2018-2020
NURSING ANNUAL REPORT

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

MEMORIAL HOSPITAL
BELLEVILLE • SHILOH

BJC HealthCare

Letter from Michael McManus, President

Memorial's nursing and ancillary staff demonstrate daily our core values of compassion, respect, excellence, safety, and teamwork. It is these values along with our mission of providing exceptional healthcare and compassionate service that makes Memorial thrive. Nursing is the backbone of patient care in a hospital. Nursing sees the whole patient and has a unique combination of clinical skills, communication deftness, and emotional support that is vital to great patient care and superior outcomes.

Another source of pride is our Magnet® designation. Memorial Hospital Belleville, Memorial Hospital Shiloh and Memorial Care Center are among only 6% of hospitals across the nation to achieve this distinction for nursing excellence. This program designates organizations where nursing leaders align their strategic goals to improve patient outcomes. Memorial Hospital Belleville and Memorial Care Center first achieved Magnet® designation in 2008 and were subsequently re-designated two more times (2013 & 2018). Memorial Hospital Shiloh opened its doors in 2016, and was included in the organization's third designation in 2018.

Memorial's nursing and ancillary staff, under the direction of Terri Halloran, Ph.D., RN, NE-BC, CNO and Vice President for Patient Care Services, continues to elevate the standard for high quality patient care. Building upon our established relationship-based model of care along with mentoring, shared governance and providing professional development opportunities fosters pride, professionalism, and accountability among our staff. Continuous process improvement initiatives – many of them lead by nursing – along with open communication, has raised the bar on what our patients have come to expect from Memorial.

2020 has been a challenging year for all of us, but particularly for those on the frontline in healthcare. I want to take a moment to recognize everyone who has stepped up at our two hospitals, day in and day out, during the COVID-19 pandemic. It takes courage and resilience — for that we have unending gratitude.

Sincerely,

Mike McManus
President

Letter from Terri Halloran Ph.D, RN, NE-BC; Vice President for Patient Care Services & Chief Nursing O cer (CNO)

Dear Nursing Colleagues, Patients, Families, Friends, and Community Members,

I am pleased to share with you the Memorial Hospital 2018-2020 Nursing Annual Report. This annual report includes highlights and exemplars of nursing excellence, outstanding regional and national recognition of our staff, and reflections of professional practice. I would like to thank all of our nurses for their unwavering commitment to our patients and organization. I would be remiss not to acknowledge and recognize the dedication and selfless acts of kindness demonstrated by our front-line nurses and nurse leaders during the COVID-19 pandemic. I am not only in awe, but am utterly speechless and forever grateful and thankful to serve with this team of nurses. THANK YOU, MEMORIAL NURSES! Your service to meet our mission to the community has been unwavering.

Over the course of the past two years, we have had a keen focus on nursing quality. We have established councils for Quality & Nursing Practice, and Nursing Quality Peer Review. The Quality and Nursing Practice Councils (one for each Memorial Hospital Belleville and Memorial Hospital Shiloh) are the pillars of our shared/professional governance structure. These councils serve as mechanisms to provide a standard approach to evaluate nursing quality metrics and the individual practice of our nursing staff. This report includes details on our quality improvement initiatives and our successes with enhancing clinical practice. Our focus and emphasis on quality outcomes will remain a primary driver of our shared governance structure.

The World Health Organization designated the year 2020 as the "International Year of the Nurse and Midwife", recognizing and honoring a milestone of our profession, as well as Florence Nightingale's 200th birthday. During the course of our journey, Memorial nurses, who are heroes, have transcended our expectations when it comes to resiliency. It is ironic that this past year health care workers have earned increased respect and recognition from the community – well deserved and long overdue. In 2020, *TIME* magazine named its "Guardian of the Year" as Dr. Anthony Fauci and the front-line heath care workers fighting the pandemic. "Guardians put themselves on the line to defend the ideals sacred to democracy. On the front line against COVID-19, the world's health care workers displayed the best of humanity – selflessness, compassion, stamina, courage, while protecting as much of it as they could" (*TIME* Magazine). Our Memorial Nurses have been Guardians of our community.

This past year has been full of change and uncertainty; however, the constant is the dedication and commitment to caring for our patients, community, and each other. I invite you to enjoy the meaningful stories and extraordinary milestones that are detailed in this annual report.

Sincerely,

Terri Halloran Ph.D, RN, NE-BC; Vice President for Patient Care Services & Chief Nursing Officer

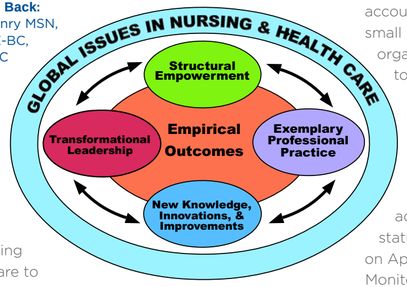
MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

The Magnet® Recognition Program

Magnet® Recognition is the highest honor awarded by the American Nurses Credentialing Center (ANCC) and nationally recognizes Memorial Hospital's ability to provide quality patient care, and initiate innovation in professional practice. Magnet® is a nursing recognition program that was developed in the 1980s to recognize the work of nursing in an organization. The program acknowledges organizations for continual innovation in nursing practice, excelling in quality patient outcomes, and the ability to draw patients and employees to the organization.

Memorial Hospital celebrates 3rd Designation as a Magnet® recognized organization at the 2018 ANCC National Magnet Conference in Denver, Colorado. **Pictured: Front:** Melissa Pluff MSN, RN; Maria Ballard DNP, RN. **Back:** Penny Bopp MSN, RN, CPN; Vickie Henry MSN, RN, CPAN; Cindy Wilson MSN, RN, NE-BC, PCCN; & Terri Halloran PhD, RN, NE-BC

Magnet® recognition promotes a culture of a positive working environment, professional autonomy, advancing standards of practice, nursing professional development, attracting and retaining professional talent, and a focus on continuous improvement. As the public grows increasingly medically savvy, they rely on Magnet® designation as an important indication of quality patient care when choosing a healthcare provider.



The Magnet® Recognition Program has provided Memorial Hospital with a roadmap in the quest for excellence. The program has allowed us to implement, revise, and sustain a strong professional governance model; nurses at the bedside making decisions about how to provide care to their patients through integration of best practices and clinical expertise. We have also been able to provide more professional development opportunities for nursing staff, including support for returning to school for higher education, and encouraging nurses to become certified in their specialty, validating their expertise as a nursing professional.

The Magnet® Recognition Program allows Memorial to embrace, change, and adapt to the many competing priorities in the healthcare environment, including Health Care Reform, nursing policy and legislation, and our obligation to the nursing profession. Through the Magnet® Recognition Program, our nurses, along with other interprofessional disciplines, have enhanced patient care at the bedside, reviewed and implemented strategies to improve outcomes, and adopted Relationship-Based Care as a central theme for how patient care should be delivered at Memorial Hospital.

Proudly, Memorial is one of 540 Magnet® facilities worldwide, which only accounts for approximately 6-7% of hospitals in the United States. The small percentage of organizations that have been recognized as a Magnet® organization indicates the rigor, organizational commitment, and dedication to the profession of nursing at Memorial Hospital.

Attaining Magnet® Recognition has been a strategic priority for Memorial Hospital long before 2008, when Memorial was initially recognized as a Magnet® organization. Since that time, Memorial was proudly re-designated in August 2013, and again in April 2018. Every four years, the hospital must re-apply and provide extensive documentation of adherence with standards and data in order to maintain Magnet® status. Memorial Hospital will submit documents for our 4th designation on April 1, 2022. In the meantime, we submitted our two-year Interim Monitoring Report to demonstrate adherence with the Magnet® guidelines, and are on the right track to successfully obtain redesignation in 2022.

Nursing Excellence & Recognition

Each year Memorial Hospital recognizes and honors excellence among our nursing staff through the Excellence in Nursing Awards. Nurses may be nominated by their colleagues, physicians, or patients.

The award program was established to recognize nurses who demonstrate excellence and leadership in their role and practice setting. The recipients are selected by the awardees from the previous year based on the Magnet® domains of Transformational Leadership; Structural Empowerment; Exemplary Professional Practice; New Knowledge, Innovations and Improvements; and Empirical Outcomes.

Nurses who receive this award are role models for nursing excellence, provide excellent care in a professional and competent manner while demonstrating a holistic approach to caring. They have personal qualities that enhance practice and relate to patients, families, and their peers. They participate in quality, research, and strive for professional development through certification and education. They are nurses who truly advocate for patients and their families.

In 2018, we initiated the first ever 'Distinguished Magnet Nurse of the Year'; an award intended for a nurse who fully encompasses all of the Magnet® components in their professional practice.

2019 Nursing Excellence Awards (Above)

Front row, left to right: Angela Hampton RN-BC (2 South); Christina Jenkins MSN, RN, CPAN (PACU); Joyce Muskopf RN, CEN (Emergency Dept.); Kellie Haar, RN (Emergency Dept.); Denise Burns BSN, RN, CGRN (GI Lab); Bonnie Carrillon RN (MCC).

Back row, left to right: Lindsey Wilson MSN, RN-BC (Nurse Manager); Anna Nowak BSN, RN, CCRN (ICU); Megan Kinsella BSN, RN-BC (MCC); JoAnne Sehr MSN, RN, CAPA (Clinical Education Specialist)-Distinguished Magnet Nurse of the Year; Crystal Neuwirth RN-BC (Pain Center), Holly Buhler BSN, RN, CCRN (ICU), Mary Marlen BSN, RN-BC (Nurse Manager)

2018 Nursing Excellence Awards (Left Side)

Front row, left to right: Lauren Bovenzi RN, CGRN (GI Lab); Mary Jane Maxfield, RN, ACM (Care Management); Cathy Fenton MSN, RN, CNOR (Operating Room)-Distinguished Magnet Nurse of the Year; Kristina Schmuck BSN, RN-BC (1 Center); Brittany Schulte RN-BC (4 South)

Back row, left to right: Jessica Nave BSN, RN (Emergency Dept.), Brittni Jackson BSN, RN (PACU); Candice Varel BSN, RN-BC (Med-Surg 4); Kristen Kustermann MSN, MBA, MHA, RN, CCRN (Night Resource Nurse & ICU); Denis Huelsmann BSN, RN, CEN (Emergency Dept.); Jennifer Durbin MSN, RN-BC (Nursing Director); Chrystal Kamm BSN, RN-BC (Family Care Birthing Center)

Not Pictured: Joanne Wood RN-BC (Pain Center)

Nursing Excellence & Recognition *(continued)*

During the 2018 & 2019 Nursing Excellence Awards banquets, nursing also recognized the Quality Rising Star Nominees. The Quality Rising Star Award is used to recognize individual dedication that goes above and beyond the expected in providing quality care for patients and families. The nominee should exhibit one or more of the following criteria:

- Has an active role in unit-based quality improvement initiatives
- Helps create an atmosphere that fosters success with quality improvement initiatives

2018 Quality Rising Stars
Vicki Drennan (Operating Room), Maddie Boucher (Memorial Care Center)
Not Pictured: Beth Vayette (Care Management), Jamie Marshall (Med-Surg 4)

2019 Quality Rising Stars
Dawn Kendall (Med-Surg 5); Rita Knau (PACU); & Madison Reed (2 Center)

Unit-Based Quality Awards are given to individual units or departments for outstanding achievement in Structural Outcomes including RN Education and RN Certification Rates, and Empirical Outcomes which include recognizing units that outperform an appropriate comparative benchmark of internal goal for Nursing Sensitive Quality Indicators. See on right the Unit Quality Award Recipients from 2018 and 2019.

Quality Awards Acronyms

HAPI: Hospital-Acquired Pressure Injury
CAUTI: Catheter Associated Urinary Tract Infection
CLABSI: Central Line Associated Blood Stream Infection
AMA: Against Medical Advice

2018 Unit Quality Award Recipients

Memorial Hospital Shiloh:

- **Intensive Care Unit:** Excellence in Structural Outcomes: RN Education & RN Certification and Excellence in Clinical Outcomes: Fall with Injury; HAPI, CAUTI, CLABSI
- **Family Care Birthing Center:** Excellence in Clinical Outcomes: Falls; Fall with Injury; CAUTI; CLABSI
- **ATC/OPS/PACU:** Excellence in Structural Outcomes: RN Education & RN Certification

Memorial Hospital Belleville:

- **Emergency Department (ED):** Excellence in Throughput Measures: Left AMA; ED Arrival to Admit Decision; Admit Decision to Departure; ED Arrival to Discharge
- **2 South:** Excellence in Clinical Outcomes: HAPI, CAUTI, CLABSI
- **2 Center:** Excellence in Clinical Outcomes: HAPI, CAUTI, CLABSI
- **Pre-Admission Center:** Excellence in Structural Outcomes: RN Education & RN Certification and Excellence in Clinical Outcomes: Falls/Falls with Injury
- **Cardiac Cath Lab:** Excellence in Structural Outcomes: RN Education & RN Certification and Excellence in Clinical Outcomes: Falls/Falls with Injury
- **Family Care Birthing Center:** Excellence in Clinical Outcomes: Maternal Hypertension Nurse Sensitive Indicator

2019 Unit Quality Award Recipients:

Memorial Hospital Shiloh:

- **ICU:** Excellence in Clinical Outcomes: Falls/Fall with Injury, CAUTI, CLABSI
- **Family Care Birthing Center-LDRP:** Excellence in Clinical Outcomes: Falls, Fall with Injury, CAUTI, CLABSI and Excellence in Structural Outcomes: RN Education & RN Certification
- **ATC/OPS/PACU:** Excellence in Structural Outcomes: RN Education & RN Certification and Excellence in Clinical Outcomes: Falls/Falls with Injury
- **Emergency Department:** Excellence in Throughput Measures: ED Arrival to Admit Decision; Admit Decision to Departure

Memorial Hospital Belleville:

- **4 South:** Excellence in Clinical Outcomes: CAUTI, CLABSI
- **ICU/IMCU:** Excellence in Clinical Outcomes: Falls/Fall with Injury, CAUTI
- **Emergency Department:** Excellence in Throughput Measures: ED Arrival to Admit Decision; Admit Decision to Departure and Excellence in Clinical Outcomes: Falls/Falls with Injury
- **2 South:** Excellence in Clinical Outcomes: CAUTI, CLABSI
- **Pre-Admission Center:** Excellence in Structural Outcomes: RN Education & RN Certification and Excellence in Clinical Outcomes: Falls/Falls with Injury

March of Dimes Awards:

Each year the March of Dimes recognizes extraordinary nurses in efforts to help moms and babies across Missouri and Metro East Illinois. The March of Dimes organization takes nominations for outstanding nurses in 23 different disciplines, and hosts an annual Nurse of the Year Awards banquet and dinner to celebrate nursing achievements. The seventh and eighth Annual Nurse of the Year Awards Banquet and Celebration took place in 2018 and 2019. Over 800 nominations were submitted each of these years. When a nurse is nominated for an award, they are required to fill out extensive documentation of their achievements within nursing including: professional development, patient care, and community service/outreach. Finalists are chosen in each of the 23 different disciplines, and then one winner is selected in each group.

In 2018, six nurses from Memorial were recognized as finalists during the March of Dimes banquet. In four disciplines, a Memorial nurse was recognized as the 2018 March of Dimes Nurse of the Year Winner in their specialty.

2018 March of Dimes Nurse of the Year Awards
From Left to Right: Donna Stephens DNP, RNC-OB (Nursing Director) - was recognized as a 2018 Champion of Nursing; Cathy Fenton* MSN, RN, CNOR (Operating Room) - Surgical Services Discipline; Janet Heck* RN-BC (Med-Surg 4) - General Medical/Adult Care Discipline; Maria Ballard DNP, RN (Magnet Program Director-Banquet Attendee); Tammy Dauphin* MSN, RN-BC, ACM, CNL (Care Management) - Case Management Discipline; Amy Hamilton DNP, RN-BC (CPE)-Education Discipline; Terri Halloran PhD, RN, NE-BC (VP of Nursing Services/CNO-Banquet Attendee); Mona LeGrand* MSN, RNC-OB, C-EFM - Clinical Informatics Discipline; & Angie Mann MSN, MPH, RNC-OB, IBCLC (CPE)-Education Discipline

*Denotes WINNER in the selected category.

In 2019, seventeen nurses from Memorial were recognized as finalists. In two disciplines, a Memorial nurse was recognized as the 2019 March of Dimes Nurse of the Year Winner in their specialty (see photo on pg. 8).

Nursing Excellence & Recognition *(continued)*

2019 March of Dimes Nurse of the Year Awards

Front Row: Charlotte Ligon RN-BC (Care Management)-General Medical Discipline; Brittany Schulte* RN-BC (4 South)-Rising Star Discipline; & Maria Ballard DNP, RN (Magnet Program Director)-Nursing Administration Discipline

Middle Row: Jeannine Kochmann MSN, RNC-OB, C-EFM, WHNP (Family Care Birthing Center): Women's Health & Obstetrics Discipline; Kim Howell DNP, PhD, RN, CCRN (Nursing Director): Nursing Administration Discipline; Deborah Gross BSN, RN, IBCLC (Family Care Birthing Center): Women's Health & Obstetrics Discipline; Vickie Henry MSN, RN, CPAN (Nurse Manager): Nursing Administration Discipline; Jennifer Hill* RN, CPAN (PACU): Surgical Services Discipline; Mary Jane Maxfield RN, ACM (Care Management): Case Management Discipline

Back Row: Kristin Atchisson BSN, RN-BC (4 South): Charge Nurse & Frontline Supervisor Discipline; Grant Herring BSN, RN (ICU): Student Discipline; Barry Payne BSN, RN, CCRN (ICU): Charge Nurse & Frontline Supervisor Discipline; Jennifer Sturgeon BSN, RN, RNC-OB, C-EFM, RNC-MNN (Family Care Birthing Center): Women's Health & Obstetrics Discipline; Jennifer Durbin MSN, RN-BC (Nursing Director): Nursing Administration Discipline; Carrie Christ MSN, RN-BC, ACM (MCC/Care Management): Community Skilled Nursing Discipline

Not Pictured: Vicki Hilmes MSN, RN (ICU)-Critical Care Discipline; & Cheryl Wright MSN, RN-BC, CIC (Infection Prevention): Infection Control & Quality/Risk Management Discipline

*Denotes WINNER in the selected category.

