NK8: Describe and demonstrate innovations in nursing practice.

The nursing staff and leaders at Riverside Medical Center value the use of innovations in nursing practice. We embrace the definition of innovation used by the American Nurses Credentialing Center, and derived from Greenhalgh (2004): innovation is a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users’ experience and that are implemented by planned and coordinated actions. Nurses from all levels at Riverside Medical Center simply see Innovation in nursing practice as a new idea or method of doing something that results in improved structures and processes and optimal outcomes.

Structures and Processes

Innovations can arise from any structure at Riverside including internal or external councils, committees, or individuals. We use multiple processes to implement innovative practices. These processes may include our quality improvement model of Plan-Do-Check-Act (previously described in NK6 and NK7) and our EBP and Research models (also described in NK6 and NK7). One innovation mentioned throughout these sources of evidence is our Vigilance Professional Nursing Practice Model, which was developed to reflect our unique care and practice environment and our philosophy of nursing. We purposely chose to create a pictorial representation of our nursing practice that was innovative and unique to Riverside, rather than adopting an external model and attempting to “fit” that model in our organization. We believe our model quickly reached enculturation because we based it on the way we have always practiced.

Our process of implementing innovations generally involves the origination of an idea by any Riverside employee or group, piloting or testing the idea for feasibility and general acceptance, making revisions, changing external ideas to “fit” within our environment, implementing the innovation, monitoring the outcomes, and remaining open to making future changes. We believe that patient care and nursing practice is not stagnant, but always evolving, and we continue to strive for better ways of delivering care that result in optimal outcomes.

Our beliefs surrounding innovation will be demonstrated using four examples from various times: our implementation of varied and flexible shift start and end times, our weekend program, our development of an innovative way of educating and informing nurses about the use of unsafe abbreviations, and one nurse’s development of a Code STEMI tool to identify abnormal EKGs. Long-standing shift times demonstrate the enculturation of innovation in staffing practices involving nurses at all levels in the organization. The weekend program will demonstrate our leaders’ attention to meeting the scheduling needs of our staff while maintaining safe staffing levels. The development of the 3M QUILT to disseminate and enculturate our use of only safe abbreviations arose from staff nurses.

Shifts Times
Many hospitals have adopted 12-hour shift for nurses because this tends to be a nurse satisfier. While the shifts are longer each day, nurses need only to work three days per week to maintain their full time status, an important consideration for those who rely on benefits such as health insurance for their families. What is different about Riverside’s 12-shifts are the start and end times: 5:00 a.m. to 5:30 p.m. (days) and 5:00 p.m. to 5:30 a.m. (nights). In addition, innovative staffing models in the E.D. and other areas have provided our nurses with many options, have helped meet the needs of our patients, and allowed nurses who are in school to prioritize their time.

**ICU**

One unit involved in implementing the innovative shift times in 1981 was the Intensive Care Unit. (There was only one ICU in the hospital at that time.) The ICU nurses were working eight-hour shifts. The unit was exceptionally busy and filled to capacity at all times. ICU leaders were struggling with staffing issues and high burnout for the nurses who were working many days in a row to meet patient needs. Nursing leaders were considering implementation of 12-hour shifts, and had searched the literature for information and spoken with representatives from other hospitals where 12-hour shifts were implemented.

After a thorough investigation, Riverside nursing leaders decided to implement this change. The ICU began the twelve-hour shifts with start and end times of 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. Staff were very satisfied, with one exception: the day shift was not able to leave early enough to spend quality time in the evenings with their families. The ICU then changed shift times to 5:00 a.m. to 5:00 p.m. and 5:00 p.m. to 5:00 a.m. This allowed day staff to arrive home in time to see their children after school and before bedtime. The night shift arrived home in time to help their children get ready for school. The ICU staff were very happy with the change.

The change in shift start and end times was presented as an option to other nursing areas. Dissemination of this nurse satisfier took place, and nurses in all units voted on their desired shift length and times. They chose between the 6 – 6 shifts or the 5 - 5 shifts. The majority selected the 5 – 5 shifts and this change was made. Because nurses sometimes worked in different departments, establishing standardized 12-hour shift start and end times was essential, especially among specialty areas.

