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ABSTRACTS

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New Orleans, LA

G1. Multidimensional Measurement of Fatigue in an Adult Pulmonary Hypertension Population

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Background/Purpose: Pulmonary hypertension (PH) is a progressive and ultimately fatal disease. Despite the pharmacologic advances in the last several years, fatigue remains a common symptom in patients with PH. The purpose of this descriptive cross-sectional study was to examine the prevalence and severity of fatigue, conceptualized as a multidimensional symptom, and to explore relationships between individual demographics and the dimensions of fatigue in patients with PH.

Methods: A convenience sample of 126 participants between the ages of 19 and 79 years were recruited from the Pulmonary Hypertension Association's 11th International Pulmonary Hypertension Conference and Scientific Sessions in Indianapolis, Indiana. Each subject completed the Multidimensional Fatigue Inventory Scale (MFI-20). New York Heart Association (NYHA) functional class, body mass index (BMI), oxygen use, and medication use were also assessed.

Results: The participants reported a high prevalence and severity of fatigue for the 5 dimensions of fatigue (general fatigue, physical fatigue, reduced activity, reduced motivation, and mental fatigue). The overall prevalence of general fatigue, physical fatigue, reduced activity, reduced motivation, and mental fatigue was 98%, 98%, 94%, 90%, and 91%, respectively. A multiple linear regression was calculated to predict participants' fatigue based on age, NYHA functional class, BMI, oxygen use, and medication use. The regression equation was not significant. The fatigue means of participants were compared using a one-way analysis of variance. No significant difference was found between level of fatigue and age, NYHA classification, BMI, oxygen use, or medication use. The majority of participants experienced fatigue despite age, NYHA classification, BMI, oxygen use, and medication use.

Conclusion: Fatigue, an initial symptom in the PH population, is often overlooked and is usually attributed to deconditioning. Fatigue is a prevalent and distressing experience as all dimensions of fatigue were present in the PH population. Routine assessment of fatigue in the PH population should be performed by healthcare professionals.

G2. Dedicated Education Units: An Innovative Academic/Practice Partnership

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An increasing challenge for nursing schools with shrinking fiscal budgets is to increase student enrollment to meet the need for a 30% increase in the nursing workforce by 2020. An innovative strategy to increase nursing faculty and improve the student experience in clinical rotations is the implementation of dedicated nursing units (DEUs). The DEU is an innovative partnership between nursing schools, nursing school faculty, and clinicians in nursing units to provide nursing students with a progressive and highly supportive learning environment for their clinical rotations. The DEU model utilizes a blend of the traditional teaching/learning strategies of nursing school faculty with the expertise of active clinicians and nurse educators to obtain the optimal clinical rotation experience. The purpose of this project was create DEUs of various practice specialties to facilitate the didactic and clinical experiences for junior and senior level nursing students so they could progress to skilled professional nurses. Twelve units were designated as DEUs in a 436-bed academic medical center in south Texas. Of the 86 nurse clinicians who attended preceptor classes, 28 actively hold a nurse clinician instructor role. From January 2013 to summer 2014, a total of 276 nursing students completed a DEU rotation, 54% of the total undergraduate enrollment of 2013.

Informal reports of the DEU experience from students, faculty, and the nurse clinicians were all positive. More rigorous program evaluation is warranted; however, this innovative strategy to improve the nursing clinical rotation experience holds the potential to increase nursing school enrollment to meet the nursing workforce shortages through the incorporation of nurse clinician instructors. Effective collaboration and intraprofessional partnerships between academia and the healthcare delivery system are essential to professional skill development of the nursing workforce.

The School of Nursing (SON) has been steadily increasing enrollment since 2008 in efforts to double enrollment. Having accomplished this and currently enrolling 310 students a year, the SON is still charged with increasing this number and will increase to 320 during the 2014-2015 academic year. Barriers to continuous increases in enrollment are clinical placements and faculty shortages. The DEU assists in addressing both barriers by providing nurse clinician instructors who provide supervision for 2 students each, allowing SON faculty to provide overall supervision to 12 students instead of 10. Additionally, the layout of the DEUs in this implementation allows the units to place 12 students rather than 8. With the continued success of the DEUs, we hope to continue to address these issues by increasing the number of students the faculty can supervise to 15-20 while in the DEUs.

G3. A Long Journey to Zero CLABSI

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Strong evidence supports the standardization of a multicomponent intervention bundle to reduce healthcare-acquired infections; however, sustaining compliance with practice changes can be challenging. The goal of this project was to implement and sustain a customized prevention program to achieve zero central line-associated blood stream infections (CLABSI) in our Level III Regional Neonatal Intensive Care Unit (NICU). Starting in 2003 and using rapid-cycle Plan-Do-Study-Act methodology, the following best practices were implemented: standard intravenous tubing configuration and medication administration system, sterile IV tubing change, and scrub the hub prior to central line access. The staff was introduced to the best practices using one-on-one sessions and yearly competency validations during the annual skills fair. In 2009, the CLABSI rates decreased to zero for 2 months, but the improvement was not sustained. In 2011, the unit participated in the On the CUSP: Stop BSI (Comprehensive Unit-Based Safety Program: Stop Blood Stream Infection) program funded by the Agency for Health Research and Quality. The unit CUSP team leaders worked with an interprofessional team to create a customized central line dressing change kit and an insertion checklist. Using daily huddles, interprofessional rounds, and parent/family education, the CUSP team leaders were able to drive compliance with all best practices for central line management except for hand hygiene. In the open bay unit, the staff used alcohol rub at the bedside; however, after moving to the new private room NICU, the staff needed to be reeducated on the use of alcohol rub before and after private room entry. Compliance with hand hygiene continues to improve. By the third quarter 2012, the CLABSI rate dropped to zero and has been sustained for 18 months except for 2 occurrences. A key driver of success was the interprofessional commitment to sustain best practices using the CUSP safety initiative.

G4. Influencing Cost and Care: Can Modified Early Warning Systems Help?

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Specific Project Aim: To test if this electronic medical record-based modified early warning score (MEWS) and the Rapid Response System (RRS) work as intended. More specifically, when the program goes live, do staff members respond appropriately? Does accurate, complete, and timely data entry coupled with appropriate response to triggers lead to better patient outcomes, especially the clear bottom line outcomes of reduced codes and unexpected deaths?

