was. I don't know how they did it. God bless them and KRMC.” -KRMC patient

Comments have also informed us where we could improve. On the intermediate care unit, patient comments about their food caught the attention of Tessa Gilbert and Sonya Solum. A workgroup including nursing, dietitians and nutrition services staff members has been making efforts to improve timely delivery of meals and assisting patients to understand their menu selections.

Hourly patient rounding during day time hours and every two hours at night has been a particular focus for third floor surgical and first floor oncology units. The surgical unit has developed an SBAR (situation, background, assessment, recommendation) pocket card to improve bedside shift report and has begun notifying patients and their families that they can be present for this handoff. Our patient experience scores reflect very positively and sustained improvement from this effort for third floor surgical and for KRMC in general.

The intensive care unit revised their patient family visitor’s guide, worked to open visitation hours, and added a computer station to the waiting room to allow patients’ families to access online sites like Caring Bridge to improve communication with families and friends.

Home Options implemented use of the “Social 10”. This practice sets aside ten minutes for the nurse and patient to have uninterrupted time to talk at the beginning of the visit. Early results of this action plan were positive. Their overall rating of care improved by three percent and their “likelihood of recommending” scores increased from 74 percent to 81 percent during the second quarter of 2017.

The HealthCenter inpatient unit has focused on use of scripting to improve communication. Their patient experience scores have seen a significant improvement in the last quarter of 2017.

In 2018, KRH will have the benefit of input from 11 patient family advisory councils from the nine primary care clinics and the KRMC patient family advisory council. There are plans to convene patient family advisors for pediatric patients and their families. Another group of leaders is in the process of forming a group of advisors for those diagnosed with cancer experiencing treatment across various service lines.
Bridging the Gap

Lesly Starling, BA, BSN, RN

Measuring success by the delightfully exuberant patient proclamation, “Not the hospital. Not today,” may seem counterintuitive to health care organizations. At KRMC, I have had the opportunity to measure success by extending care beyond exam rooms and hospital walls to help build a healthier and stronger community, one patient at a time.

In May 2016, Mountain Pacific Quality Health contracted with KRMC for a special innovations project to enhance outcomes for high cost, high need patients at risk for readmission and challenged by multiple comorbidities and polypharmacy. I had the privilege to step out of direct patient care and step into the lead of what was ultimately branded as the ReSource Team; a grassroots effort to transform complex care management in a rural context compounded by social factors and aggravated by isolation and scant resources.

To best serve Flathead County residents, team organizers looked to the success of national transitional care models as well as data revealing a minority of patients use the majority of health care resources. The eventual result was a dyad structure between a registered nurse and a community health worker. Relying on the support and generosity of community-wide resources and the imperative role of primary care coordination, the goal of these partnerships was to increase patient self-sufficiency and self-management skills. Local barriers to the goal’s success included low health literacy, lack of transportation, lack of affordable housing and social isolation.

By October 2016, the ReSource Team began to onboard its first 65 patients for 30 to 90 days of intensive outpatient management after discharge from the hospital. Charging forward, the team began home visits; entering the patient’s world instead of forcing the patient to enter theirs. It was firmly established that the ReSource nurse did nothing to duplicate Home Options Home Health, and that at the end of 90 days, the patient would be completely transitioned to primary care coordination.

The team quickly learned that in managing complex care, the patient ultimately had control of their forward motion to self-sufficiency. Labels of non-compliance, frequent fliers, super-utilizers and thoughts of “what’s the use?” were put aside. Instead, new concepts, ideas and technology, along with innovative short- and long-term solutions, were employed with the understanding that most health care decisions occur outside clinical walls. Patients simply fared better with intense medical and social support to fill the gap between inpatient care and returning home.

To shift patient apathy toward engagement and activation, the team turned to motivational interviewing as a counseling approach. Through health surveys, Meditech self-monitoring equipment, telehealth technology, and the support of their ReSource Team members, patients had the tools to make informed health care choices.

The ReSource Team reimagined what was considered inclusive health care by extending its reach. This new approach focused on the whole person; facilitating the provider plan of care as well as patient-stated goals. Alleviating food scarcity or helping a patient...
with sometimes tricky wintertime transportation became equally as important as attending a follow up appointment or having a pharmacy consult.