2019 St. Louis Magazine Nurse of the Year Awards:

Each year, St. Louis magazine recognizes the remarkable efforts of nurses throughout the St. Louis region and the metro east. For the 2019 10th Annual Excellence in Nursing Awards celebration, finalists were chosen from a pool of nearly 300 nurses. The finalist and award winners were chosen by a distinguished selection committee based on their nominations.

At the 2019 reception event, two Memorial Hospital nurses were recognized as finalists in their respective categories.

- **Joanne Wood, RN-BC, (Pain Management)** in the category of Community Care/Ambulatory Care
- **Kristen Kustermann, MSN, MHA, MBA, RN, CCRN (ICU & Night Resource Nurse)** in the category of Intensive Care

Joanne Wood

Kristen Kustermann

In additional to being named as a finalist, **Kristen Kustermann** was declared the winner in the Intensive Care category, as well as receiving one of only three awards for receiving a perfect score from the selection committee.

Please help us recognize these exceptional nurses for being chosen as finalists and/or winner in their categories. We are so proud of these nurses and their recognition for excellence!

Recognizing Individual Nursing Achievements:

Barb Masters MSN, RN-BC, CCRP: Recipient of the 2020 Anne Gavic Award

The Anne Gavic Award is the Illinois Society of Cardiopulmonary Health & Rehabilitation (ISCHR) most prestigious award for individual's whose leadership, ideas, and committee work have significantly benefited the ISCHR. This award annually recognizes one individual for their clinical contributions to the field of cardiac and/or pulmonary rehabilitation. Anne Gavic was the founding member of ISCHR, and the award is dedicated in her honor. Barb, as the award recipient, received a free annual ISCHR membership and registration to the annual conference. Congratulations Barb on your prestigious award!

Barb Masters

Lindsey Wilson MSN, RN-BC: Recipient of the 2020 Outstanding Leadership Award

The Outstanding Leadership Award is intended to recognize directors, managers, and supervisors at Memorial Hospital, who are role models and consistently exceed expectations. All directors, managers and supervisors were eligible provided he/she has worked at Memorial for at least one year and has received a formal performance appraisal. The year 2020 marked the first ever Outstanding Leadership Award. Eleven nominations were submitted in the nursing/clinical category and five nominations in the non-clinical/support category.

Lindsey Wilson MSN, RN-BC (Nurse Manager) received the first Outstanding Leadership Award in the nursing/clinical category. She received numerous nominations, all which spoke of her strong leadership characteristics, as well as her compassion. She is an effective communicator and listens to her staff. Congratulations Lindsey on this accomplishment!

Lindsey Wilson

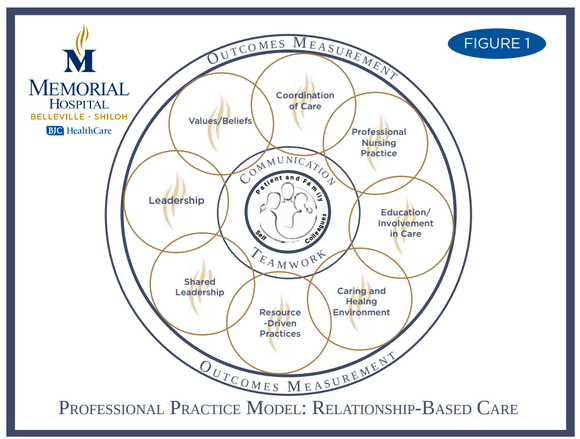
Thank you Nurses for the difference you make every single day.

Nurses are the role models for excellence, providing excellent care in a professional and competent manner while demonstrating a holistic approach to caring. They have personal qualities that enhance practice and relate to patients, families, and their peers. They participate in quality, research, and strive for professional development through certification and education. They are nurses who truly advocate for patients and their families.

Nursing's Professional Practice & Professional Governance Models

The Professional Practice Model (PPM) at Memorial Hospital is a common way of understanding and describing nursing regardless of practice setting. The PPM is based on Dr. Jean Watson's Theory of Human Caring, which describes the profound nature of caring and specific healing practices. The construct of caring as described by Dr. Watson's and other similar nurse theorists is the essence of nursing practice and has been operationalized into the transformational model, Relationship-Based Care (RBC), which provides the conceptual framework for care delivery. The current nursing PPM was developed in 2010 and has been evaluated and revised since its conception.

To weave RBC into the fabric of Memorial, the organization has established the expectation that all employees attend a three-day retreat, Reigniting the Spirit of Caring (RSC). The organization has provided RSC since 2010. There are trained facilitators for RSC who lead the 8-10 retreats annually. In addition, in 2016, a four-hour RSC course was added to the second day of new employee orientation. The four-hour course provides opportunity for all hospital employees to renew their understanding of RBC principles, and for new team members to better understand the principles of RBC before attending the three-day retreat.



PROFESSIONAL PRACTICE MODEL: RELATIONSHIP-BASED CARE

The PPM is a blueprint for nursing at Memorial, depicting through its schematic, how nurses practice, collaborate, and develop professionally to provide the highest quality of care to the patients they serve (See Figure 1: Professional Practice Model).

The PPM schematic illustrates the three defining relationships of RBC in the center of the model, which serve as the foundation for the PPM. Caring practices are activities that are responsive to the individual patient/family's unique needs and create a compassionate, therapeutic environment. The core relationships are surrounded by two essential components of RBC: communication and teamwork, which are integral to every successful relationship. The three relationships are:

- **Relationship with Self**
  - Awareness
  - Balance
  - Self-care: a fundamental requirement for quality care
- **Relationship with Colleagues**
  - Mutual respect
  - Trust
  - Open, honest communication
  - Consistent, visible support
- **Relationship with Patients & Families**
  - Patient and family are the central focus of our work
  - Caring for mind, body, and spirit
  - Learning what is most important to the patient/family
  - Engaging the patient in all aspects of their care

Additionally, Memorial has defined eight supporting components of nursing practice that are intertwined, overlapping each other. The eight domains are surrounded by outcomes measurement, which defines the impact of nursing practice in a healthy work environment. These eight interwoven components (circles in the PPM schematic) strengthen the three relationships at the core of the PPM, and are outlined below.

Leadership - RBC "calls forth the leader within each one of us." It asserts that every nurse is a leader, whether leading from the bedside or from an executive role. This occurs when individuals take ownership for their work. Leadership development prepares nurses at all levels to assume professional roles in practice, leadership, education, and research. Caring and compassion are leader behaviors.

Values and Beliefs - The culture of the organization is a collection of traditions, beliefs, values, and behaviors that comprise the context for how care is delivered.

Coordination of Care - is an essential component of high quality, safe patient care.

- Coordinated care begins upon entry to Memorial and continues through discharge.
- The nurse responsible for the patient when the patient presents for care takes ownership for the patient's safety and satisfaction.
- The 'responsible nurse' is accountable for coordinating patient care and communicating the patient condition, priorities, and concerns during transfer of care.
- The 'responsible nurse' communicates with interprofessional colleagues to coordinate care and meet patient-specific and family needs.

Professional Nursing Practice - is the cornerstone of care delivery and exists within a caring and therapeutic relationship between a nurse and patient.

- Continuity of the nurse/patient relationship is supported by the healthcare team through work schedules and assignments.
- The nurse has authority to delegate nursing activities to other caregivers of the interprofessional team consistent with the scope of practice defined in the Illinois Nurse Practice Act.
- The responsibility and accountability for professional growth and development are shared by the nurse and organization.
- The ANA Code of Ethics for Nurses and Scope and Standards of Nursing Practice are integrated.

The schematic of the Professional Governance Structure (identified on the next page) develops the framework for nursing professionalism. It is an expectation that professional standards of practice define care delivery.

Education/Involvement in Care - the nurse and patient are mutually responsible for determining the plan of care and outcomes. The nurse:

- Provides health teaching that addresses healthy lifestyles, developmental needs, preventative self-care and risk-reducing behaviors.
- Uses teaching methods appropriate to the situation and patient's developmental level, learning needs, language preference, and culture.
- Provides educational resources to help patients understand diagnostic tests, diagnoses, medications, and follow-up required.

Caring and Healing Environment - quality care attends to the whole person - mind, body, and spirit. The combination of therapeutic relationships and an environment that provides comfort and meets the patient/family's physical needs promotes healing. It includes the following beliefs:

- Initiating and sustaining a healing environment creates the environment for healing.
- Care innovations and system design impact the therapeutic relationship between a nurse and patient.
- A caring and healing environment creates circumstances for patient-centered, relationship-based care.

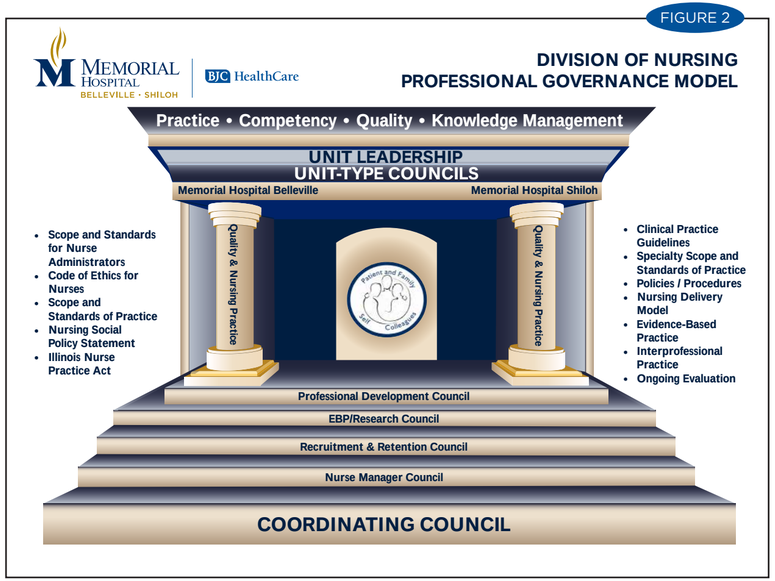
Resource-Driven Practice - A focus on what resources are available and prioritization of what matters most to the patient and family to be a strong steward of resources.

- Clinical staff, managers, and supervisors share responsibility for resources to provide quality care.
- A new mindset encourages "resource-driven" thinking versus "needs-driven" thinking.
- Critical thinking, creative thinking, and reflection help transform ineffective ways of thinking and doing work.
- Resource allocation requires commitment of all staff; clinical nurses, managers, and nurse leaders.
- Continuity of care promotes increased productivity and patient safety.

Shared Leadership (Professional Governance) - serves as the foundation for shared decision-making between management and clinical nurses, placing the authority, autonomy, and accountability for nursing practice at the bedside. Nursing's Professional Governance model was developed in 2004 and has been revised/updated on an ongoing basis to meet the needs of the organization and the goals for the nursing services department. (See Figure 2: Nursing Professional Governance Model)

- This model empowers all members to have a voice in decision-making.
- It empowers professional clinical nurses, nurse managers, and nurse leaders to contribute collectively to the decision-making process related to nursing practice, standards, and procedures. Shared leadership contributes to improved patient outcomes.
- Memorial's Nursing Services department has five central governance councils and a Coordinating Council, which oversees the activities of the other councils.
- Each unit-type has a Unit-Type Council (UTC) designed to plan, implement, and continuously improve patient outcomes and processes for the specific patient type.
- Additionally, each unit has a Unit Leadership Team (ULT) whose role is to plan, implement, and continuously improve the unit's practice, quality, and competency for their individual patient population.

FIGURE 2



Nursing Leadership at All Levels

Health care is constantly evolving and requires transformational leaders who can navigate the complexity of the health care system and influence change. Our nursing leaders build upon Memorial's culture of excellence and set high expectations of care and practice.

Transformational nurse leaders are apparent in all levels of the nursing division, including administration, management, and frontline nursing staff providing direct patient care. Bedside nurses are leaders when they advocate for their patients and keep their colleagues accountable for professional nursing practice. Administrators, nurse managers, and nursing directors guide and facilitate a shared decision-making approach at Memorial, contributing to empowerment of nurses at the point of service to collectively manage practice, quality, and competency for nursing services. The nursing vision and professional practice model are the foundation for nursing practice at Memorial.

Through the years we have seen tremendous growth in leadership by the professional governance chairs and councils. Many of the council chairs, over time, have moved into leadership roles within the organization. Nursing leaders at Memorial continue to inspire, facilitate, and mentor new leadership within the organization. Memorial is committed to 'growing our own' leadership team through professional development opportunities including educational webinars, nursing professional development portfolios, and support for specialty certification and higher education.

BJC HealthCare System Resources for Leaders & Professional Development at All Levels

The BJC Institute for Learning and Development (BILD) offers a variety of training and personal/professional development courses. Leaders, specifically, are offered the StartingLine Course; a program developed to inform and train leaders on the various aspects of people management. Leaders can also complete a Leadership Certificate through the BILD. Other offerings through the BILD for all employees include various tools and software system training such as: Microsoft Office (Word, Excel, PowerPoint, Access). Other courses offered build on the softer skills needed in healthcare including: Challenging Communication, Resiliency, and Emotional Intelligence, among others. Prior to COVID-19, the majority of classes were held in-person, but the BILD has now transitioned to virtual options, making them more convenient for employees in our current environment. Additionally, if there is a large need for a course or development/training at a specific system hospital, the organization can request an onsite class instead of having employees travel to the BILD. The BILD is a great resource for employees who are looking for growth in their current role, or would like specific training for future advancement.

Assistant Nurse Manager Role Development

In mid-2018, Memorial nursing leaders began looking at a new role to implement into practice; the role of the Assistant Nurse Manager (ANM). Throughout the BJC HealthCare system, the ANM role is present in most of the organizations, and Memorial sought to identify the value of the role and structure within our own organization. Memorial's nurse leaders used the system-level job description to redefine the role within our specific organization. The ANM role development included a hybrid leadership role that was both clinical and administrative; the ANM would serve as a liaison between the clinical staff and the 24/7 nurse manager for the unit/department. The ANM would complete employee performance evaluations, employee scheduling, etc. on the administrative side, and would function as a charge nurse or take a team of patients on the clinical side.

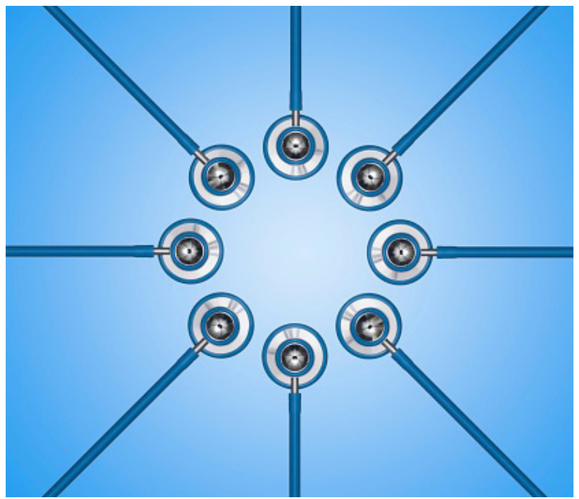
Additionally, the Assistant Nurse Manager (ANM) would be responsible for, but is not limited to, patient satisfaction, quality, and safety. This would include managing the daily flow of the unit by:

- Monitoring productivity and Memorial Hospital's operational goals
- Coordinating patient care, personnel management, and maintenance of equipment
- Managing individuals including new graduate nurses and new hires
- Participating in the development of staffing and implementation of budgetary goals
- Providing and overseeing patient care related to quality and implementation of appropriate plan of care
- Coordinating staff communication
- Evaluating performance reviews and conducting corrective actions

Many of the ANMs were selected based on previous leadership and charge nurse experience on their units. On units with more than one ANM, it was decided that the ANMs could potentially work varying shifts if needed based on the following criteria: shift with the greatest need in terms of staffing; or growth opportunities (new graduates, low employee engagement, etc.). Those interested in the ANM position had to apply, and go through a series of interviews during the selection process. The first group of ANMs were hired and trained in their new roles starting in October 2018.

To assist with the development and training of the new ANMs, a variety of tools and resources were utilized. The Assistant Nurse Manager Career Pathway Inventory is a tool used throughout the system to guide the professional development of the ANM. The inventory is completed upon hire, and then after 6, 12, and 18 months, respectively. The inventory covers a number of categories needed in the ANM role including: Financial Management (basic knowledge), Human Resources Management, Information Management Systems, Staff Development, Quality & Performance, Shared Governance, Transformational Leadership, Evidence-Based Practice, and Day-to-Day Work Environment. At the end of the inventory there is an open comment area for the ANM, nurse manager, and director, to have a discussion and note some future goals and next steps to complete the training. The ANMs were also provided an orientation guide that outlined more specific training needs and competencies for the role, including meeting with internal experts for different training needs. The ANM orientation checklist is reviewed on an ongoing basis with the nurse manager, and then retained in the employee file once completed. The ANMs were also offered to attend a variety of courses available through the BILD.

Development of the ANM role is an ongoing process, and we continue to learn from those currently in the role regarding additional learning and role development opportunities.



Hot Topic: Malignant Hyperthermia (MH) Crisis

Malignant Hyperthermia is a potentially fatal inherited disorder associated with the administration of certain general anesthetics and/or the drug, succinylcholine. The disorder is caused by an increased metabolism of the skeletal muscle. When an MH crisis occurs, the anesthesiologist is the key person to diagnose and initiate treatment. All involved departments must be knowledgeable to manage this crisis safely. Because the disorder is a rare, life-threatening event for the operating room and supporting departments, education of early recognition, treatment, and management is vital.

In 2018, a competency for management of Malignant Hyperthermia (MH) was scheduled for annual education. JoAnne Sehr, MSN, RN, CAPA, PeriAnesthesia Clinical Education Specialist, asked Cathy Fenton, MSN, RN, CNOR, Operating Room (OR) RN, to present a MH annual education module for the Post Anesthesia Care Unit (PACU) and Outpatient Surgery (OPS) RN staff. While Cathy was providing this education, she discovered opportunities to improve the policy & procedures, and general emergency preparedness for this crisis.