Background: MEWS is a physiological scoring system that has been used at the bedside to identify medical patients at risk of catastrophic deterioration. RRS is a safety mechanism to support patients who suddenly become critically ill and have a disparity between needs and resources. Patients whose condition acutely declines in the hospital often exhibit warning signs in the hours before clinical deterioration such as acute changes in heart rate, blood pressure, respiratory rate, oxygen saturation, level of consciousness, urinary output, or bleeding. The combination of MEWS and RRS may assist in early detection of patients' deteriorating condition and enhance patient outcomes.

Significance: Institutional growth necessitated reevaluation of resources to ensure availability of a reliable patient emergency response system. In 2006, Ochsner Medical Center implemented an RRS. Since 2006, RRS activations increased from 15 per 1,000 discharges in 2007 to 50 per 1,000 discharges in 2014. Despite these increases, cardiac arrest rates remained stable, ranging from 2 to 4.7 per 1,000 discharges.

Intervention: The MEWS system within an electronic medical record was implemented on 2 medical-surgical floors at Ochsner Medical Center. Implementation involved setting up needed software, training the staff in how to enter needed data and interpret program outputs, and a go-live.

Results: MEWS was implemented on June 12, 2014. On-unit coaching was conducted. Random audits of MEWS reports were reviewed. Findings included inconsistent vital sign documentation patterns, identification of learning needs, and discovery of system defects.

Implications for Practice: MEWS and RRS have the potential to improve the process of care and improve patient outcomes.

G5. Cost-Effective Evidence-Based Practice: Impact on IV Therapy Practices

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Background: Within a 500+-bed hospital, inconsistent intravenous (IV) therapy practices were recognized as issues impacting clinical and financial metrics. A project was developed to focus on variations in IV supply use, differences in bedside clinical practice, and the perceived increase in utilization of peripherally inserted central lines (PICCs). The number of central line-associated blood stream infections (CLABSIs), use of thrombolytics to declot central lines, and associated costs were identified as metrics that could be affected by implementing evidence-based practices. Within the hospital, 2 types of IV needleless system connectors (one positive pressure and one negative pressure connector) were in use. The flush/disconnect sequence varied, based on the type of connector. Incorrect flush sequence results in backflow of blood into the connector, providing an optimum environment for bacterial growth and the promotion of CLABSI. The 2011 recommendations from the Centers for Disease Control (CDC) recommend standardizing to one IV connector within a facility. An additional gap in clinical practice identified continuous IV tubing changes occurring more frequently than recommended by the CDC.

Methods/Results: A project was undertaken with the goals to reduce spending on tubing/connectors by 10% and to reduce placement of PICC lines by 10%. Interventions included implementing a new IV connector, revising existing IV therapy policies and procedures, and addressing PICC insertions in daily quality rounds. As a result of interventions, an impact was noted on the number of CLABSIs, thrombolytic usage, and PICC insertions. The annualized financial impact was $616,000.

G6. Critical Care Telemedicine: Using Technology to Enhance Care

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Specific Project Aim: The purpose of this project was to establish standardized, benchmarked best-practice surveillance for the critical care units using technology.

Background/Significance: Critical care units manage the sickest, most complex patients in the hospital who have the highest incidence of death and suffering. Studies suggest that only about 50% of critical care patients receive the required elements of evidence-based best-practice bundles recommended in nationally recognized specialty guidelines. Additionally, healthcare staffing shortages impede provision of quality critical care and decrease the capability to institute and evaluate evidence-based best practices at the front lines.

Intervention: Staff was trained to use electronic monitoring systems to enhance best practices, manage individual plans of care, decrease response times to alarms and abnormal laboratory values, and escalate initiation of lifesaving therapies. Critically ill patients were risk stratified in outcome comparisons using the Acute Physiology and Chronic Health Evaluation (APACHE) IV, allowing for predictions on severity-adjusted mortality and length of stay.

Results: Process, utilization, and outcome metrics have gradually improved. Examples of process metrics include venous thromboembolism prophylaxis from 91% to 98%, beta blocker therapy from 78% to 82%, and stress ulcer prophylaxis for ventilated patients from 94.5% to 96.2 %. Utilization metrics include increased unit stays from 1,100 to 1,700 and average daily census from 30 to 55 (potential 88). Outcome metrics include decreased critical care readmission rates from 3.85% to 2.3% despite increasing APACHE IV scores from 55 to 65 and actual:predicted mortality ratio of 0.75 to 0.83 and length of stay ratio of 0.5 to 0.6.

Conclusion: Critical care telemedicine offers supplemental support for bedside providers and acts as a safety net for patients by decreasing variation in practice, eliminating waste, and bridging gaps in care delivery.

G7. Quality Improvement in Cardiac Surgery: Translating Systems-Based Research into Practice

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Background: In 2011, the University of South Alabama (USA) Medical Center recognized a quality gap in cardiac surgery. Mortality was 12.7% above the expected rate. A team of cardiac surgery stakeholders reviewed national guidelines for cardiac surgery and multidisciplinary best-practice literature. The evidence suggested that a protocol-driven multidisciplinary team approach provided best outcomes. Additionally, the 2011 American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) Guidelines for Coronary Artery Bypass Graft Surgery provided direction for selection and timing of surgery.

Methods: A translational research model was utilized to develop and implement a quality improvement (QI) project. The objective was to determine if implementing evidence-based protocols through a collaborative systems-based care model would improve patient outcomes and reduce resource utilization. Guidelines-based protocols were implemented to improve patient selection, and the USA Heart Team was developed to consistently implement the protocols. Data matrices of more than 40 clinical processes and outcomes were recorded for 12 months preintervention and 24 months postintervention. Quality matrices were based on the following: ACCF/AHA Guidelines, Society of Thoracic Surgeons clinical outcomes, Surgical Care Improvement Project measures, and fiscal measures.

Results: The QI project was associated with a decrease in all-cause morbidity and mortality. Mortality decreased 8.7% in the 2 years following implementation. By streamlining care through care coordination and improving clinical processes, the USA Heart Team has also reduced resource utilization for cardiac surgery patients.