Simultaneously in 2017, primary care began the transition from a fee-for-service to a value-based model of care called comprehensive primary care plus (CPC+). The CPC+ model embeds care coordination into primary care offices. With both CPC+ and the ReSource Team taking off, both initiatives were able to share in learning and implementation processes.

The beginning efforts of the ReSource Team to redefine the traditional health care model received national press the following summer. The team was featured on PBS NewsHour highlighting the shift in health care culture in rural Montana.

Since the feature aired, the team has accomplished notable financial and clinical outcomes. With the lack of reimbursement from Medicare, Medicaid and private insurers, the team anticipated issues with expanding the model outside of rural Montana. Instead, the team’s success and the growing integration of value-based care has allowed the ReSource Team to incorporate into CPC+. This partnership is not only a win for Medicare, Medicaid and KRH, but most importantly, a win for patients.
Nurse Sensitive Indicators
Kalispell Regional Medical Center (bed size 100-199)

Source: NDNQI

Injury Falls Per 1,000 Patient Days

Percent of Surveyed Patients with Hospital Acquired Pressure Injuries
Stage 2 and Above

Central Line Associated Blood Stream Infections (CLABSI) Per 1,000 Central Line Days

Catheter Associated Urinary Tract Infections (CAUTI) Per 1,000 Catheter Days
Nurse Sensitive Indicators
The HealthCenter (bed size <100)

Source: NDNQI

Percent of Surveyed Patients with Hospital Acquired Pressure Injuries Stage 2 and Above

Injury Falls Per 1,000 Patient Days

Central Line Associated Blood Stream Infections (CLABSI) Per 1,000 Central Line Days

Catheter Associated Urinary Tract Infections (CAUTI) Per 1,000 Catheter Days
"Connecting with patients and their families within, around and beyond the nursing skills we deliver is most meaningful to me as a nurse. Finding a way to balance that role with compassion, humor, and healing is my daily invitation."

- Brenda Hanson, RN, CRNI, infusion
Nurse of the Year celebration 2016

2017 Nursing Annual Report
– Karen Lee speaking at organization, we have improved the quality of care that we provide to outcomes. Through collaboration with departments throughout the then making changes on their units that resulted in improved patient outcomes. Nurses became more active participants in identifying opportunities to us to better prepare young leaders in their role as charge nurse. Clinical

Our first Charge Nurse Academy, developed by nurses for nurses, allowed community.

practice models to better reflect our commitment to our patients and Nurses worked to revise both the shared governance and professional

and currently the only, accredited program in the state of Montana.

Our nurse residency program was accredited with distinction by based councils have expanded our ability to change our culture. It gives ultimately improve patient outcomes. Our shared governance and unit

would be a marathon and not a sprint. Over the past years, we have

Karen Lee, MHA, BSN, RN, Chief Nursing Officer

I will be retiring at the end of this year, and I want each of you to know what an honor and privilege it has been for me to serve you and this organization as your Chief Nursing Officer. You have heard me say many

all are truly the best!

Karen Lee, MHA, BSN, RN, Chief Nursing Officer

CNO Reflections of 2017

Susan Davidson, ADN and Palliative Nurse Advance Certified Hospice

Mary Adams, MSN Adult Psychiatric & Mental Health Nurse Practitioner

Colleen Moore, BSN Adult-Gerontology Primary Care Nurse Practitioner

Mary Adams, MSN Advance Certified Hospice and Palliative Nurse

Susan Davidson, ADN

DEGREES
Karen Blaisius, BSN Margaret Cornell-Honcoop, ADN Meredith Gargas, BSN Lindsey Herdon, BSN Brenda Houston, BSN Beth Kimbrough, BSN Renae Kramer, ADN Lara McDonnell, BSN Annette Partridge, BSN Angela Romero, BSN Margaret Skinner, BSN

CERTIFICATIONS

Acute Care Nurse Practitioner - ANCC Joan Driscoll, MSN

Acute Critical Care Knowledge Professional Corrie Casey, BSN (Pediatric) Benjamin Sletvold, BSN (Adult)

Acute/Critical Care Nursing (Adult) Christina Armstrong, BSN Amanda Bailey, MSN Kathleen Beveridge, ADN Whitney Connor, BSN Shannon Eve, BSN Meredith Gargas, ADN Lindsey Herndon, BSN Cynthia Hinzman, BSN Laurie Kitchen, BSN Kira Kitchens, NP Kaia Lockhart, BSN Theodore Morejou, BSN