**MHU**

In some cases, nurses were allowed to establish different shift times. For example, the Mental Health Unit decided to maintain their 8-hour shifts, and did not change their shift lengths until June of 2009, when they started experimenting with 10- and 12-hour shifts. Nursing staff desired the change and worked with nursing leaders to establish staffing grids that would allow adequate coverage. Currently, some nursing staff work 8-hour shifts throughout the week and 12-hour shifts on the weekend. To better coincide with their 8-hour shift times of 7:00 a.m. – 3:00 p.m.; 3:00 p.m. – 11:00 p.m.; and 11:00 p.m.
– 7:00 a.m., the MHU nurses established their 12-hour shift start and end times 7:00 a.m. and 7:00 p.m.

**OB**

Another example of unit-specific preferences being honored was in the obstetrical (OB) unit. Nurses in the three OB areas – Labor & Delivery, Post Partum/Gyne, and Nursery – determined each area’s shift length and times. Labor & Delivery and Nursery nurses adopted 12-hour shift starting and ending at 5:00. Nurses in Post Partum/Gyne, at that time, were generally older than in the other two areas and did not feel they could work the 12-hour shifts; they kept the 8-hour shift length and times. Since the late 1980s/early 1990s, all areas in the OB department have adopted 12-hour shifts.

**E.D.**

The Emergency Department (E.D.) is another area where innovative staffing has been implemented to satisfy nurses and meet the needs of patients. As described and demonstrated in EP8, the E.D. staff has transitioned from standardized 12-hour shifts five years ago to a variety of shift start and end times, based on patient needs and volumes.

**All Units**

Nurse leaders in all areas work have developed innovative scheduling due to the large number of nurses who are back in school pursuing advanced degrees. Approximately 90 nurses, including direct care staff, managers, and directors, are working on BSN- and MSN-completion degrees. Accommodating these nurses’ school schedules requires a great deal of flexibility and innovative staffing. This can be very challenging in areas such as 5ICU where many night-shift nurses are in school!

In addition, five nurse managers have been allowed to alter their work days and times so they can complete BSN degrees by the end of 2010. Some of these managers are working longer days from Monday through Friday or are working on weekends so they can devote time to their studies. An additional innovative option for these nurses is to apply for a unique, one-time Pay Forward Tuition Reimbursement Program, which was approved by our CNO, Dave Duda, RN, MSN, and our Vice President of Human Resources, Becky Hinrichs. These five nurses applied for and received tuition reimbursement funds beyond the usual amounts. They will not be able to apply for additional tuition reimbursement funding until they work the required number of semesters after their graduation dates. However, this program has allowed them to obtain additional funding this year, when they need it.

Outcomes related to innovative shift times include the following comments from our staff nurses: Angela, RN, stated, “The twelve-hour shifts offer me more time off with my family. I don’t know if I could get all the work that needed to be done in an eight-hour shift.” Brandi, RN, agreed, noting, “The twelve-hour shift gives me more time to get my
work done and more time off with my family.” Joy, ICU Manager, shared that she would not be able to finish her degree for several years if she had not received funding from the Pay Forward Tuition Reimbursement program. The Tuition Pay Forward Program will allow us to achieve a goal for January 1, 2011 – to have 80% of our nursing directors and managers hold a minimum of a BSN degree.

**Weekend Program**

Another innovation in nursing practice at Riverside Medical Center is the Weekend Program. The Weekend Program is a staffing and scheduling option available to nurses who need or desire to work weekends only. This is an attractive option for nurses with small children and whose spouses work during the week. The Weekend Program can help nurses hold down costs for childcare.

The Weekend Program requires that nurses work a minimum of two 12-hour shifts between 5:00 p.m. on Friday and 5:00 a.m. on Monday. The program allows for one weekend off every quarter and full time benefits are provided while the nurse is in this program. Nurses are hired at a 0.6 FTE (full time equivalent). Some nurses also work extra shifts from Monday through Friday.