Conclusion: The QI project combined valuable aspects of leading quality and safety models into a single blueprint for building support structures capable of improving outcomes. At this time, the project has moved into the sustainability phase. The team is managing threats to sustainability by educating team members, receiving feedback, and modifying protocols as necessary.

G8. Advanced Practice Nursing Role Delineation in Acute and Critical Care: Application of the Strong Model of Advanced Practice

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The Consensus Model for APRN Regulation has led to concerns regarding the clinical nurse specialist (CNS) and nurse practitioner (NP) roles and whether they would lose their uniqueness because of the lack of explicit differentiation between these 2 historically distinct roles. A literature review revealed that the Strong Model of Advanced Practice was used to distinguish between CNS and NP roles. We wanted to use this model to examine current CNS and NP roles to inform stakeholders in our organization and ensure the most appropriate APRN candidates filled available positions. In our setting, the differences and similarities between the roles of CNSs and NPs were not well understood. The purpose of this study was to differentiate CNS and NP roles in various hospital clinical settings in one multihospital system.

A descriptive exploratory survey design was used to guide this study. A convenience sample of all CNSs and NPs employed by system hospitals was invited to complete an online survey using the Strong Model of Advanced Practice Role. The survey comprised 5 domains: direct comprehensive care, support systems, research, education, and publication and professional leadership. Each domain had a series of tasks specific to the domain (for a total of 41 tasks within the survey). Participants were asked to evaluate the tasks within each domain. Tasks were appraised based on frequency performed by the participant and the value (importance) each participant placed on the task.

The Fisher exact test was used to determine if there were differences in distribution of scores based on role (CNS and NP). When evaluated by frequency of task performed, the domains of direct comprehensive care ($p=0.0069$) and education ($p=0.01114$) were statistically significant between CNSs and NPs regarding their roles. Data revealed differences in frequency for 10 individual questions within the 2 domains. When evaluated by importance of task, CNSs and NPs did not differ in perceived importance for all 41 individual questions, except in domain 1 (direct comprehensive care).

Conclusion: Survey results indicate NPs are more focused on direct care and CNSs emphasize the education component of their role. Nursing leaders should consider these results when determining APRN alignment with facility needs.

C1. Non–Medically Indicated Deliveries Prior to 39 Weeks' Gestation

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Morbidity and mortality rates are greater among neonates delivered during the early-term period, 37-38 weeks' gestation, compared with those delivered between 39 and 40 weeks' gestation. Despite this evidence, the number of non–medically indicated early-term deliveries continues to increase in the United States. In 2010, Louisiana ranked 49th in the United States for overall birth outcomes. Therefore, the purpose of this project was to assess the number of early-term deliveries in our organization and develop strategies to reduce early-term deliveries to improve birth-related outcomes in this population.

In 2011, our organization joined the Louisiana Department of Health and Hospitals Birth Outcome Initiative that provided supportive strategies to reduce the incidence of non–medically indicated early-term deliveries. The baseline assessment of early-term non–medically indicated deliveries ranged from 0%-10% during the previous 18 months. Next, the following strategies were implemented: (1) created a dedicated scheduler to ensure delivery criteria were met, (2) provided the scheduler with an algorithm decision tree to implement a hard stop on scheduled non–medically indicated early-term deliveries created by the March of Dimes and the California Maternal Quality Care collaborative, and (3) improved provider buy-in through evidence-based education and guideline development. The dedicated scheduler screened all scheduled deliveries for infant gestation and utilized the algorithm for a hard stop to decrease scheduled early-term non–medically indicated deliveries. Since project inception in the third quater 2012, the number of scheduled early-term deliveries decreased to <5%, a 64% improvement from baseline measurements. Additionally, the number of neonatal transfers to a higher level of care for this population was eliminated.

Infants born before 39 weeks' gestation have an increased risk of developing respiratory and nonrespiratory complications. By implementing strategies to decrease the number of early-term non–medically indicated deliveries, it is possible to improve birth outcomes for these infants.

C2. Update: An Evidence-Based Approach to Creating a Restraint-Free Environment in the Pediatric Intensive Care Unit

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Since 1996, The Joint Commission has published guidelines that establish requirements for the safe use of restraint and seclusion procedures for patients. Physical restraint has historically been common practice in pediatric intensive care units (PICU) despite a lack of empirical evidence to support its use. Children in pediatric intensive care are frequently sedated to decrease anxiety, as well as prevent accidental dislodgement of medical devices needed to monitor and sustain life. However, any form of restraint should only be used as a safety measure of last resort. An interdisciplinary task force was created in the PICU to decrease restraint usage by 50% within 2 years using evidence-based strategies. The task force consulted PICUs around the country as well as scientific evidence to develop a daily checklist to assess the need for restraints. Numerous Plan-Do-Study-Act cycles were used to (1) educate the staff on appropriate use of restraints, (2) identify methods to be used as alternatives to restraint usage, (3) increase staffing to allow more time at the bedside to ensure safety, and (4) conduct weekly chart audits to assess staff compliance with restraint guidelines. Since inception of the new restraint guidelines, the rate of restraint usage was decreased by approximately 68% at 1 year and 97% at 2 years. In addition, patients spent approximately 2 fewer days in restraints for each restraint episode. The PICU continues to provide a near restraint-free environment for children and families and is currently in the process of implementing a nurse-managed sedation titration protocol for mechanically ventilated children to further promote patient comfort.

C3. Skin-to-Skin Contact after Birth—An Integrated Review of the Literature and Practice Implementation

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Skin-to-skin contact (SSC) involves placing the newborn directly onto the mother's chest without any clothing between them. SSC is associated with improved outcomes for both mother and infant; however, SSC after birth is not universally implemented as standard practice. The aim of this project was to conduct a state-of-the-science review to examine the evidence on the effectiveness of initiating SSC after birth and disseminate the findings to the healthcare staff of the maternal child units to promote buy-in for this practice change. A secondary aim was to track compliance with this practice change as well as breastfeeding exclusivity rates that have been associated with SSC. Literature published in English from 1980-2013 was identified using the following search terms: skin-to-skin contact after birth, skin-to-skin contact AND vaginal delivery, skin-to-skin contact AND cesarean delivery, and skin-to-skin contact AND full-term newborns. Twenty-five articles were selected for review. Evidence from the selected articles was evaluated and organized using a data collection instrument validated by Ursi (2005) to systematically evaluate the quality of the evidence and identify key concepts. The studies were organized into 3 subgroups based on the effectiveness of SSC: breastfeeding benefits, physiological benefits to the newborn, and emotional benefits to the mother. No adverse effects of SSC were identified in the literature. Dissemination of the benefits of SSC found in this review included monthly unit meeting discussions and a poster outlining the scientific evidence that supports SSC. The compliance rates of SSC after birth for healthy mothers and infants remain inconsistent but are trending toward improvement following the dissemination of the benefits of SSC. Breastfeeding exclusivity rates have increased from 30% to 65% since implementation of SSC.