Acute/Critical Care Nursing (Neonatal) Amanda Blair, BSN

Acute/Critical Care Nursing (Pediatric) Emily Casey, BSN Amanda Stewart, BSN

Adult Nurse Practitioner - AANPCP Melanie Zander, MSN

Adult Nurse Practitioner - ANCC Carrie Thompson, MSN

Adult Psychiatric & Mental Health Nurse Practitioner Colleen Moore, BSN

Advance Certified Hospice and Palliative Nurse Susan Davidson, ADN

Advanced Oncology Certified Nurse Leah Scaramuzzo, MSN Michelle Willis, ADN

Cardiac Medicine (Subspecialty) Certification Lara Mcdonnell, ADN

Cardiac/Vascular Nurse Annette Bean, BSN Kamera Kennedy-Collins, MSN Kelly Thies, BSN Rexanne Wieferich, ADN Aimee ZuPichic, MSN


Certified Breast Care Nurse Kim Grindrod, BSN Melissa Vornbrock, BSN

Certified Breastfeeding Counselor Debbie Miller, ADN Joan Siderius, BSN Tracy Willis, BSN Doris Yeatts, ADN

Certified Case Manager Michelle Montini, BSN

Certified Childbirth Educator Cathlyn Mendius, BSN Christie Weseman, BSN

Certified Diabetes Educator Cody Bartholomew, ADN Colleen Karper, BSN

Certified Emergency Nurse Judith Baker, BSN Kathleen Beveridge, ADN Anaka Broste, BSN Andrew Burbine, ADN Jon Carlson, BSN Linda Chambers, ADN Leon Dejong, ADN John Fitch, BSN Joy Fortin, ADN Stuart Hedingham, ADN Jessica Herman, BSN Austin Hughes, BSN Elizabeth Kimbrough, BSN Valerian Kryshak, BSN Patricia Kurschat, BSN Steven Lamb, ADN Darren Lobbestael, BSN Gina Lundberg, BSN James Maxwell, BSN Courtney Mohatt, BSN Debbie Mulcahy, BSN Jason Pitts, ADN Michele Reyes, BSN Larissa Roberge, ADN Meg Rowe, BSN Jared Sibbitt, BSN Risa Sibbitt, BSN Mary Stubbs, MSN Stephanie Sugars-Morsett, BSN Travis Willcut, BSN Rebecca Wilson, ADN

Certified Flight Registered Nurse Kathleen Beveridge, ADN Henry Dietrich, ADN Jason Pitts, ADN

Certified Gastrointestinal Registered Nurse Marah Connolly, BSN John Hampson, BSN Linda Harmon, ADN Irina Moore, Diploma Susan Moore, BSN

Certified Hospice and Palliative Nurse Heather Dawson, BSN Kathleen Folts, BSN

Certified Infant Massage Instructor/Educator Becki Cronley, BSN


Certified Neuroscience Registered Nurse Shelby Liebelt, BSN

Certified Nurse Midwife Amber Lavin, NP Debbie Miller, ADN

Certified Nurse Operating Room Alyssa Barton, BSN Rachel Brewer, BSN Nancy Compton, Diploma Judy Cowan, BSN Chris Daly, BSN Paul Elsberry, ADN Amanda Evers, BSN Shannon Fitch, BSN Lorri Ford, ADN Alice Fortenberry, Diploma Leanne Guillory, ADN Joseph Harris, ADN Jan Layton, BSN Susan Leblanc, BSN Jeffrey Lyngholm, BSN Kathy Menghini-Shanahan, Diploma Toni Price, ADN Elizabeth Quinn, ADN Lisa Saito, BSN Derek Starker, ADN Kallie Woods, BSN James Yopp, ADN

Pursuing Excellence: Direct Care Degrees, Certifications and Portfolios

Kalispell Regional Healthcare
Pursuing Excellence:
Direct Care Degrees, Certifications and Portfolios, continued

Certified Pediatric Nurse
- Shelly Green, ADN
- Whitney Hart, BSN
- Elizabeth Hedington, ADN
- Amber Hewitt, ADN

Certified Post Anesthesia Nurse
- Eloise Backer, BSN
- Jane Beck, BSN
- Susan Burt, ADN