Ms. Fenton & Ms. Sehr decided to conduct an analysis of the current structure and process for managing MH and review of current practice. The main opportunities identified included:

- Review and update Malignant Hyperthermia policies
- MH emergency cart content evaluation
- Need to collaborate with all stakeholders involved with MH
  - Nursing
  - Anesthesia Providers
  - Pharmacists
  - Laboratory
  - Respiratory Care
  - Safety & Security
  - Nursing Supervisors
  - Communications Operator

Upon completion of the analysis and review of current practice, a meeting was scheduled with all key stakeholders. The goals for the meeting included the following:

- Discuss roles & responsibilities
- Policy review and updates
- Propose method to use current technology to declare a MH Crisis
- Revise & update MH Cart Supplies

At the conclusion of the meeting the following was decided:

- All agreed to consolidate policies and approved proposed updates
- Roles & Responsibilities were clarified
- All Dantrolene would be kept on the MH cart in the Operating Room
- All Dantrolene would be mixed at the point of care instead of in the pharmacy
- An anesthesia provider would need to declare the MH Crisis
- What to say when declaring a MH Crisis
- An automated communication system will be used to send alerts of the MH Crisis to all team members
- Location of ice delivery clarified
- Identified need to develop a Malignant Hyperthermia documentation form
- Content of Malignant Hyperthermia cart was updated

After receiving feedback from key stakeholders, the process and structure for management of a MH Crisis began to unfold. The following designated nurse roles where identified, and the importance of each role/responsibility was discussed. Because a MH Crisis is a low volume, high risk situation, nurse duty cards were developed to reduce role confusion. Nurse duty cards define the role of an individual nurse during the crisis. Laminated nurse duty cards, that included a name badge clip, were placed on the MH Cart. Each card listed duties for the assigned nurse. Identified nurse roles include:

a. Delegating Nurse
b. Dantrolene Nurse (Figure 1: Dantrolene Nurse Role Example)
c. MH Crisis Recorder
d. Medication Nurse
e. Cooling Nurse

A Malignant Hyperthermia Crisis Documentation Sheet was developed by Ms. Fenton and Ms. Sehr based upon current literature and Ms. Fenton's attendance at the Association of PeriOperative Registered Nurses National Convention. The draft was shared with many OR & PACU staff nurses and anesthesia providers. Changes were made to the documentation form based on feedback and the document obtained final approval (Figure 2: MH Documentation Form).

Ms. Sehr & Ms. Fenton also met with the Director of Emergency Management, Phillip Pugh, to use newer technology for the announcement of a crisis. For both hospitals, Memorial Hospital Belleville (MHB) & Memorial Hospital Shiloh (MES), lists of roles and phone numbers were entered into the notification system so crisis team members would be notified quickly.

Another key change, recommended by the Pharmacy Director, Ryan Birk, was to house all lifesaving medication to treat the MH Crisis in the operating room on the MH Cart (See Figures 3 & 4: MH Cart and Drawer of Medication). Ms. Fenton in collaboration with Toni Williams BSN, RN, Operating Room RN at MES, worked to assure emergency supplies in the MH cart at each hospital were the same.

The Malignant Hyperthermia Crisis policy was also updated, reviewed, and approved. Ms. Sehr & Ms. Fenton presented the new structure & process for the management of a Malignant Hyperthermia Crisis to the Nursing Evidence-Based Practice & Research Council in May of 2019. Addditionally, they received an invitation from this council to share the evidence-based approach to Malignant Hyperthermia at Memorial's Annual Nursing Research Symposium later that year. The multimodal education included a variety of face-to-face learning during team huddles, review of the MH cart, education modules, review of policy guidelines, and completing drills that included all key team members.

In conclusion, a Malignant Hyperthermia Crisis is rare and life threatening. Implementing measures to prepare key staff members to respond to this crisis is critical. Collaboration of all team members was essential to the success of developing a strong team approach to addressing this crisis.

FIGURE 1

MALIGNANT HYPERTHERMIA DANTROLENE NURSE

NURSING RESPONSIBILITIES

DELEGATING NURSE

DANTROLENE NURSE

1. OBTAIN MALIGNANT HYPERTHERMIA (MH) CART
2. BEGIN MIXING DANTROLENE
   a. SUPPLIES
      i. 36 VIALS KEPT ON THE MH CART
      ii. PRESERVATIVE FREE (PF) STERILE WATER,
      iii. USE MINI SPIKE DISENSING PINS (TRANSFER DEVICE)
      iv. 60 ML SYRINGES
   b. USING TRANSFER DEVICE, MIX 60ML OF PF STERILE WATER INTO ONE VIAL OF DANTROLENE
   c. SHAKE UNTIL CLEAR (MAY TAKE GREATER THAN 2 MINUTES)
      i. PROTECT DANTROLENE FROM DIRECT LIGHT
      ii. DANTROLENE MUST BE USED WITHIN 6 HOURS OF DILUTION
      iii. DOSE: 2.5 GM/KG (SEE DOSING CHART ON MH CART)
      iv. ADMINISTER RAPID IV PUSH ONCE DILUTED PER DIRECTION OF THE ANESTHESIOLOGIST
         1. WATCH IV SITE CARFULLY TO AVOID INFILTRATION
      v. TRACK NUMBER OF VIALS MIXED AND ADMINISTERED.

IMPORTANT: ACCURATELY REPORT/RECORD AMOUNT OF DANTROLENE GIVEN

MALIGNANT HYPERTHERMIA CRISIS RECORDER

MEDICATION NURSE

COOLING NURSE

FIGURE 2

Time:_____ Operator_____
Time:_____ On Call CRNA_____
Time:_____ On Call MD_____

MALIGNANT HYPERTHERMIA CRISIS DOCUMENTATION SHEET

Page 1

Cooling Measures/ Interventions	
◯ Discontinue warming measures if applicable	Insertion of Monitoring lines: ◯ Arterial Line Time:_____ Location:_____
◯ Place urinary catheter with temperature probe Time: _____	◯ Central Venous Catheter: Time:_____ Location:_____
◯ Cool IV Normal Saline Time:_____	◯ IV Site : Time:_____ Location:_____
◯ Apply ice to body (i.e. groin, neck, axilla, etc.) Time Initiated:_____	◯ IV Site : Time:_____ Location:_____
◯ Cool saline to sterile field if applicable. Time:_____	◯ Other:_____
◯ NG Tube: (site) _____ Time:_____ Comment:_____	

Staff Present

Anesthesia Providers:_____Time:_____
Anesthesia Providers:_____Time:_____
Anesthesia Providers:_____Time:_____
Delegating Nurse:_____Time:_____
Dantrolene Nurse:_____Time:_____
Medication Nurse:_____Time:_____
Cooling Nurse:_____Time:_____
Other:_____Time:_____

Vital Signs

Time	BP	Temp	Pulse	Resp Rate	SPO2	ETCO2	Oxygen	ECG Rhythm

Progress Notes

FIGURE 3

MH Cart

FIGURE 4

Drawer of Medication

Hiring Practices and Integrating New Graduate Nurses into the Workforce

Hiring Nurses

Nursing Services practices Relationship-Based Care at the bedside, in daily interactions, and in hiring new team members. Leaders strive to find new hires who encompass the values of compassion, caring, dignity, and respect. Applicants are interviewed to ensure the right fit of staff who will support the mission and values of the organization as well as the culture on the nursing unit. Commitment to quality, values, personality, and being a team player are key. Key interview questions are used to identify new graduates/experienced nurses who will be a positive force, caring colleague, and leaders in practice on the unit.

New Graduate RN Residency Program

New graduates at Memorial are valued members of the team and provide refreshing energy to the units. This new energy is palpable from the first day of RN Residency. Memorial has a 12-month RN Residency Program for new graduate nurses to enhance the transition from academics into professional nursing practice for safe quality care. In the RN Residency Program, new graduates are taught by clinical experts to support their growth, resiliency, and knowledge in their first year of practice. The evidence-based Residency Program has been in place since 2006 with over 700 attendees since its conception. The program has been regularly evaluated using the reliable and valid Casey-Fink New Graduate Experience Survey to enhance the program and participant outcomes. During the 12-month program, new graduates attend eight didactic/hands-on learning sessions based on body systems (i.e. integumentary, cardiac, etc.). In addition, residents attend two simulation labs at a local state university nursing school to practice codes, assessment skills, and patient events on high-fidelity mannequins. A two-day skills lab is also required for new residents and includes hands-on skills practice for various nursing tasks and procedures.

Specialty Orientation Programs

Memorial has also dedicated resources for onboarding programs of specialty areas including: Emergency Department, Intensive Care, Perioperative Services, and Obstetrics & Gynecology. These onboarding programs are designed to integrate nurses into a specialty practice area by providing unique education and hands-on training opportunities for care of the specialty area patient. The clinical education specialists assigned to these specialty areas are responsible for the specialty onboarding programs, including the development, implementation, and ongoing evaluation of content/learning experiences.

RN Mentor Program

During the orientation period, new graduate nurses are offered and enrolled in the RN Mentor program. The RN mentor (separate from the preceptor) role is to support a nurse's growth and professional development, knowledge, critical thinking skills, and problem-solving skills while assimilating into the culture of an acute care community hospital. The mentor provides relational and emotional support for the novice nurse in a safe environment. The goal is for the relationship between mentee and mentor to formally continue for at least one year.

Resource Nurse Role

In 2018, Memorial Hospital: Belleville & Shiloh created the role of the Resource Nurse. The role of the Resource Nurse is to support and develop new graduate RNs on the night shift during their first year in practice. This role has proven invaluable in supporting new graduate nurses in addition to newly hired nurses on nights as a resource for practice, policies, guidelines, and orientation. The night resource nurse travels between the two hospital campuses to assist RNs at the bedside with skills, procedures, and ongoing education in real time. The resource nurse follows up with all new graduate nurses (less than one year of practice) each night they work to provide guidance and assistance. New graduate nurses have stated the value of the night resource nurse and have appreciated having someone to go to during the night shift, when resources are generally more limited.

Summary

The RN Residency Program, specialty orientation programs, and roles of the Nurse Mentor and Resource Nurse are testimony to nursing leaderships' commitment to new graduate nurses and the future of the nursing profession. Collaboratively, these programs and clinical experts have demonstrated the support needed to foster professional development, staff engagement, and retention of our new graduate nurses.

S.T.A.R.R. (Safe Training and Responsible Restraint) Training Program

In the Spring of 2018, House Bill 4100 'Health Care Violence Prevention Act' was passed outlining responsibilities and procedures for healthcare providers and law enforcement to more effectively ensure the safety of health care workers while providing care to "committed persons". With this, a new law, Public Act 100-1051 was introduced and became effective in January 2019. The act provided guidance for workplace safety, reporting workplace safety incidents, resource availability, and workplace safety program structure and requirements.

Memorial's Journey

Memorial has had a Workplace Violence Committee in place since 2017. It is a multidisciplinary team that is responsible for reviewing workplace violence incidents, identifying equipment/programs needed for staff safety, and subsequently reports to the Environment of Care Safety Committee. So, why was there such a need for this committee? Over that last decade, there has been a significant increase in violence within health care due to the following:

- More mental health patients, including those with Alzheimer's disease or dementia
- Patients exhibiting drug-seeking behavior
- Patients or visitors under the influence of drugs or alcohol
- ED crowding, wait times
- Perception of patient/visitors that hospital staff are not being attentive to their needs

Between 2002 and 2013, incidents of serious workplace violence were four times more common in health care than in private industry (OSHA). The data (from OSHA) speaks for itself in that:

- 97% of physical assaults perpetrated by patients; 65% not reported
- 92% of verbal abuse perpetrated by patients; 86% not reported
- 1 out of 9 emergency department staff are physically assaulted every week

S.T.A.R.R. Program

In February 2018, members of the Workplace Violence Committee along with members from Senior Leadership were involved in an evaluation of safety programs for staff. Historically, Memorial had used a different program, but there was increasing concern with the limited number of trainers and staff that had actually been through the program, as well as frequent cancellation of classes due to trainer availability. The Workplace Violence Committee conducted a thorough review of available programs, in addition to looking at what BJC HealthCare had implemented at specific organizations within the system.

A decision was made to pursue a contract with Mitigation Dynamics, Inc. (MDI) who runs the S.T.A.R.R. (Safe Training and Responsible Restraint) program. MDI physically came onsite to provide information and demonstration to the leadership team and to 'train the trainers'. The training was rigorous, and the trainees are evaluated for successful completion of the trainer program. Ongoing education is needed as well to maintain a trainer position.

Between August 27-31, 2018, MDI was onsite to train 20 new trainers at Memorial across multiple disciplines (Safety & Security, Social Service, Nursing, Environmental Services, Hospital Administration, and Emergency Preparedness). Additionally, 80 end-users of the S.T.A.R.R. program were initially trained as well. At the end of training, end-users should have a thorough understanding of multiple techniques and principles including: indicators of potential violence, heightened situational awareness, effective escape techniques, verbal de-escalation, conflict resolution, and restraint techniques (if required). The goal of the program is to help healthcare professionals with little or no prior experience to build on their abilities to control, de-escalate, and effectively manage verbal and physical crisis situations; thus increasing staff and client safety.

Training Components

S.T.A.R.R. training is a hybrid model that includes both didactic lessons and physical/hands-on return demonstration of techniques. The following paragraphs provide a more in-depth look at specific training components.

During the didactic portion of training, end-users learn how to have a professional presence when engaging with clients; a critical component to creating a stable environment and maintaining an objective view of the situation. Trainees also learn how to identify a series of nonverbal predictors of potential assault, including but not limited to: change in facial complexion, sweating, exaggerated movements, too much attention to professionals or ignoring professionals, clenched fist, and client stance. After acknowledging these potential predictors, trainees walk through the steps of the Crisis Resolution cycle: Crisis, Think, De-escalation, and Implement. They are taught various implementation techniques to help resolve or de-escalate a situation including: professional objectivity (avoiding over and under reaction), empathizing with clients, appropriate use of body language, appropriate communication (articulation, tone, volume, cadence), effective listening, and welcoming, validating, and verifying client concerns. End-users are taught to use verbal de-escalation as a first step, and to avoid physical techniques in most circumstances. Following the didactic portion of the course, end-users are placed into situations to practice these verbal de-escalations techniques.

Additionally, S.T.A.R.R. program trainers have identified that avoiding physical techniques in client situations is not always possible. Therefore, end-users are taught physical safety techniques that include hands-on and return demonstration of those techniques. Employees are taught to protect themselves from danger by practicing a variety of escape techniques. In the event that a client becomes physically combative, the end-user will have been taught appropriate escort techniques to restrain and remove the client from the vicinity. 'Take-down' techniques are taught to aid healthcare professionals when a situation continues to escalate. (*all physical training for S.T.A.R.R. is completed in a safe environment with trained professionals to avoid injury). Safe patient handling is taught to prevent injury to client or healthcare provider and includes the use of proper body mechanics. The final lesson is on teamwork.

The training has proved to be a valuable resource for our employees, giving them the tools to have confidence and the needed skill set to manage our increasingly violent environment. Our internal goal is to train as many sta as possible on these important techniques.

Ongoing Work & Next Steps

Until COVID-19, S.T.A.R.R. training took place on a monthly basis with approximately 20 new end-users per training. To date, Memorial trainers have completed end-user S.T.A.R.R. training for 407 employees. Work also continues on the full implementation of the policy outlining the S.T.A.R.R. techniques that are taught during training, titled "Unarmed Combative Person Policy, Code White".

The training has proved to be a valuable resource for our employees, giving them the tools to have confidence and the needed skill set to manage our increasingly violent environment. Our internal goal is to train as many staff as possible on these important techniques.

Reference: Mitigation Dynamics, Inc. (MDI), 2018. S.T.A.R.R. Safe Training and Responsible Restraints: Instructor Manual. S.T.A.R.R. Control SystemTM. St. Louis, Missouri.