C4. Intraoperative Pressure Ulcer Prevention: Strategies for Success

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Nearly half of all hospital-acquired pressure ulcers originate in the surgical environment and cost $750 million to $1.5 billion annually. The unique environment during surgery involves many of the known risk factors for pressure ulcer formation: immobility, patient positioning dependent upon procedure, intensity and duration of pressure, and moisture and temperature variances. Risk of pressure ulcer development is also influenced by comorbidities and hemodynamic issues, presenting challenges for the entire surgical team.

A performance improvement team committed to reducing intraoperative pressure ulcers developed a quality improvement project. Stakeholders included perioperative staff, operating room management, and the wound care nurse. A Plan-Do-Study-Act methodology was used to guide development and implementation of this 36-month project. Project components included (1) synthesis of scientific evidence, (2) adoption of a new best practice, (3) staff education, (4) phased implementation of practice changes, and (5) measurement of project-related outcomes.

The high-risk services targeted were cardiovascular, transplant, neurosurgery, and complex general surgery. Staged practice changes included new therapeutic support surfaces, different positioning techniques, addition of heel suspension boots, removal of cooling and heating blankets (when possible), and the addition of a soft silicone dressing over the patient's sacrum.

Following this staged implementation over 3 years, pressure ulcer development dropped to zero in 3 of the 4 specialties. Overall, the incidence of pressure ulcers decreased from 1.51 per 1,000 procedures in 2009 to 0.16/1,000 by 2011 and 0.55/1,000 in 2012, with sustained downward trending in 2013. This decrease resulted in an estimated savings of $890,000 annually based on preproject incidence and published treatment cost estimates. The success of this multipronged approach resulted in positive outcomes for intraoperative patients at greatest risk for pressure ulcer development and significant healthcare savings.

C5. The Use of Aluminum-Based Antiperspirant to Manage Secondary Hyperhidrosis to Facilitate Negative Pressure Therapy

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Statement of Clinical Problem: Sustaining effective negative pressure therapy in patients with hyperhidrosis is frequently a challenge, one that was not easily addressed in a complex paraplegic patient. This 52-year-old male, paraplegic, with secondary hyperhidrosis, osteomyelitis, uncontrolled type 2 diabetes mellitus, hypoalbuminemia, severe protein-calorie malnutrition, neurogenic bladder, and urethral fistula was admitted with septic shock and unstageable eschar-covered ulcers involving the sacrum and right ischial tuberosity. Physician progress notes documented grave prognosis with little chance of wound healing or survival.

Description of Past Management: Initially, the stage IV sacral ulcer was managed using surgical debridement and wet-to-dry dressings for one week without improvement. The wound care team was consulted and negative pressure was initiated on week 2. However, the traditional vacuum application using multiple trials of skin barrier products and compression garments failed to maintain dressing adherence, secondary to hyperhidrosis, for longer than a few hours.

Current Clinical Approach: Although no published evidence supports any specific products that improve wound dressing adherence in hyperhidrosis, reports describe the use of aluminum-based antiperspirants to ameliorate the symptoms of secondary hyperhidrosis. Based on this limited evidence and an anecdotal report from a colleague, an aluminum-based antiperspirant was trialed with application to a 3-inch periulcer area, followed by benzoin, prior to securing the negative pressure therapy.

Patient Outcomes: The addition of the antiperspirant as a skin prep resulted in uninterrupted dressing adherence for up to 3-4 days at a time over an 8-week period. Despite improved protein-caloric intake and glucose control, malnutrition persisted (albumin=1.7; pre-albumin=5); however, the sacral ulcer size decreased from 24 × 16 cm to 16 × 14 cm.

Conclusion: Exploring a nontraditional solution to control moisture due to hyperhidrosis played a critical role in management of this paraplegic patient's stage IV sacral ulcer.

C6. Nurses' Perception of Competence and Clinical Comfort with Managing the Care as the Primary Nurse of a Patient Involved in an Investigational Study

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In the ever-evolving medical landscape, the surge of agreements between private community hospitals and public graduate medical education programs has health systems reevaluating their policies and procedures. The transference and development of a teaching facility involves all disciplines and departments. Most significantly, these private community hospitals are experiencing a paradigm shift that involves the increase of academic and clinical research at the bedside. For bedside nurses, becoming an extension of the research study coordinator is a formidable undertaking. To ease the transition, nursing leaders are maximizing the use of automated systems to integrate research protocols in the standard operating procedures of these units, educating bedside nurses on specific research proposals, and developing nurse-driven studies to coincide with clinical trials. To assess the staff's readiness to assist with the frontline research milestones, it was imperative to better understand the nurses' perception of knowledge and clinical comfort with managing the care of a study patient.

This pre-post pilot study used anonymous web-based surveys. The surveys were created and validated by an internal group of researchers. Nine bedside registered nurses of a 10-bed pediatric hematology/oncology unit, part of a 104-bed children's hospital, completed the surveys. The surveys were available online for 2 weeks. Surveys 1a and 1b were offered 1 month after an educational presentation to the unit's staff. The educational presentation consisted of an intensive explanation of executing a clinical trial's protocol within the standard operating procedures of the nursing unit. Surveys 2a and 2b were offered 8 months after the initial surveys. Between surveys 1 and 2, the nurses were presented with reference materials, workflow tools, and a mock patient simulation training session with a stepwise overview of capturing the protocol's deliverables.