The impetus for implementing this program in 2001 was nurses’ desire for a better balance between work and home life. Additional factors that convinced Riverside leaders to implement the program were the 1) high turnover rate in some departments; 2) high use of agency nurses, and 3) an increase in call-offs during weekend shifts. Riverside nursing leaders researched various weekend program options used in other organizations when they developed the one for Riverside nurses. Leaders also surveyed nursing staff to obtain their input into the program. Once the program was developed, information on this scheduling option was disseminated to nursing staff via informational letters and meetings. Nurses on any unit that provided 24-hour care could apply for the program. Initial response from nurses was overwhelming, with 21.4% of nurses opting for the program initially.

Nurses opting for the Weekend Program must sign a contract every June. The annual contract renewal structure and process supports the potential need to change the program from year to year, based on the needs of the nurses and/or the organization.

Outcomes related to the Weekend Program include fewer call-offs and better work-home balance, as reported by nursing leaders and nursing staff. Approximately 100 RNs are currently enrolled in BSN- and MSN-degree completion programs. Nurses in these programs have also found the Weekend Program provides them with more time to devote to their studies. Following are comments on the Weekend Program provided by Riverside nurses who have chosen this scheduling option:

“The Weekend Program has provided me with the flexibility to take care of my aging family members and the availability to transport them to physician appointments and tests.”

- Patti Dunn, RN, 2nd Medical/Surgical Unit
“It [the Weekend Program] has provided me with the flexibility to be able to work two jobs.”
- Candi Nehls, RN, 2nd Medical/Surgical Unit

“It [the Weekend Program] has allowed me to be a stay at home mother during the week and work full-time.”
- Holley Doud, RN, 2nd Medical/Surgical Unit

Nurses who work Monday through Friday are also pleased because the Weekend Program decreases the number of weekend shifts they are required to work, as demonstrated in the following comment:

“The Weekend Program has given me the opportunity to have more weekends off, which in turn allows me to have more personal flexibility and time.”
- Andrew Higgins, RN, 3rd Ortho/Neuro Unit

The Weekend Program, in existence for eight years, has improved satisfaction of both the weekend and weekday nurses. This program will again be evaluated in the spring of 2010. The economic downturn, shifts in patient care from inpatient to outpatient settings, and few RN openings may compel leaders to revise the program.

Unsafe Abbreviations

Riverside nurses on the Quality and Safety Council developed an innovative approach to educating nurses on unsafe abbreviations. Avoiding use of unclear or misleading abbreviations was a 2006 National Patient Safety Goal (NPSG) from The Joint Commission (TJC). In 2008, the Quality and Safety Council reviewed our data as part of our ongoing preparation for our 2008 Joint Commission survey. The Quality and Safety Council data did show improvements in the decreased use of unsafe abbreviations but council nurses felt there was room for improvement, wishing to achieve 100% compliance. The Quality and Safety Council brainstormed ideas to improve the awareness of unsafe abbreviations.

An RN, from the Mental Health Unit, developed the acronym, 3M2QUILT, to help direct care staff remember which abbreviations are unsafe. The three M’s stand for Magnesium Sulfate (MgSO4) and morphine sulfate (MS and MSO4). The two Q’s stand for daily (QD) and every other day (QOD). The remaining letters stand for units (u), international units (iu), lack of a leading zero (l) and use of a trailing zero (t). All of these abbreviations and use of leading zeros have been identified as sources for medication errors when the abbreviations have been used.

To educate the staff about the unsafe abbreviations and disseminate this important information, the Quality and Safety Council created flyers depicting a quilt. The quilt squares spell out the unsafe abbreviations (see illustration below). The Quality and Safety Council displayed their project via a poster at the 2008 Evidence-Based Practice/Research Poster Fair.
To remind physicians and nurses of unsafe abbreviations to avoid, every patient chart also has a laminated reference tab showing the unsafe abbreviations. Members of the Quality and Safety Council and the Quality Improvement department staff regularly audit a specified number of patient charts each month, looking for use of these abbreviations. If a nurse, physician, or other care provider has used the unsafe abbreviations anywhere in the chart, a form letter (included below) is sent to that care provider with a reminder to avoid using the abbreviation. This action has several benefits:

(1) The letter allows us to monitor who is making the error so remedial education can be done if the error is repeated and

(2) The letter provides the caregiver with the correct abbreviation(s)
Date:

Re: Unsafe Abbreviation Compliance

To:

As you know, a random review of medical records to determine compliance with the Unsafe Abbreviations Policy is being completed. In an effort to achieve 100% compliance, nurses, pharmacists and therapists will continue to review orders when they are written. When an unsafe abbreviation is found, they will ask you to clarify; or if you have left the unit, they will hold the order and call you to obtain clarification.