Certifications

Accredited Case Management:

Lisa Altland, RN
Amy Cagas, RN
Carrie Christ, RN
Tammy Dauphin, RN
Paula Dierkes, RN
Melissa Doles, RN
Amber Farlin, RN
Charlye French, RN
Mary Hagene, RN
Cheryl Klein, RN
Susan Loepker, RN
Barbara Mueller, RN
Dolores Schuette, RN
Heather Valesano, RN
Lisa Wagner, RN

Adult-Gerontology Primary Care Nurse Practitioner:

Aunye' Amos, RN

Ambulatory Care Nursing:

Dana Baker, RN

Ambulatory Perianesthesia Nursing:

Rebecca Czerniejewski, RN
Robert Gunter, RN
Marcy Hitt, RN
Cory Knapp, RN
Jennifer Mayer-Smith, RN
Rhonda Mense, RN
Christina Nester, RN
Cheri Obermeier, RN
Sara Reuss, RN
Joanne Sehr, RN
Deborah Smalling, RN
Alicia Stevens, RN
Celeste Wiesner, RN

Breast Patient Navigator-Cancer:

Terri Hundelt, RN

Cardiac-Vascular Nursing:

Stephanie DeGeare, RN
Emily Grannis, RN
Barb Masters, RN

Certified Cardiac Rehabilitation Professional:

Shelly Doerr, RN
Barb Masters, RN

Certified Clinical Documentation Specialist:

Jennifer Blondin, RN

Certified RN First Assistant:

Julie Maloy, RN

Clinical Nurse Leader:

Tammy Dauphin, RN

Critical Care Nursing:

Fatima Arabia, RN
Suzanne Beach, RN
Brooke Beck, RN
Dawn Beintker, RN
Craig Brazelton, RN
Holly Buhler, RN
Emily Derry, RN
Andrea Gross, RN
Kimberly Howell, RN
Joseph Huber, RN
Monica Kabat, RN
Paige Kalmer, RN
Patricia Knecht, RN
Michele Koch, RN
Kristen Kustermann, RN
Annaleen Nehr, RN
Anna Nowak, RN
Barry Payne, RN
Bethany Phillips, RN
Philip Sinn, RN
Sandra Thornhill-Alvarez, RN

Critical Care Nursing-Cardiac Medicine Subspecialty:

Sandra Thornhill-Alvarez, RN

Diabetes Educator:

Marilyn Cron, RN

Electronic Fetal Monitoring:

Erin Biehl, RN
Marilyn Bogan, RN
Janine Brammeier, RN
Christine Chadwick, RN
Jennifer Creek, RN
Desiree Davies, RN
Michelle Frey-Bohn, RN
Danielle Gilmore, RN
Kelly Harre, RN
Renee Junker, RN
Jeannine Kochmann, RN
Karen Loos, RN
Liz Pardee, RN
Susan Ruth, RN
Ann Schneider, RN
Jennifer Sturgeon, RN
Melissa Thurlow, RN

Emergency Nursing:

Gustavo Alcazar, RN
Katarina Clemens, RN
Adam Courtial, RN
Karla Dean, RN
Diane Dischinger, RN
Jacqueline Flanagan, RN
Daina Greathouse, RN
Angela Gretzinger, RN
Jill Houba, RN
Denis Huelsmann, RN
Sara Huge, RN
Kimberly Kesting, RN
Jennifer Marsala, RN
Donna McGinnis, RN
Karen Morrow, RN
Joyce Muskopf, RN
Wendi Robinson, RN
Cindy Sanden, RN
Sarah Tucker, RN

Emergency Medical Technician:

Christopher Bridges, RN
Renee Kleiser, RN

Certifications

Family Nurse Practitioner:

Melissa Rehkemper, RN
Cindy Sanden, RN

Gastroenterology Nursing:

Lauren Bovenzi, RN
Denise Burns, RN
John Swanson, RN
Janice Walton, RN

Gerontologic Nursing:

Carrie Christ, RN

Infection Prevention & Control:

Cheryl Wright, RN

Inpatient Obstetrics:

Kathryn Berndsen, RN
Janine Brammeier, RN
Alexis Deutsch, RN
Robbyin Etheridge, RN
Janice Gebke, RN
Lisa Hildebrand, RN
Renee Junker, RN
Jeannine Kochmann, RN
Debra Konradt, RN
Jennifer Laubscher, RN
Alison Lentz, RN
Natosha McEvers, RN
Donna Stephens, RN
Jennifer Sturgeon, RN
Robyn Ward, RN

International Board Certified Lactation Consultant:

Deborah Gross, RN
Robyn Ward, RN

Low Risk Neonatal:

Anne Bruns, RN
Katherine Camp, RN
Beth Catanzaro, RN
Tiffany Dial, RN
Kelsey Dunning, RN
Natosha McEvers, RN
Karen Morris, RN
Briana Swierczek, RN

Maternal Newborn Nursing:

Christine Chouinard, RN
Johanna Smith, RN
Jennifer Sturgeon, RN

Medical/Surgical Nursing:

Janet Alexander, RN
Leah Alexander, RN
Cathy Allen, RN
Renee Amann, RN
Tory Amburn, RN
Rebecca Anderson, RN
Diane Ashmann, RN
Kristin Atchisson, RN
Amy Attaran, RN
Barbara Bagby, RN
Lisa Baskette, RN
Cambria Beckmann, RN
Jodi Bennett, RN
Valerie Beyersdorfer, RN
Amanda Bleisch, RN
Donna Boushard, RN
Chris Breidenbach, RN
Rachel Brock, RN
Sarah Brooks, RN
Jessica Bunting, RN
Lisa Busane, RN
Deborah Chavez, RN
Carrie Christ, RN
Kimberly Conner, RN
Tammy Dauphin, RN
Lynn Davis, RN
Maria Davis, RN
Mara Delgado, RN
Rebecca Denbow, RN
Alex Dierkes, RN
Jennifer Durbin, RN
Laketria Durham, RN
Stacy Elliott, RN
Allison Falbe, RN
Denise Fisher, RN
Ronald Foster, RN
Jennifer Frankenfield, RN
Linda Fritsche, RN
Lindsey Gause, RN
Mary Greninger, RN
Chris Griebel, RN
Carrie Guthrie, RN
Diana Hainline, RN
Amy Hamilton, RN
Heather Hanna, RN
Ofelia Harvey, RN
Emily Heslop, RN
William Scott Holder, RN
Sara Huge, RN
Sarah Jacobs, RN
Letitia Johnson-Cross, RN
Daimecia Jones, RN
Monica Kabat, RN
Marcella Kalert, RN
Chrystal Kamm, RN
Kimberly Kell, RN
Megan Kinsella, RN
Christa Kirby, RN
Annette Klein, RN
Scott Klosterman, RN
Jacqueline Kluthe, RN
Margaret Kress, RN
Renee Kuehne, RN
Linda Laskowski, RN
Tammy Lewin, RN
Charlotte Ligon, RN
Beth Little, RN
Linda Loomis, RN
Cynthia Marcus, RN
Mary Marlen, RN
Jenisha McNealy, RN
Brandi Miles, RN
Rebecca Miller, RN
Stacy Miller, RN
Jenny Mueller, RN
Laura Mueth, RN
Maryann Munie, RN
Josefina Nance, RN
Stacey Netemeyer, RN
Crystal Neuwirth, RN
Judith Ostendorf, RN
Susan Parker, RN
Pennie Pavlisin, RN
Cheryl Pozdol, RN
Billie Ragain, RN
Kim Range, RN
Joy Rexford, RN
Rachel Robben, RN
Kristina Schmuck, RN
Danielle Schrage, RN
Brittany Schulte, RN
Lesley Shaffer, RN
Jeanne Smith, RN
Alicia Stevens, RN
Christina Stiles, RN
Kari Stordahl, RN
Deyona Storey, RN
Donna Stout, RN
Lori Sum, RN
Ashley Tasso, RN
Kayla Tate, RN
Kim Thornton, RN
Andrea Toennies, RN
Candice Varel, RN
Kristi Verstegen, RN
Tammy Vogt, RN
Cindy Wagner, RN
Rachel Walther, RN
Marjorie Weber, RN
Lanie Weber, RN
Sheridan Westcott, RN
Lindsey Wilson, RN
Julia Wolf, RN
Joanne Wood, RN
Cheryl Wright, RN
Margie Wuebbles, RN
Kelsey Yates, RN
Eliane York, RN
Farida Zapanta-Luddeke, RN

National Healthcare Disaster Professional:

Scott Klosterman, RN

Nurse Executive:

Lisa Altland, RN
Terri Halloran, RN
Barb Jany, RN
Cindy Wilson, RN

Nurse Manager and Leader:

Sandra Hill, RN

Oncology Nursing:

Connie Dolce, RN

Operating Room Nursing:

Lauren Abrahamson, RN
Daniel Barton, RN
Andrea Beizer, RN
Elizabeth Bibeau, RN
Marlana Blomenkamp, RN
Nancy Burk, RN
Shannon Craycroft, RN
Brooke Dierkes, RN
Cathleen Fenton, RN
Paula Folder, RN
Louis Grieco, RN
Janell Hinkelman, RN
Brittany Hinojosa, RN
Elizabeth Kemper, RN
Regina Lunk, RN
Julie Maloy, RN
Charlotte McDonald, RN
Laura McDonald, RN
Megan McElvain, RN
Joyce Neff, RN
Alice Pautler, RN
Lori Pickel, RN
Shelly Popp, RN
Rhonda Price, RN
Jennifer Range, RN
Alicia Rednour, RN
Angela Scheessele, RN
Melissa Sohn, RN
Margaret Timmerman, RN
Lisa Tobin, RN
Kim Trost, RN

Orthopedic Nursing:

Emma Kellmeyer, RN
Diane Kizziar, RN
Lisa Meisel, RN
Molly Zaring, RN

Pediatric Emergency Nurse:

Karla Dean, RN
Cindy Sanden, RN

Pediatrics:

Penny Bopp, RN
Margaret Lopez, RN
Shirley Almeda Walker, RN

Post Anesthesia Nursing:

Stacy Baur, RN
Teresa Black, RN
Sandy Griesbaum, RN
Vickie Henry, RN
Jennifer Hill, RN
Christina Jenkins, RN
Elena Lehr, RN
Brian Ripperda, RN
Rachel Schaefer, RN
Julia Lesicko, RN

Progressive Care:

Melissa Barney, RN
Linda Fritsche, RN
Dana Hehmann, RN
Janis Swank, RN
Cindy Wilson, RN

Registered Cardiac Sonographer:

Tami Wielgus, RN

Registered Rehabilitation Nurse:

Anne Ruggiero, RN

Registered Vascular Technologist:

Rebecca Crews, RN
Michelle Meentemeyer, RN
Sheila Revoire-Payne, RN
Renee Taylor, RN

Vascular Access Board Certified:

Dana Newsom, RN

Women's Health Nurse Practitioner:

Jeannine Kochmann, RN

Wound Ostomy Continence Nurse:

Janet Brammeier, RN
Gail Oldehoeft, RN

EPIC Planning & Implementation

Overview of EPIC Teams and Benefits — EPIC is a single electronic healthcare record system allowing staff and providers to document and view patient information in one portal. Once Memorial Hospital is fully implemented with EPIC, the entire BJC HealthCare system will be on one electronic health system.

At Memorial, the EPIC site sponsor is Terri Halloran PhD., RN, NE-BC; and the site liaison is Cindy Wilson MSN, RN, PCCN, NE-BC. The site sponsor and liaison are responsible for oversight of the planning and implementation here at Memorial with the EPIC build team; these two roles also oversee all of the core teams set up for the different components of EPIC implementation. The Site Engagement Team Leaders for the core teams are as follows:

- Inpatient – Jennifer Durbin MSN, RN-BC
- Outpatient/Ambulatory – Cathy Dent BSN, MBA, RN; & Lauren Beach MPT
- Safety/Quality – Kerry Wrigley CPHQ
- Operations-CIS – Kim Karn BSN, RN
- Provider Readiness – Dr. Hans Moosa
- Finance Readiness – Jane Gusmano
- Revenue Cycle Readiness – Allison Myers

In each of these core teams are a number of smaller operational teams to manage a specific component of implementation. The Site Engagement Team Leaders are responsible for ensuring the facility meets the organization directives and is ready for the EPIC program. Additionally, the Site Engagement Team Members serve as operational experts for their respective departments/specialties throughout the EPIC install.

Many benefits are associated with the full implementation of EPIC including:

- Improved safety and quality in patient encounters
- Efficient charting and documentation tools
- Easier registration and scheduling
- Comprehensive view of patient history
- Enhanced communication tools
- Information sharing between providers and patients

Timeline

Memorial Hospital is following a rigorous timeline for the various components related to EPIC implementation. The first real glimpse of EPIC occurred during the virtual roadshow in September 2020 where staff were able to view the different charting components (inpatient, bed placement, outpatient/ambulatory, reporting functions, etc.). The roadshow showcased the integrative capabilities of EPIC by providing demonstrations of specific clinical functions and a 90-minute workflow demonstration of an end-to-end workflow. All staff were encouraged to participate in the roadshow if they were able.

Besides the various teams that are working on implementation, a large focus has been placed on the Organizational Change Analysis (OCA) sessions that also began in September 2020. These OCA sessions focus on reviewing changes from their current state to EPIC. With all changes, these sessions focus on one of the following four change options: people, process, policy, or technology; as well as the impact level of the change: high, medium, or low impact. Frontline staff are highly encouraged to attend and provide input at the OCA sessions as they will be highly affected by the day-to-day changes as we implement this new technology. After review from the OCA sessions, teams will begin to focus on workflow changes and closing the gaps between current and future processes.

Between September and October 2020, the organization completed EPIC role validation to determine how each employee would need to access and use EPIC. Many different care modules exist within EPIC, and appropriate training is required based on job role and function.

Go-live for EPIC was originally planned for February 27, 2021, but was subsequently postponed until June 5, 2021 due to the rising number of COVID-19 cases throughout the region.

Training

A lot of focus has been placed on the who, what, when, where, and how regarding training. With the COVID-19 pandemic, the organization has had to evolve the training plan to a more virtual environment. To ease the transition to EPIC, Super Users have been identified. The Super Users are staff who will serve as champions of EPIC, support user adoption, and solicit feedback to maximize implementation success through the proactive engagement of end users. The Super Users will help lead the technology changes and increase the staff acceptance of that change. It has been found that early engagement [with the Super Users] creates excitement among peers. The Super Users are those staff who are most familiar with their unit/department workflows and will be available to help staff [end-users] through training and over the first couple of weeks after go-live for ongoing support. Super User training will take place March 29-April 17, 2021, and all end-user training will occur April 19-May 29, 2021.

Due to social distancing requirements and the expansion of virtual meeting space, staff will be able to complete their training virtually from home if they elect to do so. Staff will receive assistance and instructions on how to complete training off-site in a virtual environment. As the last BJC Healthcare system hospital to go-live with EPIC, this is a new option that is being offered to the organization due to the existing circumstances around COVID-19. However, there will be offerings for staff to complete onsite training as well if they prefer at both Belleville and Shiloh. Safe social distancing measures will be in place, as well as the donning of masks, use of headphones, and frequent cleaning/sanitizing of the work area. Extra computers will be brought in and set up for training in various spaces at both campuses. Once training is complete, staff can log into EPIC and utilize the practice environment, EPIC playground.

Hours of training needed will be dependent on job role and responsibilities. The list below includes the average training hours for the various roles within nursing services:

- Inpatient Nurse: 17-18 Hours
- Emergency Department Nurse: 13-14 Hours
- Pre-Op, Operating Room, Ambulatory Surgery, & Post-Anesthesia Care Unit Nurse: 5-10 Hours
- Patient Care Technician: 4-5 Hours
- Unit Secretary: 3-4 Hours

Infrastructure

A significant amount of infrastructure changes were needed as well, including:

- Installation of data cables-each patient room had to be rewired to be able to install the new hardware
- Upgrading the wireless network
- Updating the computer arms and full mounting of computer stations in every patient room and work area
- Whole units and departments were moved to support the EPIC construction as needed

Preparation for Go-Live

In preparation for go-live, a technical dress rehearsal is completed to ensure all the computers and printers are working. A soft go-live occurs, which consists of a manual appointment conversion for cases that were scheduled. Prior to go-live, cutover occurs. Cutover is where a group of professionals (nurses, pharmacists, etc.) insert clinical information from Meditech (our current documentation system) into EPIC 24 hours prior to go-live.

Go-Live

All teams involved in the planning and implementation of EPIC have been working diligently to ensure a smooth and seamless go-live transition. While this has been a busy time to plan to implement a new technology such as EPIC, we, as an organization, are looking forward to the benefits that will result from this change.

Both our Belleville and Shiloh campuses will go live June 5, 2021.

Epic1

Implementing Resiliency Strategies at Memorial Hospital

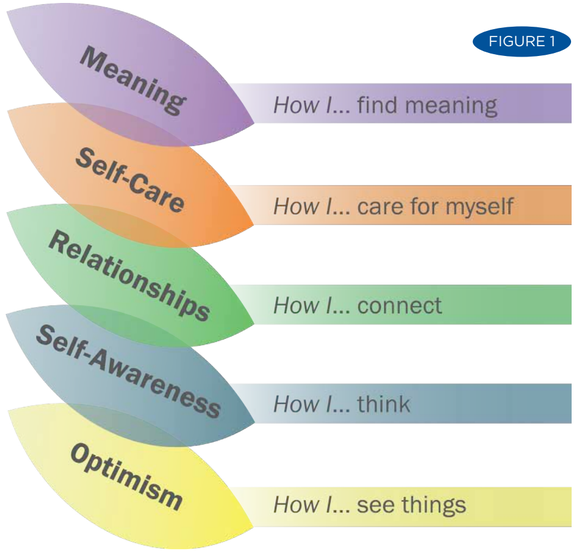
In March of 2018, with the help of the BJC Institute for Learning and Development (BILD) team, Memorial Hospital leaders developed a plan to expand the resiliency practices at Memorial from leaders to all employees, as it was felt that the resiliency components aligned with Memorial's Practice Model of Relationship Based Care. The implementation action plan included: identifying executive resiliency sponsors, raising awareness around resiliency, promoting understanding of resiliency components, and incorporating into current workflows.

The BJC HealthCare system developed, and now provides all system hospitals with tools and resources to empower employees to build and strengthen skills that support their individual resiliency, and promote practices that support resiliency throughout the organization. Resiliency within BJC is comprised of five components including: Meaning, Self-Care, Relationships, Self-Awareness, & Optimism (See Figure 1).

In June 2018, a small team of Memorial employees developed a plan to raise resiliency awareness and implement at both Memorial campuses; and thus the Resiliency Steering Team became active. Each department was asked for 1-2 volunteers for those interested in becoming Resiliency Champions. The training included the opportunity for employees to understand the concepts of resiliency, and how to incorporate these concepts amongst their teams. More than half of the champions were from nursing services, and the rest from other departments throughout the hospital(s).

While the training was occurring, the Resiliency Steering Team developed a plan for ongoing communication with the new resiliency champions, including monthly Get Togethers. The team specifically avoided use of the word 'meeting' to describe these gatherings, as the intent was to foster collaboration, joy, and meaning amongst the champions. The intention was for the champions to view this time together as something different than the day-to-day work. The Get Togethers would be a comfortable space to meet, gather, and share ideas/innovative methods for diffusing the resiliency concepts. The first Get Together occurred in November 2019 and continues to this day on a monthly basis, although we have had to evolve in 2020 due to physical distancing constraints.

FIGURE 1



Memorial Resiliency Champions

Juanita Smith, MCC Activity Therapy, shares her beautiful singing talent at the Memorial Hospital East employee/visitor entrance in December 2020.

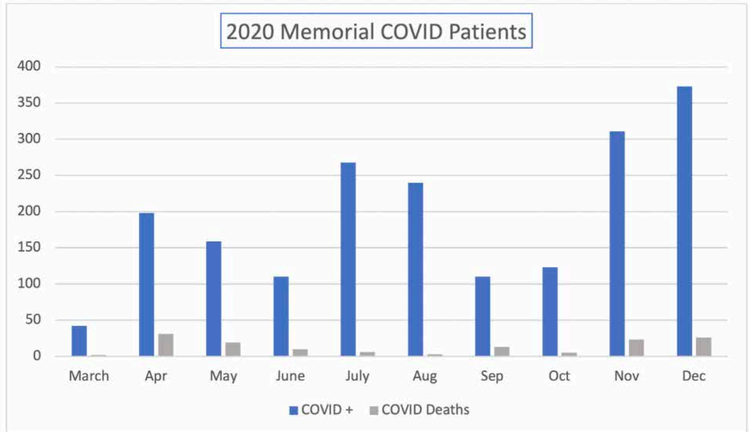
During the Get Togethers, the champions focused on a variety of activities using the aspects of resiliency as their guide. Resiliency activities have ranged from sharing personal stories, bulletin board activities, recognition and appreciation of co-workers, the "golden rock hunt," and even coordinating onsite therapeutic neck and back massages for employees.