Methods: Surveys 1a and 2a sought a quantitative understanding of the nurses' perceived competence based on the following ranking scale: 1 - not competent, 2 - competent with full assistance from research staff and resources, 3 - competent with minimal assistance from research staff and resources, 4 - competent with accessible resources, 5 - competent independently. The 1b and 2b surveys sought a qualitative understanding of the nurses' clinical comfort based on a free-text description by asking the nurses to describe how comfortable they were with managing the care, as the primary nurse, of a patient enrolled in a research study.

Results: The baseline surveys expressed the apprehension of the nurses with managing the care of a study patient. Fifty percent of respondents ranked their competence level as not competent or competent with full assistance of staff and resources. Fifty percent of respondents ranked themselves as competent with minimal assistance of staff and resources. None of the respondents ranked themselves as competent. In the descriptive responses, nurses expressed their competence and comfort with managing these patients because they are the usual caretakers of this patient population. However, the high specificity of research deliverables, including time sensitivity, dependence on the execution of other departments, uncertainty of polices, and the desire to perform at their usual high level, negatively affected the nurses' perception of competence and comfort with managing a study patient. In the follow-up surveys, 25% of respondents ranked themselves as not competent or competent with full assistance of staff, and 75% ranked themselves as competent or competent with minimal assistance of staff and resources. The descriptive responses on the follow-up surveys reflected the nurses' increase in perceived competence and comfort. They noted the following limiting factors: fear of making a mistake, reassurance/assistance during the initial hours of subject enrollment, and readily available reference materials.

Conclusion: The study provided some insight into the perceived competency and clinical comfort level of nurses as they proceed through the new experience of managing the care of a patient involved in a clinical research study. The need for nursing leaders to be creative in developing training tools and reference materials and to integrate the protocol's deliverables in the standard operating procedures of the unit is vital. In terms of their positive development, the nurses identified the session with the mock patient simulation as the most valuable training component. The ability to maintain the quality and humanized care of a nursing unit by using the usual nursing team, as opposed to a research nurse, to facilitate research deliverables cannot be determined by this single study. However, this study shows the need for continuous investigation into the perception of competence and the clinical comfort of nurses with managing the care of a patient involved in an investigational study.

P1. Medication Safety Best Practices for Hospital

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Assess the Need: In January 2014, the Institute for Safe Medication Practices (ISMP) introduced the *2014 – 2015 Targeted Medication Safety Best Practices for Hospitals*. The purpose of this document is to identify consensus-based best practices related to specific medication issues that have caused harm and fatalities within the acute care environment despite previous recommendations and to mobilize national adoption of these best practices. Striving for exemplary professional practice within an interdisciplinary shared governance structure, the Clinical Practice Council (CPC) in this Magnet organization took on the task of formulating recommendations for achieving the ISMP best practices.

Gather the Evidence: In the United States, medication errors are the eighth leading cause of mortality and account for 44,000 to 98,000 deaths with an estimated cost exceeding $44 billion annually. Within the healthcare setting, medication errors are the most frequently identified error. ISMP is a nonprofit organization devoted to preventing medication errors and designing safe medication practices.

Translate Into Practice: An interdisciplinary work group reviewed the 6 targeted medication best practices. A system assessment was completed to determine opportunities for implementing best practices. Interdisciplinary collaboration among bedside nurses, nursing leadership, pharmacy, medical staff, materials management, and information systems is ongoing in achievement of the medication safety practices.

Evaluate and Maintain: After completion of the system assessment, 2 of the best practices—removal of glacial acetic acid from hospital areas and the measurement of patient weights in metric units only—were attained. A strategy was developed and implemented for the deployment and education of oral syringe usage for all in-patient units which is a third best practice. The fourth best practice is the use of an oral dosing device with a metric-only scale, and product options are being explored. The work group continues to consider implementation strategies for the 2 remaining best practices related to vincristine mini-bag administration and ordering of weekly oral methotrexate. A culture of medication safety requires interdisciplinary collaboration and ongoing error reporting to identify the structure and processes that are needed to sustain medication safety best practices.

P2. Hardwiring the Post-Fall Huddle, Purposeful Hourly Rounding, and Patient and Family Education of Fall Precautions During Bedside Shift Report

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Falls and fall-related injuries are the most common adverse hospital event. A fall is an unplanned descent to the floor (or extension to the floor), with or without injury, in an eligible clinical setting. Healthcare expenditures related to fall-related injuries are estimated to exceed $19 billion annually. Evidence suggests that multicomponent interventions are the best strategy for fall prevention. Including patient/family education on fall prevention has been shown to be an effective component. The fall rates on our 33-bed medical-surgical unit have been variable and have not reached the national benchmark of 3 falls/1,000 patient days. Therefore, the purpose of this evidence-based project was to implement a comprehensive fall prevention program to reduce falls and falls with injuries. The program included (1) patient and family education regarding fall risk and related fall prevention strategies during bedside shift report, (2) implementation of post-fall huddles to review the fall occurrence and discuss barriers/solutions to fall prevention strategies, (3) creation and implementation of a rounding tool for compliance on components of the fall prevention program, (4) implementation of structured hourly nurse rounding, and (5) real-time data feedback on fall prevention compliance and fall rates. Nursing compliance with patient/family education of fall risk and prevention has increased but is not yet sustained (89% in 2012, 95% in 2013, 93% in 1Q 2014, and 95% in 2Q 2014). Fall rates also remain variable but are trending downward (5/1,000 patient days in 2012 to 3.7/1,000 patient days in 2Q 2014). To hardwire evidence-based practice changes, it is important to give staff real-time feedback on their compliance with the practice changes and monitor outcome data over time. Providing staff with the opportunity to communicate process issues using daily staff huddles and monthly staff meetings can improve buy-in for the practice changes.