Please find below a list of the unsafe abbreviations and the preferred terms to replace them. We have indicated the unsafe abbreviation(s) found during our random chart review.

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for 0 (zero), the number 4 (four) or cc</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other. Period mistaken for “I”</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod (every other day)</td>
<td>and the “O” mistaken for “I”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td></td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO4 and MgSO4</td>
<td>Confused for one another</td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

Please strive to use the preferred term(s) when writing orders, progress notes or any written documentation in a medical records.

Thank you for your dedication to patient safety.

In addition to the memo above, which might be sent to any care provider, a memo specific to physicians, is sent to a physician when continued noncompliance with our
unsafe abbreviation standards is found (see physician memo template below). The Chair of our Quality Improvement Committee, Dr. Sutherland, signs this letter. This physician-specific letter is the next step in progressive discipline for medical staff. If a Riverside-employed, non-physician care giver such as a nurse or pharmacist, continues to use unsafe abbreviations, that employee would follow our progressive discipline progress, which may include disciplinary actions up to and including termination.

Date:

Dear Dr. ___________________,

As you are aware, Joint Commission regulations include National Patient Safety Goals prohibiting the use of Unsafe Abbreviations. Unsafe Abbreviations are listed on the Physician Order chart divider in the patient’s medical record and regularly monitored. It has been noted that you have a pattern or trend using unsafe abbreviations, particularly:___________________

The Quality Improvement Committee requests that you not use Unsafe Abbreviations. If you continue to use Unsafe Abbreviations, this will be reported as a quality issue to your Department Chairman for review.

Thank you for your cooperation in providing safe quality care to our patients.

Sincerely,

David Sutherland, MD
Chairman, Quality Improvement Committee

Unsafe abbreviation use is monitored as an outcome. In the graph below, our abbreviation compliance rate for 2007 – 2009 is shown. TJC first introduced this measure as a National Patient Safety Goal and it surveyors found at least 3 charts with unsafe abbreviations, this became a Requirement for Improvement. Elimination of unsafe abbreviation use is now part of a TJC standard. For monitoring purposes, we use the 90% target rate because this is the compliance rate for the TJC standard.

The graph below demonstrates that we have exceeded our target of 90% compliance for every quarter since we started to track this safety indicator. The red arrow shows
when the 3M2QUILT education took place. A significant increase in compliance was realized after dissemination of the 3M2QUILT flyer to nursing units.

**Abbreviation Compliance Rate by Quarter**

*Target = 90%*

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline June 2005-June 2007</td>
<td>93%</td>
</tr>
<tr>
<td>2007-Q3</td>
<td>97%</td>
</tr>
<tr>
<td>2007-Q4</td>
<td>96%</td>
</tr>
<tr>
<td>2008-Q1</td>
<td>96%</td>
</tr>
<tr>
<td>2008-Q2</td>
<td>98%</td>
</tr>
<tr>
<td>2008-Q3</td>
<td>97%</td>
</tr>
<tr>
<td>2008-Q4</td>
<td>95%</td>
</tr>
<tr>
<td>2009-Q1</td>
<td>95%</td>
</tr>
<tr>
<td>2009-Q2</td>
<td>95%</td>
</tr>
<tr>
<td>2009-Q3</td>
<td>95%</td>
</tr>
<tr>
<td>2009-Q4</td>
<td>97%</td>
</tr>
</tbody>
</table>