This work has never been more important than in the present crisis we are experiencing. As many employees are caregivers on the front line of this pandemic it is imperative we continue to offer moments of optimism, gratitude, and connection as that is how we will survive and hopefully...THRIVE!

COVID-19 Response

"Healthcare Heroes", "Devoted Fighters", "Dedicated Professionals"... phrases commonly used to describe Memorial Hospital staff members who are unwavering in this unprecedented time. As we reflect on the past year it becomes increasingly evident that Memorial's mission *"Providing exceptional healthcare and compassionate service"* is intact. Reviewing this journey leaves us awestruck by the power of illness and the resiliency of our patients, families, and caregivers.

COVID-19 caused by the SARS-CoV2 virus was first identified in Wuhan, China in December of 2019 and was initially described as a pneumonia of unknown origin. Within four weeks, this virus demonstrated that it had no borders by appearing in 21 countries, including the United States. The initial U.S. cases were connected to overseas travel, cruise ships, or contact with someone that had been overseas. However, very soon, devastating outbreaks verified community spread. A global emergency was declared by the World Health Organization on February 11th, and on March 11th, COVID-19 became the first documented coronavirus pandemic in history.



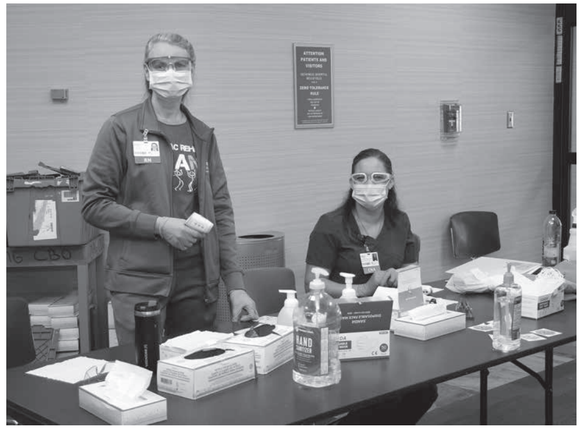
This virus has now affected the life and health of more than 80 million people worldwide. At the end of 2020, the United States accounted for over 20 million of those cases. Illinois has seen over 900,000 cases and experienced at least 1,000 deaths. Locally, St. Clair County has seen 16,684 cases with 280 deaths, and Memorial ended the year 2020 with caring for 1,934 patients and experienced 133 deaths. This unprecedented crisis has overwhelmed health care systems and placed burden on all care providers. Memorial's local response to this virus was focusing on providing the best care for the community residents and supporting those health care providers entrenched in the work. Memorial's journey began March 11th, 2020 with the first positive COVID-19 patient. Currently in wave three, Memorial has pushed forward through many challenges in medical management and care of the COVID-19 positive patients.

Challenges in providing competent, compassionate care for these patients has proved to be multi-faceted. Medical management, patient care, laboratory testing capabilities, regulatory reporting, supply gaps, financial strain, and staff burnout were all areas of great concern. Health care workers can attest to the warp speed in which COVID-19 evolved. Memorial Incident Command Center, in cooperation with BJC HealthCare Incident Command led the efforts for the pandemic response.

One of the earliest barriers Memorial Hospital faced was the inability to test for the virus. Initial testing constraints included testing through the state of Illinois, and only if very stringent criteria for testing was met. While testing continues to be of concern, the initiation of multiple COVID-19 testing methods has allowed for a more comprehensive testing program. Memorial forged ahead early and trusted that the collaborative effort with BJC would bring testing capabilities in a short time. Priority was given to open a testing site to serve the community and Memorial employees. Ultimately, Memorial became the first in the BJC system to open a drive-through testing center which continues to operate today.

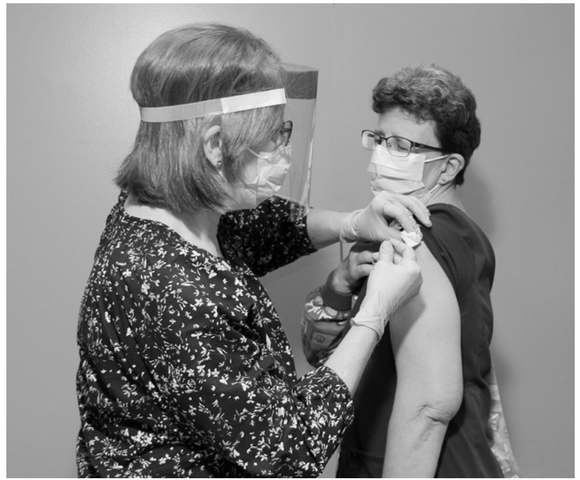
Proper use of Personal Protective Equipment (PPE) was challenging as the recommendations changed quickly and were often in opposition to previous recommendations. Initial guidelines provided from the CDC were not to wear a mask. Those that had respiratory symptoms and those caring for patients with respiratory symptoms needed to mask, otherwise it was felt unnecessary. By mid-April 2020 the spread of COVID-19 from patients and staff with no symptoms or just prior to symptom onset was recognized as a major contributor to the spread of COVID-19, and universal masking began to take shape. Memorial became an early adopter of universal masking but also recognized the perils of aerosol generating procedures when an outbreak occurred among staff and patients on a nursing unit. Masking recommendations at Memorial were modified to include respiratory protection appropriate for these types of concerning treatment modalities; BJC soon followed suit.

Memorial was not immune to the national PPE shortage. The Materials Management team worked continuously to secure adequate PPE for all staff. Lack of protective gowns meant that nurses used the same gown from one COVID-19 patient to the next prior to removing. Lack of masks required staff to place their mask in a paper bag and reuse it for several shifts. BJC was able to do mask decontamination for a short period of time, and this helped alleviate some concern in mask reuse. Several local businesses assisted by printing and donating 3D face shields. Cleaning supplies dwindled requiring staff to use alternative products which took a substantially longer time to attain proper disinfection. Donations from the community and other medical providers also helped bridge the gap.



Memorial employees are screened each day upon entry to work. Each screener asks a series of questions related to COVID-19 symptoms/exposure, and takes each employee's temperature. In this photo, Memorial Employees' Shelly Doerr RN, CCRP (Cardiopulmonary Rehab) and Mala Clark (MCC Certified Nursing Assistant) screen employees as they enter the facility for their shift.

Patient care looks and feels different during a pandemic. Providing care for these patients has required flexibility and resiliency. Until very recently, ambulatory patients entered the hospital through a tent and were triaged as "potentially infected or no infection concern". Many were treated and discharged directly from the tent and never entered the facility. While this process has moved indoors, it continues to be a mainstay of limiting patient congregation in the Emergency Department. Care teams were challenged by the severity of illness as those arriving through ambulance services tended to have more severe illness as patients delayed seeking care in fear of entering a hospital.



Susan Wagner, RN, CIS Department, gives Marjorie Weber BSN, RN-BC, 2 South, her COVID-19 Vaccination.

Early in the pandemic, many local nursing care facilities experienced outbreaks of COVID-19 leading to increased patient volumes which put strain on the staffing pool. Late in the year, the care center population has continued to present, however, a younger population of patients infected through community spread has now added to the patient volume.

Dedicated COVID-19 units were designed within the hospital and at Memorial Care Center to limit exposures and concentrate resources. Staff nurses from both hospitals staffed the COVID-19 units. Staff from various other areas were re-deployed to these units to assist the nursing staff with tasks and assure PPE was applied and removed correctly. Nursing educators took on the responsibility of reviewing proper techniques with all staff.

Facilities Management supplied filtration systems for individual rooms to scrub the air thereby decreasing the likelihood of staff becoming ill. To limit staff exposures to ancillary departments, nursing took on all tasks in the care of patients including drawing labs, respiratory treatments, delivery of food trays, and daily cleaning of the room. Nurses had to quickly learn new medications and treatment modalities, including placing a patient in the prone position. The dedicated COVID-19 floor staff became the experts in COVID-19 care and can attest to how quickly this virus can cause patient conditions to deteriorate. Following CDC recommendations, visitors were significantly reduced and at times, not permitted at all. It became common for patients and family to communicate through media resources. Many goodbyes occurred with a nurse at the bedside holding an iPad. Triumph over the disease is declared with each patient downgrade in level of care and the victory march of a discharge will forever be a part of the Memorial family. "Don't Stop Believin' (Journey) plays through the overhead announcement system as COVID-19 patients are discharged from the hospital.

The community has rallied around Memorial's staff throughout the pandemic. Donations, prayers, and well wishes are in abundance. Staff have participated in prayer gatherings to maintain their resiliency. There was a fly over by Scott Air Force Base to recognize the work of our health care providers. Many yard signs and social media posts were shared all saluting health care workers. Staff received many home cooked meals, bakery items, and treats from community members or local businesses. Personal handwritten thank you cards were received from multiple schools and churches. Staff received much needed neck and back massages by local chiropractic clinics; giving them a moment to be still and a few minutes of respite. Staff enjoyed musical instruments and singing by other Memorial employees as they arrived to work or during their shifts within their units/departments. The Memorial Hospital staff have supported, assisted, and befriended each other through this difficult time.

Memorial Hospital staff know what resiliency looks and feels like as they continue to provide care for their patients. The year 2020 was named "The Year of the Nurse and Midwife" by the World Health Organization (WHO), and it has proven to be the year that all caregivers have risen heroically and collaboratively to serve the community. As the vaccine arrives and is administered, it is with optimism that all continue to push forward.

Memorial Care Center (MCC)

The pandemic of 2020 has changed health care as we know it, and perhaps the changes are greater at Memorial Care Center, our skilled nursing facility, where the vast majority of those served are in the high-risk category for an unfavorable outcome from the virus. At MCC, we have made countless adjustments to the workflows and routines we once knew, to create an environment where our patients continue to receive the 5-star personalized care we are known for, and our staff feel supported and valued.

Patient / Family Initiatives

Our professional practice model, Relationship Based Care, recognizes the importance of family in our patients' healing process. At a time when visitors inside our building are restricted, we have enacted several initiatives to keep our patients in contact with their loved ones, and keep their families informed of their progress in rehab. These initiatives include scheduled phone calls to families, window visits, outdoor patio visits, and Zoom meeting calls.

Each of our patients are placed on 14 days of isolation from the day of admission. During this time all patient care, including therapy treatments, take place in the patient's room. The majority of our patients come to MCC following a hospitalization, where there are also restrictions on visitors; making this period of time very challenging for our patients. Unfortunately, patients can experience feelings of loneliness and depression due to these additional safety measures. Although we encourage our patients to have contact with their families as often as possible, we recognize that sometimes a phone call is not enough. The addition of an iPad with Zoom meeting capabilities offers the opportunity for a video conference between a patient and family members. Our staff schedule a time with the patient's family, then set up the iPad for the patient. The ability to see loved ones during a conversation can make all the difference and bring peace of mind to both patients and families. Our nursing and therapy staff both call family routinely to keep them involved in the patient's progress and care. This also allows for a time to discuss needs for discharge planning to ensure a safe transition home.

We are blessed to be a single-story facility, where most of our patient rooms have windows that are accessible from the outside. This gives us the opportunity for our patients to visit with family and loved ones through the window. Window visits can occur as early as the day of admission and have become a daily occurrence for many patients. We had room numbers installed on all our exterior windows to assist families and visitors to find their loved ones more easily when they visit. We do not limit the number of window visits, the length of window visits, or the age of those who can visit. Our patients have been able to see their grandchildren and great-grandchildren through the window and even their favorite pets. In fact, we had one family member bring a patient's horse to the window because our patient was extremely concerned for his beloved horse.

In addition to the window visits, this summer we were able to begin offering patio visits for patients who had completed their 14-day isolation period. Several measures are in place to ensure the safety of our patients during outdoor visits. Patio visits are monitored to ensure all parties maintain 6-feet social distancing and wear masks appropriately in accordance with CDC, state, and local guidelines. We are restricted to allow each patient one outdoor visit per day with a maximum of two visitors; we work diligently to keep our patients connected with their families. Patio furniture was added to our front porch to provide comfortable seating, and planters were added with seasonal flowers to offer a more homelike feel. We've used fans to keep our patients comfortable in the heat of summer, and blankets to keep patients warm with the brisk winds of fall. Our newest addition to the patio is a heated tent so we can continue these visits through the winter months. We have provided whiteboards to assist with communication of those who are hard of hearing, and face-shields to assist with communication for patients who are hearing impaired and read lips. Several dogs have accompanied family members to visit our patients on the patio. We know this face-to-face time has made a difference in the healing process of our patients, and it has brought joy to our staff as well.

Patient Morale

Prior to the pandemic, we would have a variety of activities from church services, musical entertainment, and group games to keep our patients active and have an opportunity to socialize outside of their room. These days, we have gotten creative to provide a fun outlet for our patients in between therapy and nursing care. Hallway bingo has become a popular afternoon activity. Instead of patients being brought to one common area to play, patients remain in their rooms with their bingo cards, and staff voice the numbers up and down the hall. And bingo is not complete without prizes; we have several donations of snacks, socks, puzzle books, and more for the winners to choose from.

Another popular activity has been our themed carts. Our recreational therapy staff have gotten their creative juices flowing and created several treat carts that travel throughout our building every Friday. Themes have ranged from a lemonade stand, hot dog cart, an ice cream sundae cart, and more. The carts are decorated to support the theme, and treats are available for all patients and staff.

Several of our patients have had birthdays during their rehab stay at MCC. When the special day arrives, we decorate the door to their room with banners, balloons, and signs to help celebrate the milestone. We also work with families to schedule an outdoor visit on their birthday. We know our patients are in rehab due to necessity, and being away from home on their special day can be tough, so we do all we can to make their day exceptional.

In November, Physical Therapy and Expressions Dance Studio had a group of their young dancers performing outside of MCC in various areas such as the parking lot, sidewalks, and chapel courtyard. Patients were able to look out of the common room areas (wearing a mask and using appropriate social distancing) to see the dancers outside the windows.

Considering the current times, we all have a focus to keep our patients safe while they are in our care at MCC. Multiple safety measures are in place to help mitigate the spread of the virus within our facility. We developed a small gift for our patients to help keep them safe once they discharge from our facility. On the day of discharge, each of our patients is provided with a reusable mask that proudly displays the MCC logo. This gift has been well received by our patients, who proudly wear their new mask as they leave our building to return home.

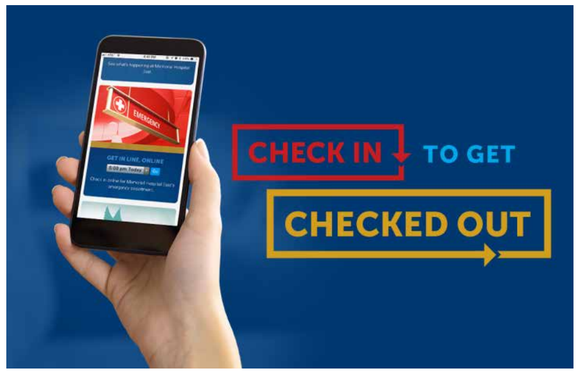
Sta Morale

At the end of 2019, the MCC leadership team had devised a plan to introduce core values of our department. The roll-out was set to begin in March of 2020, however when the pandemic hit, this initiative was placed on hold temporarily. This fall we began introducing our entire staff to our core values: compassionate, flexible, driven. The kick-off had an interactive educational session for all disciplines describing what each of the values mean at MCC. Shirts were designed and provided to all staff following the education of our plan. Staff were divided into three teams; each team has a different color shirt. Each month is assigned a value, and staff are encouraged to submit stories of staff members who they have witnessed displaying one of our chosen values. A friendly competition between the three teams was initiated to encourage staff involvement.

Throughout this challenging time, we have witnessed flexibility and interdisciplinary teamwork amongst all our staff members. Therapy staff members have volunteered to work as CNAs, and members of the administrative staff have embraced new duties to help keep patients connected with their families.

This past year has provided the healthcare world with many new challenges, but the dedicated staff at MCC have risen to the challenge to keep our patients safe.

In-Quicker: An Innovative Emergency Department Intervention for Patient Throughput



Background Information & Literature Review

Patient throughput is described as the navigation of a patient throughout a healthcare facility from presentation until the time of discharge. Patient throughput, efficiency, and quality has an impact on the organization as a whole, including patient satisfaction which is most often affected (Kane et al., 2015; Wright et al., 2013). The market of health care services has become more competitive, and there is a rising need to streamline services regarding throughput measures. As a community hospital, Memorial has growing competition in our primary service area. To increase emergency department volumes, Memorial has begun focusing efforts on increasing ED utilization which is believed to increase utilization of all services. In February 2018, a kick-off meeting was held with the interdisciplinary group tasked to work on an innovative intervention for patient throughput. The team began an evaluation of strategies and defined objectives for their project.

The proposed strategy was an online check-in system for non-urgent patient complaints that would allow the patient to wait in the comfort of their own home. Melissa Pluff, MSN, RN, was tasked to work on this goal and strategy for her Master's of Science in Healthcare & Nursing Administration scholarly project. At this time, Melissa began to evaluate evidence and organization trends in support of a web-based patient check-in system and develop a plan for implementation. She hypothesized through her research that this program would improve operational efficiencies in the ED leading to:

- Shorter wait times for non-urgent complaints
- Decreased ED length of stay (LOS)
- Reduced left without being seen (LWBS) rates
- Improved patient satisfaction
- Strengthening consumer loyalty
- Minimizing leakage to competitors

A literature review conducted by Melissa revealed the following:

- A frequent consequence of inefficient throughput is overcrowding, and leads to extended wait times, ambulance diversions, increased LOS and LWBS rates, poor patient outcomes, and dissatisfied patients.
- Strategies to improve throughput include: incorporating fast-track program, team triage approach, point of care testing, staffing and scheduling practices, and immediate bedding.
- Patients favored a time tracking display in the waiting room, as well as communication regarding the ED process, expected waits, and the offering of comfort measures by staff during their wait.
- Favorable patient satisfaction is linked to positive perceptions of quality of care.
- Wait time is agreed upon as a determinant of both positive and negative patient satisfaction with ED services. Shorter wait times imply better service which leads to positive patient satisfaction.