P3. Fast Track to CAT Scan: Decreasing Door to Needle Time

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Stroke is the fourth leading cause of death and the leading cause of disability in the United States. Early, rapid, efficient recognition and treatment are integral to quality outcomes. The administration of tissue plasminogen activator (t-PA) within a 3-hour window from onset of symptoms is associated with improved poststroke outcomes. In the United States, computerized axial tomography (CAT) scan is the primary imaging used to initially evaluate patients suspected of having a stroke. Early confirmation of the absence of intercerebral hemorrhage leads to a decrease in decision time for t-PA eligibility. The purpose of the interdisciplinary project was to decrease door to CAT scan interpretation times. Decreasing CAT scan interpretation times will have a direct impact on t-PA administration times. Flow diagrams were posted in the emergency department (ED) outlining the Fast Track to CAT Scan process. Rounds were conducted in the participating departments, ensuring the staff understood the new initiative and could verbalize the process. Nursing staff in the ED received additional training on the use of the Recognition of Stroke in the Emergency Room (ROSIER) scale. An interdisciplinary task force was initiated to ensure the goals and objectives of this project were met while having minimal impact on the units involved. Two months prior to initiation of this project, the ED was able to meet an overall average door to t-PA time below 60 minutes. The current initiative was in response to the lack of consistency in patients receiving t-PA in less than 60 minutes. Since the implementation of the project, only one patient did not receive t-PA within 60 minutes of arrival. The interdisciplinary task force will continue to collect and analyze data. Phase 2 will include routing post–t-PA transfers, who are potential thrombectomy patients, directly to CAT scan from the EMS stretcher.

P4. Mentoring New Nurses: A First Year Transition

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Combating high turnover is a challenge for hospital administrators. Turnover problems exist in all of nursing, but turnover is particularly problematic with new graduate nurses. Mentoring has been shown to be an effective approach to decreasing new graduate nurse turnover and improving job satisfaction when there is evidence of organizational commitment to formal mentoring and fostering of functional mentor and mentee relationships. Mentorship programs provide the support new graduate nurses need to successfully complete their first year of practice. The purpose of this pilot project was to implement and evaluate an evidence-based mentorship program and gauge the necessary support and resources needed for sustainability. The Donabedian framework of structure, process, and outcome was adopted to guide program development and evaluation. The theoretical frameworks of Barbara Carper and Patricia Benner guided the implementation phase of this project as new graduate nurse mentees started the professional journey from novice to expert. The mentorship program included orientation, training, and pairing of nurse mentors with new graduate nurse mentees at a 495-bed university-affiliated hospital with new graduate turnover rates >30%. Data collected after 2 weeks of program participation showed that both mentee job satisfaction and nurse confidence were moderate. The expectation was that institutional commitment to the program implementation would foster positive mentoring relationships, program satisfaction, and measured increases in confidence as well as intent to stay. Additional data collection was completed at 3 months and evaluation of the variables of interest was based on analyses of comparative mean scores. Results showed positive score increases and suggest some correlation between successful program implementation and positive outcomes that lead to successful first year transition for new graduate nurses.

P5. Pain Care Quality and Patient Perception of Care – An Interim Report

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The Hospital Value-Based Purchasing (VBP) Program, a component of the Affordable Care Act, is an important driver in reimbursement for healthcare services provided. Reimbursement will be based on the quality of care rather than the quantity of services. Providers are challenged to meet the patients' expectations of their experience as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The goal is to score >70% to achieve full reimbursement. Pain management is one dimension of the total HCAHPS score. Our baseline HCAHPS scores for pain have ranged from 79.7% (August 2013) to 50.7% (April 2014).

Evidence supports that quality pain management improves patients' reports of satisfaction even if their pain is not always eliminated. Thus, the goal of this project was to implement and sustain processes to enhance patients' perception of pain care management by using a Pain Care Quality Toolkit. In July 2014, staff education began that included the standardization of the following best practices: (1) whiteboards, (2) pain scales, (3) patient education brochures, (4) hourly rounding, and (5) nonpharmacologic strategies (positioning, heat/ice, guided imagery, distraction).

Outcomes to measure success of the project included HCAHPS scores for pain management and responses to the PainCQ-N© survey, a validated instrument for measuring patients' perception of pain care. Process measures included compliance to the Pain Care Quality Toolkit items using random audits. Baseline PainCQ-N© responses from 23 patients prior to implementation indicated that 35% of the patients experienced pain that was severe >50% of a 24-hour period. The majority of patients reported that their nurse believed their report of pain (82.6%) and that they were offered alternative approaches to pain management (74%). As the change in practice becomes hardwired, the outcome measures and compliance audits continue with the goal of improving patients' perception of pain care management.

P6. LPN-BSN: An Innovative Articulation Model

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Background: The expected nursing workforce shortage will be impacted by the increased numbers of the aging population and the nationwide nursing faculty shortage. The nursing faculty shortage will adversely impact the Institute of Medicine 2013 recommendations for nurses to advance their education to optimize patient care quality. This gap drove the creation of an interagency collaborative project to develop strategies to increase the nursing workforce.

Purpose: The purpose of this project was to implement and evaluate an accelerated licensed practical nurse (LPN) program in order to provide a seamless transition to a bachelor of science in nursing (BSN) program.

Methods: The accelerated LPN program began in January 2014 and will produce graduates in December 2014. The students are attending classes on the university campus and are being exposed to information about articulation into BSN opportunities at the university as well as the advantages of gaining a BSN for future career advancement. These students were required to have completed specific general education coursework from a 4-year university prior to being admitted.

Results: Demographic data, including preadmission test scores, are being collected for descriptive purposes. Academic performance will be measured using the following outcomes: National Council Licensure Examination for Practical Nurses (NCLEX-PN) scores, Assessment Technologies Institute Comprehensive Indicator scores, and final grade point averages. The Nurses Professional Values Scale-Revised (NPVS-R), derived from the American Nurses Association *Code of Ethics for Nursing,* will assess the student's ethical values. The expectation is no difference between the accelerated and traditional LPN students' academic performance and ethical values.

Conclusion: The success of this program will potentially impact nursing education to build a stronger, more diverse workforce. Nursing students should have access to advanced career opportunities within an academic system that allows seamless transfer opportunities.

P7. Will Electronic Health Record Reminders for Implementation of Asthma Action Plans Improve Provider Documentation and Reduce Asthma-Related Clinic Visits?