Certified Radiology Nurse
- Maureen McLean, Diploma

Certified Registered Nurse
First Assistant
- Leanne Culliory, ADN

Certified Registered Nurse Infusion
- Patricia Fogleman, ADN
- Brenda Hanson, ADN
- Alyssa Keil, ADN
- Shanti Lackey, BSN

Certified Rehabilitation Registered Nurse
- Kathleen Constantine, ADN
- Tami Degele, BSN
- Paula Huffman, ADN
- Mary Opalka, ADN
- Sandra Randall, BSN
- Ellen Wesolowski, BSN

Certified Surgical Technologist
- Jan Layton, BSN

Certified Vascular Nurse
- Lucy Van Elzen, ADN

Certified Wound Ostomy Nurse
- Jana Pursell, BSN

Clinical Nurse Leader
- Kamera Kennedy-Collins, MSN

Family Nurse Practitioner - AANPCP & ANCC
- Sadie Baldwin, MSN
- Valerie Beebe, MSN
- Paul Coats, BSN
- Julie Cook, MSN

Alexandra Flrchinger, MSN
Jessica Glover, MSN
Jaimie Gribben, MSN
Renée Iversen, MSN
Martha Jessopp, MSN
Elizabeth King, BSN
Nancy Knaff, MSN
Dawn Murray, MSN
Dawn Peters, MSN
Amy Ramer, MSN
Jennifer Steele, MSN

Flight Paramedic - Certified
- Jason Pitts, ADN

Gerontological Nurse Practitioner
- Paula French, MSN

Holistic Nurse Board Certified
- Doreen Hart, Diploma

Inpatient Obstetric Nursing
- Kimberly Bergey, BSN
- Debbie Burgi, ADN
- Beth Connelly, ADN
- Cindy Cox, BSN
- Anna Dmtryev, ADN
- Melinda Fuzesy, ADN
- Kristin Long, BSN
- Kelli McMahon-Staats, BSN
- Rochelle Mertz, BSN
- Leslie Moody, BSN
- Kathleen Olson, MSN
- Sarah Reynolds, ADN
- Lynda Storle, BSN
- Ladawna Walker, ADN
- Michelle Willis, ADN
- Tracy Wills, BSN

International Board Certified Lactation Consultant
- Jill VanNice-Steenar, BSN
- Tracy Wills, BSN

Low Risk Neonatal Nursing
- Lonna White, ADN

Medical-Surgical Registered Nurse
- Kathleen Anderson, BSN
- Mariah Connelly, BSN
- Sara Dye, BSN
- Susan Cendrea, ADN
- Ashley Cronley, BSN
- Carly Hohf, BSN
- Cheryl Holland, BSN
- Rebecca Ledonne, BSN
- Carol Mitch, ADN
- Denae Morton, BSN
- Laura Pierson, BSN
- Leah Scaramuzzo, MSN
- Jenna Upham, BSN

National Registry of Emergency Medical Technicians-Basic (Med Tech) (EMT)
- Robert Montague, ADN

National Registry of Emergency Medical Technicians-Paramedic
- Juanita Haugan, ADN

Neonatal Intensive Care Nursing
- Jessie Cady-Kaufman, MSN
- Caroline Fichter, MSN
- Carla Fields, BSN
- Melinda Fuzesy, ADN
- Tara Raats, ADN
- Ashley Roth, BSN

Oncology Certified Nurse
- Mallory Corum, BSN
- Kathi Ebert, BSN
- Patricia Fogleman, ADN
- Kim Grindrod, BSN
- Lois Cross, ADN
- Lynn Hall, BSN
- Brenda Hanson, ADN
- Carol Kodick, ADN
- Brenda Marsolke, BSN
- Coleen Moore, BSN
- Susan Sheeran, ADN
- Carrie Thompson, ADN

Orthopedic Nurse Certified
- Deborah Aragon, ADN
- Susan Gendreau, ADN

Pediatric Nurse
- Leann Kenely, ADN

Progressive Care Certified Nurse with Cardiac Medicine Subspecialty
- Barbara McConnell, BSN
- Brittnay Porter, ADN
- Rebecca Stafford, ADN