- Timely access to care is a greater motivator on patient decision of where to seek care.
- Between 10-30% of all ED visits are for non-urgent, low acuity complaints (Uscher-Pines et al., 2013); ample volume of non-urgent visits could be served by this project.

Practice Utilization

The recommendation was to implement InQuicker, a web based check-in system for non-urgent ED patients. This recommendation was a viable strategic initiative that aligned with current evidence, would further enhance the benefits of fast-track and the presence of mid-level providers in triage, and offer a throughput solution to meet or exceed the health care consumer's expectations.

With this recommendation also came some diversity concerns including internet access with a computer or smartphone as a requirement, and patients utilizing this program will likely be younger and tech savvy. There were also some ethical and legal concerns to take into account as well, including:

- Liability: patients are asked to review a brief guide on when to call 911 and state they understand online check-in/registration is not to be used for life-threatening or emergency medical conditions. By acknowledging these terms and conditions, the patient agrees their condition is not life-threatening
- Emergency Medical Treatment & Labor Act (EMTALA) guidelines remain intact
- Patient safety: protection features were built into the process. If the patent truly has a non-urgent complaint that does not require immediate treatment, then a nurse is required to review the check-in data following patient completion
- This process does not discriminate insured patients from uninsured

InQuicker Registration Process

With the InQuicker system, there is no guarantee of immediate service upon arrival, however, advanced planning and preparation assists to minimize the wait, if any. Minimal patient information is required to check-in online including, name, date of birth, the reason for visit, gender, email address, phone number, and zip code. Two required questions will be asked for trending purposes: 1.) whether the patient has visited the organization previously and 2.) if the patient has a primary care provider (PCP). The online patient registration process allows for advanced preparation prior to the patient arrival. A goal for provider evaluation within 30 minutes of patient arrival to the ED following an online registration was established by the team. If current ED capacity allows, the InQuicker patient should receive immediate bedding. The ED charge nurse will have the capability to control the flow of ED patients, as InQuicker provides the ability to block new registrations from occurring and delay arrival of previously registered patients, if needed. If a sudden surge of patients is experienced, the InQuicker patient will receive communication informing them of the delay in their treatment time and to continue waiting at home.

Interprofessional Collaboration

The interprofessional team included key people from the following areas: Emergency Department (ED), Communications & Marketing, Registration, and Information Technology (IT). Financial support for program maintenance was needed from executive leadership as well. Careful attention to the marketing strategy was essential to ensure that patients and staff understood the new process, and support from IT was required to add a link for the program to the organization's webpage. Buy-in from the ED leadership team and clinical staff was essential for success. Each of the individual team members played some part in the design and implementation success of this technology.

Go-Live

Prior to go-live, the team developed a marketing strategy including posters in the ED and for the registration staff, communication with the outreach team for the community, and internal communication with the ED team through huddles and staff meetings. The team developed education for blocking and delaying InQuicker registration when ED census is surging, as well as education for prompt review of InQuicker registrations. For the ED staff the team helped to develop a quick reference training guide and scripting to talk with patients who sign in using InQuicker. The go-live dates for Memorial Hospital Shiloh (MES) and Memorial Hospital Belleville (MHB) were July 2018 and March 2019, respectively. The same basic processes were used at both facilities.

Ongoing Evaluation

Ongoing evaluation followed implementation by the tracking and trending of established metrics including: ED LOS, LWBS, patient satisfaction scores, as well as overall ED volumes and InQuicker volumes on a monthly basis.

A survey is also e-mailed to patients who used InQuicker to gain understanding of their satisfaction with the InQuicker process; this is in addition to routine patient satisfaction surveys.

Following go-live, the InQuicker volume gradually increased as patients were more aware of the new program, and the majority of those using the system reported great satisfaction with ease of use and completing their wait at home. Monthly InQuicker reports include: Volume of InQuicker patients; demographic information; patient feedback; and mobile stats. The data below demonstrates year-to-date data ending November 30, 2020 for MES and MHB.

Data Point	Memorial Hospital Shiloh	Memorial Hospital Belleville
Number of Emergency Room visits created through InQuicker	472	331
% of surveyed respondents who indicated they would recommend online registration to their family/friends	71%	71%
% of visiting patient who indicated being new to your facility	51%	32%
% of visiting patient who indicated they do not currently have a primary care physician	18%	34%
% of facility's InQuicker users registered for their visit using a mobile device	81%	80%

Additionally, 64% of MES InQuicker visiting patients were female, and the average age of all MES InQuicker patients year-to-date is 36 years old. For MHB, 69% of visiting patients were female, and the average age of all MHB InQuicker patients year-to-date is 38 years old.

Figure 1: MES InQuicker Data

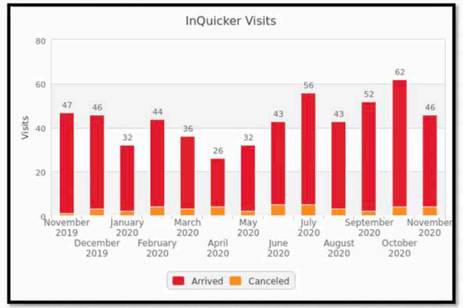
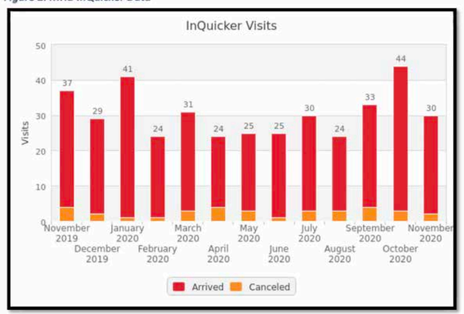


Figure 2: MHB InQuicker Data



Conclusion

Optimizing ED operations is essential to improving quality and satisfaction of ED patients while accommodating increased patient volumes. The implementation of an online patient registration and check-in platform for non-urgent ED patients promotes a positive patient experience while enhancing patient comfort by allowing the patient to wait at home, and minimizes wait time in ED waiting rooms. Ultimately, patient satisfaction may be the greatest metric used by organizational leaders to predict future utilization of services. The investment in this technology is promising as it offers a competitive edge in the market and the opportunity to increase ED volumes by attracting new patients. Expanding customer loyalty will impact revenue and have financial benefit for years to come.

References

Feinglass, J., Cooper, A.J., Rydland, K., Powell, E.S., McHugh, M., Kang, R., & Dresden, S.M. (2017). Emergency department use across 88 small areas after Affordable Care Act implementation in Illinois. Western Journal of Emergency Medicine, 18(5), 881-820.

Kane, M., Chui, K., Rimicci, J., Callagy, P., Hereford, J., Shen, S., Pickham, D. (2015). Lean manufacturing improves emergency department throughput and patient satisfaction. Journal of Nursing Administration, 45(9), 429-434.

Sharma, A.I., Dresden, S.M., Powell, E.S., Kang, R., & Feinglass, J. (2017). Emergency department visits and hospitalizations for the uninsured in Illinois before and after Affordable Care Act insurance expansion. Journal of Community Health, 42(3), 591-597.

Usher-Pines, L., Pines, J., Kellerman, A., Gillen, E., & Mehrotra, A. (2013). Emergency department visits for nonurgent conditions: systematic literature review. American Journal of Managed Care, 19(1), 47-59.

Wright, G., Causey, S., Dienemann, J., Guiton, P., Coleman F.S., & Nussbaum, M. (2013). Patient satisfaction with nursing care in an urban and suburban emergency department. Journal of Nursing Administration, 43(10), 502-508.

Transitional Care Clinic

The Transitional Care Clinic (TCC) opened its doors in 2012 at Memorial Hospital Belleville. This outpatient clinic was created in response to measures set by the Centers for Medicare and Medicaid (CMS) Hospital Readmission Reduction Program (HRRP) to provide improved care coordination and patient knowledge of disease management in order to improve patient health and avoid hospital readmission.

Heart Failure (HF) has one of the highest percentages of readmission and therefore became the first focus of the TCC. However, Heart Failure is just one of six conditions targeted by the HRRP. In 2014, COPD and Pneumonia management was targeted by HRRP and in response to this need an additional Care Coordinator and clinic hours were added to the TCC. In 2019, the members of the Cardiovascular Section Meeting noted that HF readmissions were beginning to rise. It was determined that End Stage Renal Disease (ESRD) accounts for almost 60% of the HF readmission population and could benefit from support of the TCC. Education and management of the ESRD patient was developed and implemented by the newest team members broadening the practice of the TCC. In response to the recent COVID-19 pandemic, the team developed a Home Monitoring program to support patients with detected COVID that were discharged to home from the hospital or emergency room.

The TCC staff are members of various organizational committees such as the Readmission Team, Outpatient Overall Quality of Care Team, Patient Education Committee, Cardiovascular Section Meeting, and Pulmonary Section Meeting. Involvement in these committees allow for the TCC Team to have interdisciplinary collaboration and communication in planning for the changing needs of the patient's care. The TCC team members provide staff education opportunities by speaking at RN Residency, providing information at Nurse's Day, and organizing walking rounds for education on changes in process. In March of 2019, the TCC team organized and presented at the first Learn About Lungs seminar, a professional Continuing Education event for nurses and respiratory therapists in the Metro East area. Team members volunteer for community events and lead their own bi-monthly HF support group. The TCC team continuously seeks out learning opportunities and innovative solutions to provide the most up to date care for their patients.

The Transitional Care Clinic has not only seen change and growth in the varied types of disease conditions that are being addressed, but also in the addition of staff from different disciplines. The TCC Team consists of Melissa Rehkemper FNP-C; Lauren Eversgerd Pharm D, BCACP; Jackie Kluthe MSN, RN-BC, Care Coordinator; Dani Schrage MSN, RN-BC, Care Coordinator; Barb Masters MSN, RN-BC, CCRP, Manager of Cardiopulmonary Rehab; Meghan Talkington RDN, LDN, CWP, Outpatient Dietician; Dina Chapman RD, CDE, Inpatient Diabetic Educator; and Shannah Pierce LSW, Social Services. The TCC team was assembled and is directed by Lisa Altland MSN, RN, NE-BC, ACM-RN, Director -Care Management, Social Service, Wound & Vascular Access, Disease Management-Transitional Care Clinic, Palliative Care, Diabetes Education Center. There are many levels of care for disease management beginning with patient education during admission and appropriate discharge instructions. Care coordination, care pathways, disease education, diet instruction, weight management, scheduled follow up appointments, identification of social determinants of health (SDOH), med reconciliation, phone follow up, and transition clinics add layers of support to patient's recovery and wellness. Organizations gain guidance from programs like Project RED, American Heart Association's (AHA) Get with the Guidelines (GWTG), and Vizient's COPD Care Collaborative. Development of a transition clinic is a goal for most Readmission Reduction programs if budget and resources allow. We have been very fortunate at Memorial Hospital to have the full support of leadership in developing the TCC. Our organization had a vision of commitment to care and excellence from the initiation of HRRP recommendations and recognized the role a transitional care clinic could play in the care of our patients.

The TCC at Memorial Hospital has a very unique program. In a recent participation with Vizient's COPD Care Collaborative of over 40 hospitals across the country, Memorial's Transitional Care Clinic model was of great interest to many organizations. Most of the participating hospitals do not have a transition clinic organized, let alone one with such a diverse offering of professionals. It is an amazing opportunity for our patient to take advantage of so much expertise at no cost to them. All TCC team members maintain roles in the inpatient and outpatient setting, creating a depth of experience and understanding of what is needed for a successful transition to home. The team relies on interdisciplinary communication and planning to provide complex care to their patients. The TCC has a true team dynamic which focuses on collaboration and communication, taking advantage of the wide range of staff knowledge and skills to provide excellent care of our patients. The TCC partners with physicians to assure continuity of care for the patient. The team appreciates the strengths of all the members and can flow in and out of the leadership/follower roles with ease. This respect and flexibility allow for creative solutions and excellent patient care. All team energy is directed at the best possible outcome for the patient.

Relationship Based Care (RBC), the practice model for nursing at Memorial Hospital, is key to building a relationship with patients. Creating a rapport of trust and acceptance allows patients and their family to feel safe and supported. Assessing the SDOH plays an important role in care planning and setting goals. Understanding disease management and overcoming barriers of SDOH, can increase compliance and self-efficacy. Referrals to the TCC results in an initial consultation, usually while the patient is inpatient. Knowledge of disease management is assessed, and education is provided by a Care Coordinator and/or Nurse Practitioner. At that time, an offer to follow up outpatient in the TCC is made and the patient will be followed for a minimum of 30 days. If the patient declines, the patient will still be followed telephonically if they are agreeable to phone contact for support. Key discharge management is assuring that medications have been obtained and are being used correctly, follow up appointments have been made, and the person knows how to manage their condition for recovery and when to report any changes in health. The TCC offers an assessment, coordinated health management, and education by a nurse practitioner, medication reconciliation and counseling by a pharmacist, dietary instruction by a dietician, SDOH support and resources by a social worker, and appointment and ancillary service coordination by a nurse. Patients are also connected with cardiac and pulmonary rehab referrals, physician communication, financial assistance, setting up counseling services, obtaining in home assistance services, coordination of testing, and palliative/hospice services to aid in their progression of care. The TCC collaborates with physicians to provide the best possible care for the patient. The patient is provided 1-2 hours per appointment in order to be seen by each specialist in the TCC. The outpatient setting is ideal for education and support because the patient is allowed time to learn at their own pace. Retention of information is improved as the patient is feeling better after discharge. Repetition of information is key for retention in the adult learner, so the patient may return several more times after the 30-day readmission window to build on their knowledge base and support their recovery. Medication adjustment and symptom management are also key factors in follow up appointments.

The TCC has decreased readmissions and had many patient success stories. Sometimes it takes just a few visits and the right resources to help a patient learn to manage their health and avoid readmission. Our most typical patient usually requires complex care and coordination. This can be challenging, but we know these are the people that can benefit from our services the most. We have several people that "check in" with us almost daily. Sometimes the check ins are to report issues, and we coach them on actions to take. Sometimes the check ins are just to share a bit of good news. Many of our patients have been with us for a long time and choose to follow up every six months to ensure they are managing their care to avoid hospital admission. Our patients know we will look for them if they are admitted and that the team will advocate for them because we know their medical history and more importantly, their back story. When we walk in the room, patients will say "I was just waiting - I knew you would be here". This relationship helps to provide a continuity of care. There are joys and sadness to these relationships we build. We celebrate the successes and accept the challenges. With disease processes such as HF, COPD, and ESRD there come serious conversations about care modalities and end of life discussions. We often are called on and trusted to be liaisons for these tough decisions. Through it all we are honored to be a part of our patients lives.

Transitional Care Clinic Team
Front Row: Melissa Rehkemper FNP-C; Dina Chapman RD, CDE; Shannah Pierce LSW
Back Row: Jackie Kluthe MSN, RN-BC; Lauren Eversgerd Pharm D, BCACP; Pam Nicholson RD; Barb Masters MSN, RN-BC, CCRP; Dani Schrage MSN, RN-BC

Hazardous Medication Handling Implementation Process: An Interprofessional Collaboration

USP 800 provides standards for safe handling of hazardous medications to minimize risk to healthcare providers and patients. The National Institute for Occupational Safety and Health (NIOSH) considers a drug to be hazardous if it exhibits carcinogenicity, developmental toxicity, reproductive toxicity, or organ toxicity. The USP General Chapter 800 describes the requirements and responsibilities for personnel handling hazardous medications, including procedures for manipulating, handling, cleaning, and spill control. USP 800 requires organizations to develop their own plan and process for the safe handling of these medications.

BJC HealthCare developed a hazardous medication task force at the system level, as well as at each individual hospital within the system. In the summer of 2018, Memorial Hospital formed a High Hazardous Medication Steering team that met frequently to ensure compliance with USP 800. The Steering Team was composed of members from Nursing Administration, Pharmacy, Housekeeping, Central Supply, Center for Practice Excellence, Infection Prevention, and Facilities Management.

The multidisciplinary steering team met to accomplish these tasks: identify high risk, moderate risk, and reproductive medication use per hospital unit; formulate easy to read charts that include appropriate Personal Protective Equipment (PPE) requirements for medication administration routes: by mouth, intravenous, subcutaneous, and crushed; and devise a system for easy access to PPE and waste containers.

Pharmacy provided the hazardous medication data for each unit, developed the hazardous medication charts for PPE Use (See Figure 1: High Hazardous Medications Example), and created the Omnicell (medication dispensing system at the time of project) and Medication Administration Record (MAR) Label comment sections alerting the nurse of the hazardous medication (See Figure 2). Pharmacy also installed a new hood in their department for the safe compounding of hazardous medications.

The manager for Central Supply brought all the required PPE to the meeting for the team to review. The PPE included the following: nitrile gloves, face shields, goggles, chemo gowns, poly-lined pad for medication administration, yellow trash bags, and chux for covering the toilet when flushing (See Figure 3). Central Supply also instructed the team that the medication could only be crushed with the silent knight pill crusher. This pill crusher is unique in that it contains the dust and particles from the medications during the crushing process to minimize risk of inhalation by healthcare providers.