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Asthma affects more than 22 million Americans. Asthma exacerbations lead to missed school, low quality of life, missed days on the job, hospitalizations, and emergency room visits. Multiple studies support asthma action plans (AAPs) as effective tools for asthma management. The literature suggests that increased provider utilization of AAPs will result in a decrease in the number of asthma-related patient visits to school-based health centers. However, at one school-based health center in Louisiana, the AAP completion rates declined markedly after adoption of an electronic health record (EHR). Congruent with the guidelines of the American Association of Colleges of Nursing and the Advanced Nursing Practice Essentials, this project will evaluate provider use of information systems and technology to support and improve patient care using the AAP. The implementation plan includes the construction of EHR clinical alerts, known as pop-ups, to remind providers to complete the AAP. The provider will be required to record the action items of the AAP to move beyond the pop-up alert. These clinical alerts will automatically reset yearly. Specific project goals include (1) increase provider AAP completion rates, (2) obtain continued Office of Public Health clinic funding secondary to AAP benchmark satisfaction, and (3) reduce asthma exacerbation-related clinic visits. Charts of asthmatic patients (ages 14-21) with ICD-9 codes 493.00-493.2 will be audited 9 months before and after project implementation for the presence of a completed and up-to-date AAP. Records included for review will be determined through the electronic record reporting program. Data analysis will use frequencies to compare the number of patients with completed AAPs to the number of patients without completed AAPs, as well as the number of asthma-related visits pre- and postintervention. Last, providers will be surveyed pre- and postintervention to assess their familiarity with EHR clinical alert reminders, as well as their perception of the usefulness of the EHR clinical alert reminder in their practice.

P8. Health Policy Analysis of Nurse Practitioner Initiatives to Develop Advocacy Strategies Toward Full Practice in Louisiana

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Background: The steady increase in the number of Louisiana residents needing to access the healthcare system requires greater numbers of healthcare providers to provide care. Reducing nurse practitioner (NP) practice barriers through the identification of evidence-based initiatives structured specifically for Louisiana will help increase access to the healthcare system.

Objectives: The purpose of this DNP project is to conduct an analysis and evaluation of alternative state and national policies for NP practice in order to develop an evidence-based position paper and algorithmic advocacy plan to achieve NP full practice in Louisiana.

Methods: This DNP project is a nursing health policy analysis. The data-driven policy making model will be employed. This model outlines a 4-stage interventional process consisting of definitions and priorities, data collection, assessment, and action. States selected for analysis were based on the state attainment of the Consensus Model features, APRN practice within the state, the political party of the state, and geographic state location. After consideration of all parameters and selection criteria, the 4 states selected for analysis are New Mexico, Utah, Maine, and Kentucky. Definitions and legislative priorities have been established in relation to NP practice. Data collection will include many types of data resources, such as state records of legislation, acts, board rules and regulations, and stakeholders' perspectives. In addition, a matrix of state health and demographic data will be compiled.

Results: The assessment will be composed of a thematic analysis of specific policy themes and a timeline of each state's policy events to produce policy options supported by the data for Louisiana. In addition, quantitative data (state population demographics including income levels, population density, payer mix, education, overall state health quality outcomes, healthcare cost and access to care) will be summarized with frequencies, percentages, and central tendencies.

Conclusions: The final action phase will produce a white paper and an algorithmic advocacy plan for Louisiana based on evidence to be proposed to the state's nursing health policy community.

P9. Severe Sepsis 2014: Changing Evidence, Changing Practice

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Specific Project Aim: The purpose of this project was to establish standardized practices for management of sepsis and septic shock.

Background/Significance: In 2004, the first international guidelines for sepsis management were published. These guidelines recommended 6-hour and 24-hour bundled therapies. In 2013, the guidelines were revised to 3-hour and 6-hour bundles. In 2014, evidence from a randomized controlled trial resulted in reevaluation of existing institutional strategies for sepsis management.

Intervention: An interprofessional team was reengineered to address sepsis management. The team reviewed newly published evidence and worked to create new systems for sepsis care, including algorithms, order sets, and metrics. Simultaneously, the team was involved in a nationwide collaborative that sought to improve sepsis identification on hospital floors.

Results: Data analysis showed that compliance with "perfect care bundles" decreased from approximately 65% to 3%. The Sepsis Team created a new algorithm and redefined "perfect care" metrics to evaluate revised processes. An early warning scoring system was piloted in the electronic medical record to assist in screening for sepsis on in-patient floors. Staff was educated on new processes, and standardized rapid-cycle feedback mechanisms were developed.

Conclusion: The dynamic nature of healthcare requires interprofessional teams to constantly reevaluate practices through use of the best available evidence.

P10. Communication Bundles: Satisfaction and Quality in Critical Care

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Specific Project Aim: The purpose of this project was to create a targeted performance improvement plan that would improve patient satisfaction, enhance communication, and optimize goal alignment for patients on the medical intensive care service.

Background/ Significance: A marker of high quality critical care includes palliative care. Establishing relationships with patients and families during times of critical illness is a critical care imperative. Communication bundles provide a structured evidence-based method for communication that is measurable, teachable, and sustainable. Communication bundles are comprised of several key components. Day 1 bundle components include code status verification, designation of a decision-maker, and verification of advanced directives. Day 3 bundle components include provision of social and spiritual support. Day 5 bundle components include organization of a family meeting and update of the plan of care.

Interventions: Historical data related to palliative care was reviewed. Bereavement survey question analysis was conducted to assess measurable opportunities to influence communication with the implementation of bundles. Compliance metrics were created based on data review, including the number of patients with advance directives documented on admission, number patients with code status verification on admission, number palliative care consults, number of family meetings, and length of stay.

Results: Reports were created in the electronic medical record to monitor compliance, and selected bereavement survey questions were chosen as target metrics. Analysis of 2013 data showed that satisfaction with the use of advance directives decreased from 93.8% to 84.4%, written information for support resources decreased from 89.3% to 74%, satisfaction with questions answered decreased from 87.5% to 78.1%, explanation of services available decreased from 89.1% to 72.7%, and how well spiritual needs were met decreased from 92.9% to 80.2%.

Conclusion: Integration of palliative care evidenced-based practices into critical care may influence patient satisfaction, communication, and goal alignment.