Progressive Care Nursing (Adult)
- Desiree Caro, BSN
- Stephanie Christman, BSN
- Rebecca Dickey, BSN
- Courtney Fisher, BSN
- Ann Koenig, BSN
- Rebecca Milligan, BSN
- Shirley Priestley, BSN
- Jenny Schreader, BSN
- Amanda Siemon, BSN
- Julia Tikka, BSN
- Lindsey Tufty, ADN
- Mitchell Yoder, BSN

Psychiatric & Mental Health Nurse
- Mary Hinkle, BSN
- Rhonda Niblett, ADN
- Gwyn Palschak, BSN
- Sharon Pillbury, BSN
- Issac Rajkowski, BSN
- Michelle Reimitz, BSN
- Angela Romero, BSN
- Maureen Rush, BSN
- Brittany Schultz, BSN

Sexual Assault Nurse Examiner
- Debbie Mulcahy, BSN (Adult & Pediatric)

Vascular Access - Board Certified
- Karen Florey, ADN

Women's Health Care Nurse Practitioner
- Kathleen Olson, MSN
- Karrin Sax, MSN
- Shawn Shanahan, MSN
- Cathleen Simensen, BSN
- Janna Sullivan, BSN

Wound Care Certified
- Shannon Potter, BSN

PROFESSIONAL PORTFOLIOS
- Kristie Anderson, MSN
- Mari Anderson, Diploma
- Jesse Arneson, BSN
- Mandy Arnone, LPN
- Shelley Astle, BSN
- Megan Bagnoli, BSN
- Heidi Brandt, BSN
- Jessie Cady-Kaufman, BSN
- Shawn Chouinard, ADN
- Paul Elsbury, ADN
- Courtney Fisher, BSN
- Mindy Fuzzy, ADN
- Meridith Gargarz, BSN
- Marayna Gran, ADN
- Kylee Hall, BSN
- Sarah Hartig, BSN
- Cary Heskett, MSN
- Dani Hineman, BSN
- Mary Hinkle, BSN
- Mandi Jo Hunt, BSN
- Julie Knapp, BSN
- Rebecca LeDonne, BSN
- Kelli McMahon-Staats, BSN
- Debbie McIlrathy, BSN
- Rhonda Niblett, ADN
- Gwyn Palschak, BSN
- Sharon Pillbury, BSN
- Issac Rajkowski, BSN
- Michelle Reimitz, BSN
- Angela Romero, BSN
- Maureen Rush, BSN
- Brittany Schultz, BSN
- Juna Sibbit, BSN
- Lynda Storle, BSN
- Dani Walker, BSN
My all-time favorite basketball coach is John Wooden. With ten national championships during his twelve year coaching career at UCLA, including a seven-year streak, he says, “Big things are accomplished only through the perfection of minor details.” He goes on to say that his secret to success is the power of many little things done well. In the note that I received from KRH Chief Nursing Officer Karen Lee, she says, “...it’s the small things that make this place great!”

I believe that my contributions, as small as they may seem at times, combined with the positive attitudes and contributions of every employee at KRH, are what make this a great organization. I believe my influence and presence on the floor improves patient safety, contributes to nurses doing the right thing every time, and improves job satisfaction. I believe this is true because of my daily contributions to a culture of safety and professionalism. It is not only the extra work I have accomplished this last year, but also the attitude I seek to consistently bring to my patients and coworkers every day.

I seek to know the names and stories of our housekeeping and kitchen staff because I believe that we are more likely to support each other if we know our coworkers by name and have listened to their story. This makes us stronger, safer, and ultimately an organization that I would want my family members to receive care from. If we continue to be diligent in doing the little things well, we will continue to improve our personal practice, our organization and the nursing profession as a whole. I am thankful for an opportunity to contribute every day at KRH to doing the small things well. Let’s continue to commit to doing the right thing with every patient, every time because these are the small things that make us great.

The following letter is an example of one of the small things Isaac does for patients:

As I walked through the entrance of the hospital today, a melodious sound filled the air. An older gentleman, donned in a hospital gown and oxygen tubing, was playing the piano. His eyes had a sparkle which words cannot express. Beside him was a wheelchair and his nurse, Isaac Rajkowski. Isaac’s action brought delight to this patient. The gentleman said he has played the piano for more than 50 years, but has not played it over the past several years. This simple act of kindness truly brought joy to this patient. Thank you, Isaac, for being such a compassionate team member.

-Karen Pilgrim, MSN, RN, director of nursing, KRH Physician Network
ABOVE ALL...

do the right thing!