FIGURE 1

PPE for All Employees for High Risk Drugs PHARMACY ONLY

Activity	Formulation	Chemotherapy Gloves	Impervious chemotherapy gown	Head/Hair cover includes beard & mustache cover, shoe covers	Eye/Face Protection	Respiratory Protection:	Engineering Controls
Receiving, unpacking	All	Double					Segregated in impervious plastic
Placing in storage	All	Single	Based on room requirements	Based on room requirements			
Counting and packaging	Intact Tablets and Capsules	Single					
	Manipulated tablets or capsules	Double	Yes	No must be done in BSC or CACI. If no BSC/CACI, head/hair cover required.	No if done in BSC/CACI. If no BSC/CACI, goggles, designated area and spill pad required.	No if done in BSC/CACI. If no BSC/CACI, N95/PAPR/CAPR required.	BSC/CACI. If no BSC/CACI, designated area with spill pad, pill crusher with bag use deactivation cleaning process
Manipulation	Tablets and capsules	Double	Yes	No (unless BSC located in sterile room)	No if done in BSC/CACI. If no BSC/CACI, goggles, designated area and spill pad required.	No if done in BSC/CACI. If no BSC/CACI, N95/PAPR/CAPR required, designated area, and spill pad.	BSC/CACI. If no BSC/CACI, designated area with spill pad, pill crusher with bag use deactivation cleaning process
Labeling/ Handling prepacked product that has been deactivated	All						
Repackaging/ labeling of repackaged product	Oral Liquid	Single					Designated area, spill pad, use deactivation cleaning process
	Topical	Double			No unless risk of splash		pad, use deactivation cleaning process
Compounding (Sterile)	IV, Irrigation, inhalation, intramuscular, intravitreal injection, intrathecal, subcutaneous	Double	Yes	As needed	No if done in BSC/CACI. If no BSC/CACI, goggles.	No if done in BSC/CACI. If no BSC/CACI, N95/PAPR/CAPR required	BSC/CACI. If no BSC/CACI, designated area with spill pad, use deactivation cleaning process. Exist CSTD
Compounding (Non Sterile)	Topical, Tube, Oral Liquid	Double	Yes	As needed	No if done in BSC/CACI. If no BSC/CACI, goggles.	No if done in BSC/CACI. If no BSC/CACI, N95/PAPR/CAPR required	BSC/CACI. If no BSC/CACI, designated area with spill pad, pill crusher with bag use deactivation cleaning process

[1]High Risk Hazardous Drug meets at least one of the following criteria-1. Drugs categorized as NIOSH Table 1 medications, 2. drugs that are carcinogenic, teratogenic, or cause reproductive toxicity,
[2]This PPE assumes the product was previously cleaned appropriately to deactivate any residual drug and that the container is sealed (not just closed).
[3]Tubing will be primed by the pharmacy staff with non-hazardous diluent unless this is deemed to be clinically inappropriate.
[4]Two pair of booties may be required. Follow HSD protocol.

FIGURE 2

MAR Screen Shots

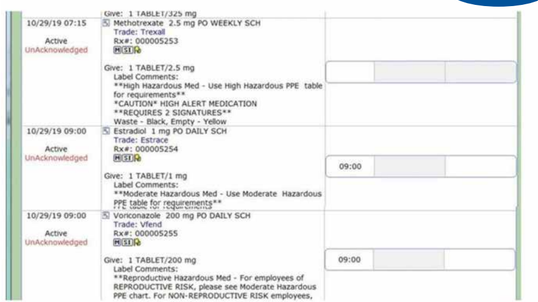
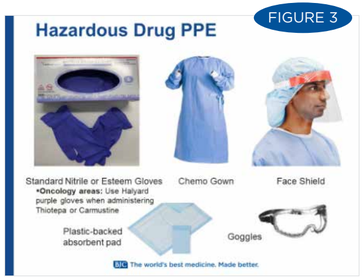


FIGURE 3



Housekeeping aided the team by ensuring that each nursing unit would have the appropriate yellow waste baskets and black waste containers for hazardous waste (See Figure 4). Housekeeping also provided resources to ensure that the appropriate chemo spill kit was available for each nursing unit.

FIGURE 4

The Center for Practice Excellence (CPE) department determined that it was necessary for all the PPE and supplies for the safe administration of hazardous medications be readily available for the nursing staff. The team felt that a cart that could be easily wheeled from room to room would be desirable.
An external medical equipment company was consulted, and a blue cart was ordered for all nursing divisions giving hazardous medications (see Figure 5).
The education department provided an educational PowerPoint via SABA (online learning management system), a quick reference sheet, staff meetings, walking rounds, and just in time education to the nursing staff and patient care technicians (PCT) prior to the go live date for high hazardous medications. Case scenarios were provided during the 2019 annual nurse competency days to ensure there was a clear understanding of these new processes.

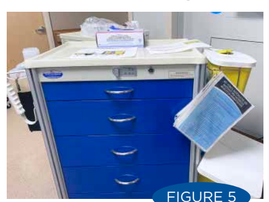


FIGURE 5

Go-live was a two stage process; April 2019 marked the go-live for the High Hazardous Medication process, and November 2019 marked the go-live for the Moderate and Reproductive Hazardous Medication process. Between April and November 2019, the team ensured that the implemented process was sustained and working prior to the second stage of go-live. The new pharmacy hood was installed during this timeframe as well.

In November of 2019 the Moderate and Reproductive Hazardous Medications went into effect. A PowerPoint was loaded into SABA from BJC HealthCare and a quick reference sheet was provided for each hazardous medication cart. Nursing huddles and staff meetings provided additional venues for education. The 2020 annual nurse competency days also provided education centering on proper disposal of PPE for soiled and unsoiled linen and PPE. The PCTs were included in the education to ensure that they were utilizing proper PPE when disposing of bodily fluids.

Since go-live, the Facilities Management team has been extremely helpful with managing safety items/items that have come up in regards to the new process.

The USP 800 seemed like a daunting task when first introduced. We had so many questions and not many answers. Luckily, we had a steering team consisting of experts from differing professional areas in our organization, and we were able to successfully launch this initiative.

Capnography/EtCO2

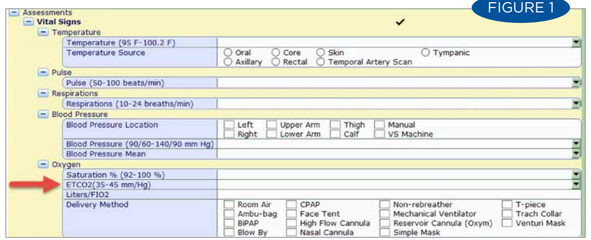
Memorial Hospital utilized the combined resources of an interprofessional team to implement an organizational policy for the use of end-tidal carbon dioxide (EtCO2) or capnography monitoring for all adult hospitalized patients actively receiving supplemental oxygen along with a narcotic pain medication.

Post Anesthesia Care Unit (PACU) nurses understand how important deep breathing is to help the body remove CO2. For this reason, they agreed to be the starting point to implement this monitoring. During a patient's post-operative stay, inadequate breathing leads to a rise in CO2 and decreased respiratory effort. The use of capnography for these patients enables a more effective way of measuring a patient's respiratory status. While pulse oximetry measures oxygenation, capnography measures ventilation. Capnography detects breath to breath ventilation and is not affected by oxygen, while pulse oximetry detects hypoxia. In other words, a patient could pause their breathing and the pulse oximetry may appear normal. With capnography, hypoventilation is detected immediately. This allows for a timelier response related to respiratory compromise.

The interprofessional team consisted of nurses from PACU as well as Inpatient Units, Respiratory Care, the Center for Practice Excellence (CPE), Clinical Informatics, Patient Quality Specialist, and a Research Consultant. Everyone on the team had a role in the implementation and education of staff.

Capnography monitors were obtained from BJC HealthCare system resources and ensured they could be connected to the monitoring system in the rooms. Ninety Capno20 units were needed in total; sixty at Belleville, and thirty at Shiloh. Most units are stored in the PACU and initiated post-operatively when a patient is receiving IV/IM narcotics while also receiving oxygen; these patients must have capnography monitored. Patients on a PCA or epidural are required to have EtCO2 whether or not they are receiving oxygen. It was also recommended that each of the inpatient nursing units keep a small number of Capno20 units on par in case a non-surgical patient may need EtCO2 monitoring. Staff received education on how to use the Capnostream monitors, and the various alarms and alert limits that they might need to identify. Patient Care Technicians (PCTs) in the appropriate departments were also educated on EtCO2 monitoring and their role in alerting the nurse when a machine is alarming. The RNs and PCTs were educated on how to record a patient's EtCO2 in the Vital Signs documentation section in the electronic health record (Figure 1).

FIGURE 1



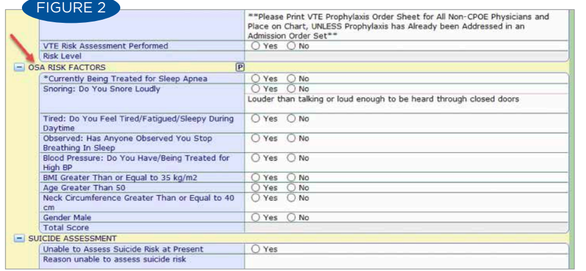
RNs and PCTs may chart the patient's EtCO2 level

Clinical Informatics ensured the appropriate documentation was available to staff, and CPE developed education tools and assisted with implementation and education. Along with implementation of EtCO2 monitoring, clinical staff also received increased education on oxygen therapy modalities and appropriate use of these modalities including the following: Nasal cannula (use for patient on 6L O2 or less); Oximyzer (when a patient is requiring greater than 6L); Simple Mask (can provide 35-50% FiO2, depending on fit, at flow rates from 5-10 LPM); Venturi Mask (delivers precise oxygen concentrations between 24-50% FiO2); Non-Rebreather (administers high oxygen concentrations of 60-80% FiO2; minimum flow of 10LPM); Continuous Aerosol Generator (humidifies the gas flow); and High Flow Nasal Cannula (liter flow is adjusted by physician order only and FiO2 can be titrated by the order guidelines). Flowmeter safety was also addressed with the nursing staff during education.

Another large change for the nursing staff was revision of an existing practice for nurses to titrate oxygen up to 6L via nasal cannula. Increased staff education on this topic was needed, as titration up to six liters nasal cannula was traditionally completed by the respiratory staff. Nurses were educated on the following topics: overuse of oxygen and its consequences; titration procedure; orders and documentation; and numerous practice scenarios.

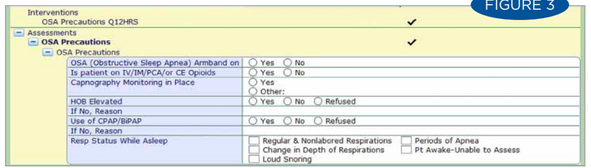
The team also took this opportunity to assess everyone admitted to the hospital for sleep apnea which can lead to respiratory complications and extended hospital stays. After a thorough review of nursing and health literature, the STOP-BANG assessment, a valid and reliable tool, was selected to assess the adult patients' risk for Obstructive Sleep Apnea (OSA). All adult patients admitted to the hospital are screened for sleep apnea; this process was previously completed for surgical patients only (Figure 2). If patients meet 'at risk' criteria for OSA, a reflex intervention order set for OSA precautions will trigger. OSA precautions include capnography monitoring in place; head of bed elevated; and frequent documentation of the patient's respiratory status (Figure 3). Additionally, all patients with diagnosed or suspected sleep apnea will be placed on EtCO2 monitoring if receiving IV/IM opioids and on oxygen.

FIGURE 2



The required STOP-BANG assessment is found in the Admission Assessment "OSA Risk Factors"

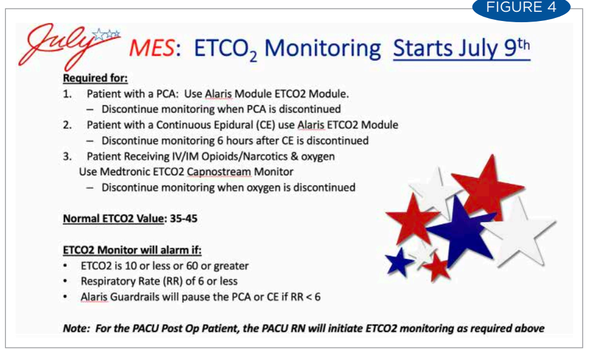
FIGURE 3



Based on scoring, the OSA Precautions intervention will reflex and will need to be done Q12H

This endeavor to implement EtCO2 monitoring started as a policy review and ended with a solution that has and will continue to provide our hospitalized and surgical patients with safer monitoring while receiving narcotics and oxygen. Assembling and seeking feedback from a collaborative team to adopt this change has had a positive impact on patients and their safety. This change converted current processes to system best practices. The new policy was approved by the Critical Care Committee and was implemented at Memorial Hospital Shiloh (MES) as a trial run on July 9, 2019 and Memorial Hospital Belleville (MHB) a week later July 15, 2019 (Figure 4).

FIGURE 4



Multi-Site Nursing Research: An Expanded Exploratory Study of Patient Falls

Memorial's Nursing Services department is part of the Illinois Downstate Magnet Consortium group that consists of representatives Magnet Program Directors (MPDs) from seventeen hospitals/health care organizations that are Magnet® designated or on the journey to Magnet®. Through this group, the MPDs share best practices amongst their organizations, use each other as experts for questions related to the Magnet® requirements, and host an annual consortium meeting. At our annual meeting in 2017, the Riverside Medical Center MPD brought forward the idea for our consortium group to engage in a multisite research study related to nursing quality outcomes. Several of the MPDs were interested in this collaboration, and four of the Magnet® facilities began the research process.

Years prior, Riverside Medical Center performed an internal exploratory study on patient falls; positive correlations were noted in this study between falls and education/certification rates of nursing staff. Riverside sought to expand this study to identify if these study findings would be replicated with a larger sample with similar organizations; Magnet® organizations. The study would be a retrospective cohort analysis utilizing cross-sectional data from 2010-2016 from the National Database of Nursing Quality Indicators (NDNQI).

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Exploring the Relationship Between Patient Falls and Levels of Nursing Education and Certification

Jeffrey A. Coto, DNP, RN, CCRN
Coleen R. Wilder, PhD
Leanna Wynn, MBA, MSN, RN

Maria C. Ballard, DNP, RN
Daniel Webel, BSN, RN, CRRN
Heather Petkunas, MHA, MSN, RN, NE-BC

OBJECTIVE: To examine if increasing the percentage of nurses with bachelor degrees (BSNs) and/or certified nurses leads to improved patient outcomes, specifically the number of reported falls.
BACKGROUND: Research suggests a link between higher levels of education and expertise and positive patient outcomes, including falls. The Institute of Medicine recommends an increase in BSN nurses.
METHODS: This was a retrospective cross-sectional cohort analysis using data from the National Database of Nursing Quality Indicators from 2010 to 2016 from multiple medical centers in Central and Southern Illinois.
RESULTS: With every 1 unit increase in the percentage of BSN nurses or certified nurses, a reduction in total patient falls per 1000 patient-days can be expected in the amount of 0.02 to 0.04 and 0.01 to 0.03, respectively, all else held constant.
CONCLUSIONS: Improvements to patient outcomes may be optimized with increased percentages of nurses with bachelor degrees and/or certifications.

Author Affiliations: Operations Director (Dr. Coto), Surgical Service Line and Wound Centers, Riverside Medical Group, Kankakee, Illinois; Associate Professor (Dr. Wilder), Information & Decision Sciences, Valparaiso University, Valparaiso, Indiana; and Affiliate Vice President and Chief Nursing Officer (Ms. Wynn), Passavant Area Hospital, Jacksonville; Magnet Program Director (Dr. Ballard), Memorial Regional Health Services, Belleville; Manager of Operations Inpatient Rehabilitation (Mr. Webel), Northwestern Medicine McHenry Hospital, McHenry; and Magnet Program Manager (Ms. Petkunas), Riverside Healthcare, Kankakee, Illinois.
The authors declare no conflict of interest.
Correspondence: Ms. Petkunas, Riverside Healthcare, 350 N Wall St, Kankakee, IL 60901 (hpetkunas@RiverCare.org).
DOI: 10.1097/NNA.0000000000000838

The study population included: acute care hospitals, and all-patient fall population including the following units: Medical, Surgical, Medical-Surgical, and Rehab. The independent variable for the study would be nursing degrees (Diploma, ADN, BSN, and MS/MSN), as well as nursing certification from a nursing board-governing body. The dependent variable was the annual number of falls between 2010-2016. The group hypothesized that there would be a negative correlation between patient falls and the level of nurse education.

After the study criteria was developed, each organization participating in the study had to submit and obtain approval from their individual Institutional Review Boards (IRB) for the conduct of human research. Once this was completed, the full study proposal, along with the individual IRB approvals, was sent to the Riverside Medical Center IRB, and was approved on January 20, 2018.

The Site Primary Investigators at each organization completed requests to Press-Ganey Associates to retrieve a customized archived data set from the NDNQI database and submit it to our team's data analyst for review. All of this data was gathered by April 2018, and analysis began on the study results. The team received preliminary results by October 2018 that showed an inverse relationship between education rates and fall rates; however, there was no significant finding with certification rates and fall rates.

Due to the nature of the study, including the larger data set and multi-site collaboration, the team decided to submit our research plan and summary of results to the Journal of Nursing Administration for manuscript publication. The draft manuscript was accepted for publication by the Journal of Nursing Administration, and was officially published in the January 2020 publication. The group looks forward to embarking on a similar endeavor in the future to advance research within the nursing profession!