P11. Accountable Care Through Nursing Professional Practice Review

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Every clinical interaction matters to both the patient and the healthcare organization. Quality of care as defined by the Institute of Medicine includes 6 key domains: safe, effective, patient centered, timely, efficient, and equitable. Establishing a quality culture in nursing practice and the structure to promote accountability of nursing care is vital. Nursing peer review is an evidence-based strategy to advance nursing quality. In the literature, nursing peer review is defined as a process to increase accountability of nursing practice and provide structural empowerment for nurses to govern their practice. Through the peer review process, improvement opportunities are identified within nursing and at the system level. The American Nurses Association *Code of Ethics for Nurses* identifies peer review as an important step in the self-regulation and accountability of professional nursing practice. Therefore, the purpose of this evidence-based practice project was to develop a professional nursing practice peer review committee to promote quality nursing care. In this Magnet organization, the peer review model was implemented using a shared decision-making structure that incorporated nursing professional standards of clinical practice to provide the format of peer review and enlisted nursing leadership support to cultivate professional accountability. Projected outcomes of this peer review process are improvement in patient outcomes, managed cost, and strengthened value of nursing in the delivery of healthcare. Understanding the difference between performance evaluation, behavioral issues, and practice evaluation is an important distinction in the peer review process. Nursing professional practice peer review promotes nursing excellence, supports autonomous practice, enhances professionalism, and drives the accountability for quality nursing care to the bedside.

P12. Safe Placement of Feeding Tubes in Neuroscience Patients

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Blind placement of feeding tubes can cause serious and fatal complications, especially in patients with a decreased level of consciousness and/or altered gag reflex that make the feeding tube placement more difficult. The most serious complication—misplacement in the bronchial tree with resulting pneumonia and/or pneumothorax—is reported to occur in more than 2% of blind placements. Tubes that are malpositioned in the esophagus can lead to aspiration. Small-bore feeding tubes can cause trauma if a stylet is used to facilitate placement. The gold standard for verification of feeding tube placement is radiographic confirmation that is typically obtained at the bedside after the initial tube insertion. However, this method does not prevent trauma during insertion. The purpose of this project was to implement a practice guideline to ensure the safe placement of feeding tubes in our unit's high-risk patients who commonly have factors increasing the risk of a misplaced tube. An interdisciplinary team collaborated to develop an algorithm to facilitate the placement of feeding tubes under fluoroscopy for high-risk patients (decreased level of consciousness and/or altered gag reflex). Unit staff education included (1) use of the algorithm decision tree, (2) processes for fluoroscopy-guided tube insertion, and (3) the importance of verifying tube placement every 4 hours. Since the implementation of this algorithm, there have been zero adverse outcomes from misplaced feeding tubes; however, it is too early to tell whether this improvement will be sustained. Nurses have expressed increased confidence with tube placement in high-risk patients under fluoroscopy. Both nursing and radiology staff have expressed satisfaction with the process changes. Next steps include chart reviews to assess decreased delays of enteral nutrition with the new process and a cost-benefit comparison with current practices.

P13. Holy Foley! A Campaign to Improve CAUTI Rates in the Cardiac-Neuro Intensive Care Unit

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The prevention of catheter-associated urinary tract infection (CAUTI) is an issue of national concern. Healthcare facilities are challenged to eliminate the incidence of CAUTI by implementing evidence-based practice prevention bundles. The prevention of hospital-acquired infections such as CAUTI is not only a quality and patient safety issue but also directly impacts financial reimbursements for health services provided. Despite relatively high compliance with the CAUTI prevention bundle (82% 1Q 2014, 87% 2Q 2014) that included hand hygiene, daily evaluation of urinary catheter need, perineal care, securement devices, and patient/family education, the CAUTI infection rates remained high. Our unit had one of the highest CAUTI rates (3.47 1Q 2014 and 7.3 2Q 2014) within the organization, which was well over the goal of <1 CAUTI/1,000 catheter days. In response to the high CAUTI rates, the Comprehensive Unit-Based Safety Program (CUSP) group launched a renewed effort in June 2014 to eliminate CAUTI in our unit and named the initiative "Holy Foley!" The initiative comprised the following: (1) daily leader rounding to monitor adherence to perineal care, (2) elimination of bath basins, and (3) 2-person urinary catheter insertion to monitor sterility. During leader rounds, the performance and documentation of the perineal care were assessed. If the perineal care had not yet been performed or the appearance of the perineal/catheter area was suboptimal, the leader performed perineal/catheter care with the bedside nurse and provided one-on-one coaching on evidence-based urinary catheter care. Physician leaders in the unit were encouraged to continue their focus on early discontinuation of urinary catheters. Preliminary data is promising: the CAUTI rate decreased to zero for the first month of this project initiative. The unit goal is to continue monitoring best-practice adherence and provide the team with real-time feedback while monitoring ongoing CAUTI rates in an effort to sustain this practice improvement.

P14. A Concept Analysis of Perinatal Death

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Perinatal loss is a newer term that describes the undesired death of a baby through miscarriage, stillbirth, or death within the first 28 days of life. The term perinatal death can be used interchangeably with perinatal loss, although perhaps the term perinatal death more clearly describes the actual loss. Despite the profoundness of perinatal death, there is little recognition in society. Nurses' interactions play an important role in the bereaved family's ability to cope with their loss. Evidence-based care is paramount to preventing psychosocial sequelae for bereaved families. Therefore, the aim of this concept analysis is to fully describe perinatal death. A concept analysis was conducted using the methods of Walker and Avant that include (1) selecting a concept; (2) determining definitions, attributes, antecedents, and consequences; and (3) creating cases. Perinatal death is defined as death before birth (stillborn) or a fetal or neonatal death occurring in the obstetric and neonatal areas, so *perinatal death* is used as an inclusive term for stillborn infants and neonatal deaths. Attributes of perinatal death include intrauterine fetal death, expulsion of a product of conception not resulting in a live birth and not due to an elective termination of pregnancy, and stillbirth. Stillbirth is individually defined by each state. The antecedents for perinatal death include a miscarriage, ectopic pregnancy, intrauterine fetal death, necessary medical termination, or neonatal death. Consequences of perinatal death include perinatal bereavement and grief. A model case would be a woman with an uncomplicated pregnancy who is told there are no fetal heart tones during a routine ultrasound at 29 weeks' gestation. Both mother and father grieve the death of their unborn child. The concept of perinatal death can be understood as a highly emotional time for those involved. Once the importance of perinatal death is recognized, nurses can receive evidence-based education to provide families with the highest quality care.