2018-2019 Podium and Poster Presentations & Publications

Sandy Thornhill-Alvarez MSN, RN, CCRN-CMC
Lessons Learned in a Lifetime of Nursing
- 2018; Podium Presentation; Memorial Hospital Nursing Certification Dinner

Sandy Thornhill-Alvarez MSN, RN, CCRN-CMC
The Devil is in the Details
- 2018; Podium Presentation; Greater St. Louis AACN Trends in Critical Care Symposium

Cathy Fenton MSN, RN, CNOR
Cathy Dent MBA, BSN, RN
Perioperative 101 Core Curriculum
- 2018; Podium Presentation; Illinois Downstate Magnet Consortium Meeting (Springfield, IL)

Cathy Fenton MSN, RN, CNOR
From Shared Governance to Professional Governance: A Hospital's Journey to Incorporate a New Hospital Campus with a Restructured Governance Model to Bridge Two Hospital Campuses
- 2018; Poster Presentation; Association of Operating Room Nurses (AORN) 65th Expo and Congress (New Orleans, LA)

Brittni Jackson BSN, RN
Kelsea Anderson BSN, RN
ICU/IMCU PACU Hand-Off Process
- 2018; Poster Presentation; Memorial Medical Center (Springfield, IL) 24th Annual Nursing Research Conference

Donna Stephens DNP, RNC-OB
Early Assessment & Resource Provision of the Pregnant Substance Abuser
- 2018; Podium Presentation; Memorial Hospital 12th Annual Nursing Research Symposium
- 2019; Poster Presentation; BJC Patient Safety & Quality Symposium
- 2019; Oral Presentation; St. Clair County Health Summit
- 2019; Poster Presentation; Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) National Conference

Beth Johns DNP, AGACNP-BC
Knowledge and Perceptions among Healthcare Providers Caring for Terminally Ill Patients in Critical Care Areas
- 2018; Podium Presentation; Memorial Hospital 12th Annual Nursing Research Symposium

Amy Hamilton DNP, RN-BC
Diane Ashmann DNP, RN-BC
Lindsey Wilson MSN, RN-BC
Kay Gaehle PhD, RN
Implementing a Dedicated Education Unit
- 2018; Podium Presentation; Memorial Hospital 12th Annual Nursing Research Symposium

Brittni Jackson BSN, RN
Kelsea Anderson BSN, RN
Sandy Thornhill-Alvarez MSN, RN, CCRN-CMC
PACU to Critical Care Handoff
- 2018; Podium Presentation; Memorial Hospital 12th Annual Nursing Research Symposium

JoAnne Sehr MSN, RN, CAPA
Rhonda Mense BSN, RN, CAPA
Alicia Stevens BSN, RN-BC, CAPA
Vickie Henry MSN, RN, CPAN
GO WITH THE FLOW! Avoiding HAZARDS with Intravesicle Instillation of BCG (Bacillus of Calmette and Guirin) Live TB for Treatment of Bladder Cancer
- 2018; Poster Presentation; Memorial Hospital 12th Annual Nursing Research Symposium
- Received the 2018 Poster Presentation People's Choice Award

Jennifer Durbin MSN, RN-BC
Beth Conrod PT
Caregiver Safety & Patient De-Escalation
- 2019; Podium Presentation; Memorial Hospital 13th Annual Nursing Research Symposium

Anne Ruggiero BSN, RN, CRRN
Best Practices in Care Transitions Advocating the Value and Role of Rehabilitation Nurses
- 2019; Podium Presentations; Association of Rehabilitation Nurses REACH (Educational) Conference; Columbus, Ohio

Anne Ruggiero BSN, RN, CRRN
Reimbursement & Quality Measures
- 2019; Webinar Presentation; Association of Rehabilitation Nurses

Anne Ruggiero BSN, RN, CRRN
Unified Post-Acute Care Prospective Payment System
- 2019; Technical Expert Panel; RTI International (a nonprofit research institute) for CMS representing the Association of Rehabilitation Nurses (ARN)

JoAnne Sehr MSN, RN, CAPA
Cathleen Fenton MSN, RN, CNOR
Hot Topic: Malignant Hyperthermia Crisis
- 2019; Podium Presentation; Memorial Hospital 13th Annual Nursing Research Symposium

Angela Mann MSN, MPH, RN, IBCLC
Alisa Williams MSN, RN, IBCLC
Development of an OB RN Residency Program
- 2019; Podium Presentation; Memorial Hospital 13th Annual Nursing Research Symposium

Cheryl Wright MSN, RN-BC, CIC
Bringing Best Practice to Point of Care: Pre-Cleaning of Instruments Outside of the Operating Room
- 2019; Podium Presentation; Association for Professionals in Infection Control and Epidemiology, Inc (APIC) 46th Annual Conference in Philadelphia, Pennsylvania

Sandra Thornhill-Alvarez MSN, RN, CCRN-CMC
PACU-ICU Handoff
- 2019; Podium Presentation; Mid-West Conference: Northwest Chicago Area Chapter AACN; Hoffman Estates, Illinois

PUBLICATION:
Coto, J. A., Wilder, C. R., Wynn, L., Ballard, M. C., Webel, D., & Petkunas, H. (2020). Exploring the relationship between patient falls and levels of nursing education and certification. *Journal of Nursing Administration*, 50(1), 45–51.

Clinical Outcomes

Memorial is committed to continuous improvement of the delivery, quality, efficiency, and outcomes of nursing practice. In their roles as leaders and partners in improvement initiatives, our nurses use the latest evidence-based practices to guide their decision making. They challenge themselves to assess the impact of their practice on patients, colleagues, the profession, and the organization. Our Professional Governance structure remains the driving force behind exceptional nursing care and provides the support for improved quality outcomes. This continuous improvement is accomplished by collecting data, performing a review and analysis of that data, and using the newly developed knowledge for informed decision making, evaluation, and implementation of process improvement activities to ultimately create a positive impact on our patient outcomes.

The National Database for Nursing Quality Indicators (NDNQI) remains the comparative external benchmark for nursing services. More than 2,000 hospitals across the nation participate in this quality database that provides the ability to examine relationships between nursing care and patient outcomes. A nurse sensitive indicator (NSI) represents a nursing practice that directly contributes to patient care. The NSIs are monitored routinely throughout inpatient, outpatient, rehabilitation, and support service environments to identify opportunities for improvement. Each area where nursing care is provided, NSIs are selected based on their patient population, a quality improvement action plan is established, and results are shared through various avenues.

Unit-specific patient outcomes are reported to NDNQI quarterly with returned benchmarked data for the following NSIs: Falls and Falls with Injury, Hospital Acquired Pressure Injuries (HAPI), Restraint Use, Catheter Associated Urinary Tract Infections (CAUTI), Central Line Associated Blood Stream Infections (CLABSI), and Ventilator Associated Events (VAE). In 2020, we began to collect data on the following NSI's: Surgical Burns, Surgical Errors, and Unplanned Postoperative Admissions. To outperform, a unit must be better than the benchmark (below the benchmark for the NSI) for the majority of the quarters (greater than 4 out of the past 8 quarters). Memorial performed well within the comparative benchmarks for their NSI's (Figure 1).

FIGURE 1

Empirical Outcomes

Status Report: Magnet Progress Report — Peer Group: All Hospitals

UNIT	INJURY Falls	HAPI+2	CLABSI	CAUTI	Restraint	VAE	Surgical Burns	Surgical Errors	Unplanned Post-Op Admit
Memorial Hospital Belleville									
ICU-MHB	6/8	5/8	7/8	1/8	6/8	5/8			
IMCU	6/8	6/7*	8/8	8/8	7/7*				
2 NE	2/8	7/8	5/8	8/8	8/8				
4 South	2/8	5/8	8/8	8/8	8/8				
2 South	2/8	8/8	8/8	8/8	8/8				
1 South	4/8	8/8	8/8	7/8	8/8				
1 Center	5/8	6/8	7/8	8/8	8/8				
2 Center	2/8	7/8	8/8	6/8	7/8				
Mother/Baby	8/8								
ED	7/8								
CCL	7/8						2/2*	2/2*	2/2*
GI Lab	8/8						2/2*	2/2*	2/2*
Pain Center	8/8						2/2*	2/2*	2/2*
PACU	8/8								2/2*
Cardiovascular	7/8								
ATC	7/8								
OPS	6/8								2/2*
OR							2/2*	2/2*	2/2*
Memorial Hospital Shiloh									
ICU-MES	7/8	8/8	8/8	8/8	8/8	6/7*			
5th Floor	5/8	8/8	8/8	7/8	8/8	1/1*			
4th Floor	5/8	7/7*	7/7*	8/8	7/7*				
LDRP	7/8		5/5*	8/8					
ED	5/8								
CCL/MCR	8/8								
ATC/OPS/PACU	8/8								2/2*
OR							2/2*	2/2*	2/2*
Number of Units Outperforming the Mean	19/24	11/11	12/12	11/12	11/11	3/3	5/5	5/5	8/8

Greater than 50% of reporting hospital units out performing the mean of our comparison peer group (All Hospitals) greater than 4 of 8 quarters

✓ Injury Falls 19/24 Units · ✓ HAPI 2+ 11/11 Units · ✓ CLABSI 12/12 Units · ✓ CAUTI 11/12 Units · ✓ Restraints 11/11 Units · ✓ VAE 3/3 Units · ✓ Surgical Burns 5/5 Units · ✓ Surgical Errors 5/5 Units · ✓ Unplanned Postop Admit 8/8 Units

Catheter Associated Urinary Tract Infection (CAUTI)

Sustained efforts to prevent CAUTI have shown positive results, both campuses remain below their benchmark per NDNQI (Figure 2). MHB and MES both agree that decreasing the use of indwelling urinary catheters is imperative in decreasing infections. The nursing focus remains on early removal of an indwelling urinary catheter along with evidence-based catheter care. In the event a CAUTI occurs, the department Unit Leadership Team (ULT) in conjunction with the infection prevention nurse will conduct an analysis of the circumstances surrounding the infection to help identify areas of opportunity. If necessary, additional education or process improvement plans are implemented to help close any gaps that are noted.

In 2019, 1 Center set focus on CAUTI prevention as one of their NSI's. They engaged staff and developed strategies to prevent CAUTI's along with monitoring the care provided through peer review activies to ensure the protocols for insertion, maintenance, and removal were followed. To date, 1 Center has gone twenty-seven months without a CAUTI.

We are proud to honor the following units that achieved zero harm from catheter associated urinary tract infections:

6 Months: 2 Center, Intensive Care Unit at Belleville

12 Months: 5th Floor Med/Surg

18 Months: 1 South, 4th floor Med/Surg

24 Months or greater: 4 South, 2 South, 1 Center, 2 Northeast, Intermediate Care Unit, Family Care Birthing Center, Intensive Care Unit at Shiloh

Central Line Associated Blood Stream Infections (CLABSI)

Central venous catheters (CVC) are often essential in the care of the critically ill patient. They allow safe administration of intravenous medications that cannot be given peripherally, aid in the administration of intravenous fluid resuscitation, and help in monitoring hemodynamic parameters in the management of patients with syndromes such as septic shock, cardiogenic shock, decompensated heart failure, and pulmonary hypertension. Despite the benefits of CVCs, they also serve as potential portals for localized and systemic bloodstream infections. For this reason, considerable effort has gone into reducing the incidence of bloodstream infections from CVCs at Memorial.

Memorial falls well below the NDNQI benchmark for CLABSI, with Shiloh reporting zero CLABSI's since opening in 2016 (Figure 3).

Falls

The focus on the prevention of patient falls remains a top priority for each nursing unit and the entire Nursing Services department. We are constantly eliminating hazards that could play a part in a patient's fall. Our attention to details and our use of appropriate resources have resulted in a lower number of avoidable falls with injury over time. A rigorous post-fall process is in place, with an immediate Post-Fall Huddle with the staff involved then an analysis of a post-fall documentation tool by the department ULT to identify any opportunities for improvement. When possible, involved staff are invited to join the ULT conversation surrounding the fall event. This practice has been able to shed light into the true cause of the falls and get staff actively involved in the process.

FIGURE 2

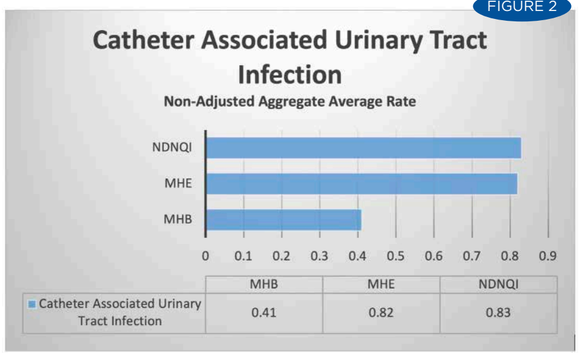
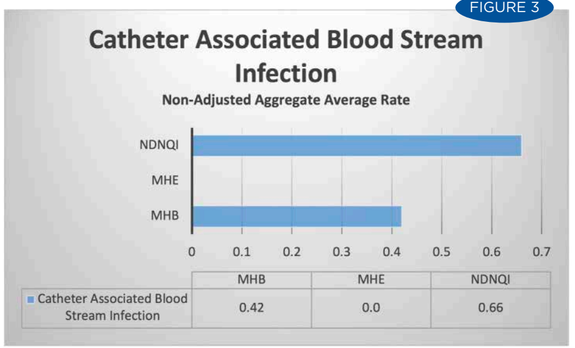


FIGURE 3



On a monthly basis, a thorough review of all patient falls is completed by the Quality Improvement department. This information is then distributed to our Nursing Leadership and Quality Specialists, bedside staff who lead quality initiatives within their department. Trends are identified and acted upon, along with recognition for units with sustained improvement. This aggregate data is also reviewed with our Quality and Nurse Practice Council (QNPC) to further identify opportunities for improvement (Figure 4).

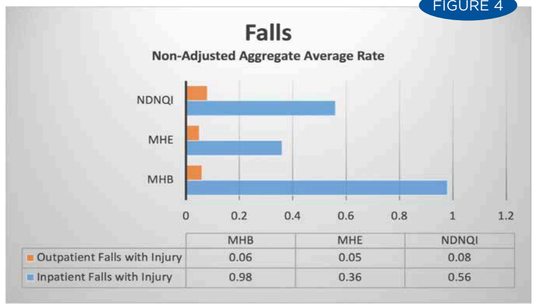
Emergency Department

The Emergency Department (ED) at Shiloh placed an emphasis on fall prevention when they noted an increase in patient falls in 2018. Their plan of action included reviewing the Fall Prevention Guidelines at daily huddles and monthly staff and ULT meetings, implementing hourly rounding, ensuring proper room placement, utilizing the Fall Prevention Guidelines during patient care, and increasing communication with the patient and their family. Peer review audits were completed to ensure compliance and their hard work paid off. They was able to decrease their fall rate in 2019 and again in 2020 (Figure 5).

Pain Center

The Pain Center identified an opportunity with their patient falls and began to rigorously work through a quality improvement action plan in 2019, which was continued in 2020. They were able to discover the root cause of their falls from previously years and work towards prevention.

FIGURE 4



	MHB	MHE	NDNQI
Outpatient Falls with Injury	0.06	0.05	0.08
Inpatient Falls with Injury	0.98	0.36	0.56

FIGURE 5

	2017	2018	2019	2020
MES ED	0.23	0.33	0.27	0.09

Sturdier chairs were purchased, aggressive staff education was completed, the patient education folders were revised to include fall prevention material, and they redesigned the patient welcome boards to reinforce fall precautions. They were able to achieve zero falls for both 2019 and 2020 (Figure 6).

Hospital Acquired Pressure Injuries (HAPI)

Much like fall prevention, preventing patient harm from hospital acquired pressure injuries continues to be at the forefront of each inpatient nursing unit. According to Health Research and Educational Trust in 2017 pressure injury incidence rates range from 0.4 to 38 percent in the acute care setting. Risks for developing pressure injuries include advanced age, immobility, incontinence, inadequate nutrition/hydration, device related skin pressure, multiple comorbidities, and circulatory abnormalities. It is estimated each year HAPI's will result in significant patient harm in more than 2.5 million patients in the US. Memorial implements a variety of tools to decrease the incidence of HAPI's, which include:

- Pressure relief mattresses
- Nurses completing a Braden risk assessment tool for patients daily
- Monitoring patients' food/fluid intake
- Excellent skin care for incontinent patients
- Rotating devices to minimize pressure/friction
- Turn and repositioning schedules

The 4th floor at Shiloh utilizes these tools along with a few they developed specific for their unit (based on a tool 1 Center created several years ago), such as requiring two nurses or a nurse and patient care tech to complete a full body skin assessment upon admission/transfer to the unit, ensuring skin is assessed every shift and appropriate protocols are in place in the case of an at risk patient, along with completing peer review activities to ensure compliance is achieved. The results they have seen are astounding, they went from thirteen reported HAPI's in 2018 down to five in 2019 and only one reported through Q2 2020 (Figure 7). They continue to work towards zero harm as they believe even one patient injury is too many.

Evolving Quality Improvement

Memorial recognizes that quality improvement is a key factor in enhancing safety, effectiveness, and efficiency in healthcare which ultimately produces better outcomes for our patients. The Quality Improvement department at Memorial has been working diligently to make changes in our approach to quality and patient safety. We are undergoing a structural change, which is bringing various groups of individuals together that were once separated, creating better communication lines, a sense of partnership, and streamlining our processes as a team.

Enlarging the department has allowed us to set focus on creating collaborative workgroups with set priorities on harm prevention. The Surgical Site Task Force is one example that has opened communication lines between the OR, Infection Prevention, and Quality Improvement. Our weekly meetings have allowed us to discover opportunities with pre and post-surgical patient care, evaluate new products, and develop education for our bedside staff.

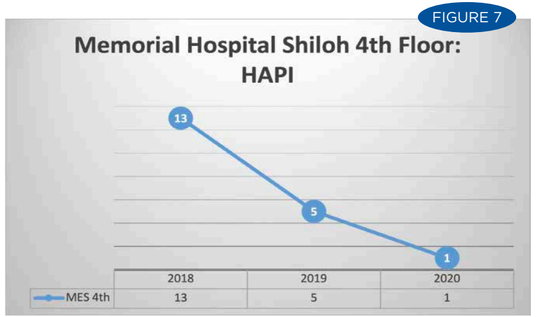
Our Medication Safety Review Team is another multidisciplinary group that meets weekly to review all the medication errors that occur throughout all three facilities. We are able to identify gaps in care and quickly react with staff education and process improvement plans to mitigate an error from occurring again. We have strong engagement from multiple Pharmacists, who provide much of the education to our bedside nursing staff on subjects such as insulin administration and the home medication reconciliation process. Each week, we develop strategies to prevent further errors from arising.

At Memorial Hospital, our leadership is committed to providing solutions and resources that enable us to continuously improve the quality of health care we deliver. They understand quality improvement involves people as part of the improvement solution and encompasses the employees that best understand the processes. While we are at the beginning stages of our new journey, we are making great strides in identifying areas of opportunity and taking the appropriate steps to focus on preventing patient harm.

FIGURE 6

	2017	2018	2019	2020
Pain Center	3	3	0	0

FIGURE 7



	2018	2019	2020
MES 4th	13	5	1

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2018-2020

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2018

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healthgrades TREATMENT OF RESPIRATORY FAILURE FIVE-STAR RECIPIENT 2018

healthgrades TREATMENT OF SEPSIS FIVE-STAR RECIPIENT 2018

2019

BEST NURSING HOMES U.S.News SHORT-TERM REHABILITATION 2019-20

ACCREDITED AMERICAN COLLEGE OF CARDIOLOGY CHEST PAIN CENTER PRIMARY PCI

2020

BEST NURSING HOMES U.S.News SHORT-TERM REHABILITATION 2020-21

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HIGH PERFORMING HOSPITALS U.S.News 2020-21 HEART FAILURE

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MemHosp.org

Memorial Hospital Belleville
4500 Memorial Drive, Belleville, IL 62226
618.233.7750

Memorial Hospital Shiloh
1404 Cross Street, Shiloh, IL 62269
618.607.1000

Memorial Care Center
4315 Memorial Drive, Belleville, IL 62226
618.257.5060

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