**Development and Implementation of an Innovative Code STEMI Tool**

In 2007, Riverside Medical Center introduced a new program called Code STEMI. Evidence in the literature suggested addressing this specific condition could save patients' lives by decreasing the amount of time damaged heart muscle goes without oxygen. According to Bradley et al. (2006), the amount of time saved by implementing Code STEMI protocol could be up to 80 minutes for patients who have this type of heart attack outside a hospital setting.
The purpose of a Code STEMI is to rapidly identify and treat a patient who is having an acute myocardial infarction, otherwise known as a heart attack. The goal of a code STEMI is to get the infarcting patient from the emergency room to the cardiac catheterization lab where the occluded cardiac vessel(s) can be opened, within 90 minutes of arriving at the hospital. Opening occluded vessels promotes restoration of oxygen-rich blood to the myocardium and decreases further damage to cardiac muscle. STEMI is an acronym for ST segment elevation myocardial infarction; this refers to a location within the heart that is being damaged or dying. During a heart attack, a person is not receiving sufficient oxygen to perfuse the cardiac muscles. This causes pain and results in damage or death of the cardiac cells. “Time is muscle” is often a term healthcare providers use to emphasize the urgency for rapid treatment of the patient with this type of cardiac condition.

In the fall of 2007, efforts to develop a code STEMI program at Riverside Medical Center were initiated. Staff from the emergency department, cardiac cath lab, and our administration team began to meet and develop a plan to incorporate the code STEMI program into Riverside’s culture of care. By March of 2008, several important steps in making the Code STEMI program a reality took place. Nurse executives; local cardiologists; Kevin Hack, Director of Emergency Services; Tanya Huston, RN, BSN, Manager of the Emergency Department; Pat Blanchette RN, Manager of Cardiopulmonary Diagnostics; and LaRee Shule, RN, MSN, CNS/APN, CCRN, CNRN, began meeting to develop the program. In November 2008, the Manager of the cardiac catheterization lab became an active participant in the process and monitoring of our Code STEMI program outcomes.

This group of professionals attended a variety of workshops and began exploring accreditation as a Chest Pain Center from the Society of Chest Pain Centers. The Society of Chest Pain Centers (SCPC) was founded in 1998 and is a non-profit international agency dedicated to eliminating heart disease as the number one cause of death worldwide. The Society has been instrumental in bridging emergency services (EMS), emergency medicine, cardiology, nursing, and other professionals to focus jointly on improving timely, quality care for cardiac patients (SCPC, 2009).

In October of 2008, Riverside Medical Center officially started the program that we commonly refer to as, “Code STEMI”. As mentioned earlier, the overall goal of a code STEMI is to identify a patient having a ST segment elevation MI and subsequently clear the occlusion within 90 minutes. Ninety minutes is the national standard that is recommended by the Society of Chest Pain Centers and by the American College of Cardiology. Our Code STEMI program was implemented in 2008, and as of September 2009, Riverside Medical Center has an average Code STEMI Door to Balloon (D2B) time of 45 minutes, which is half the time of the national recommendation of 90 minutes. We have continued to maintain this standard, consistently achieving an average D2B time of less than 90 minutes. Our exceptions included 5 of 21 patients in 2008 and 2 of 37 patients in 2009. Each exception is reviewed monthly to determine if any changes in practice could have reduced D2B time. (For more details on the Code STEMI program,
please see source of evidence, EP15. This NK8 narrative will focus on an innovative educational component of the Code STEMI program.)

Nursing staff are very dedicated to the success of the Code STEMI program. Policies had to be developed and education had to be completed at several levels (policies are included in EP15). Emergency medical service personnel have an essential role in making a Code STEMI a success for the patient. The Riverside team that worked on the Code STEMI program knew it was imperative to network, educate, and include the EMS team in our processes. LaRee Shule, our critical care clinical nurse specialist, worked with Kevin Hack and Tanya Huston in educating not only Riverside Medical Center staff, but also all EMS staff that transport patients to our emergency department. Our dedication to optimizing patient outcomes in our community is so enculturated, that Riverside leaders made the decision to also educate our nearest hospital competitor’s EMS teams on Code STEMI policies and practices.

LaRee developed an innovative tool, which she calls the EKG grid, to help EMS personnel and nursing staff determine if the EKG is normal, abnormal, or emergent, and to identify a Code STEMI situation. She got the idea after seeing something similar at a Chest Pain Society educational program. She also found a grid in the ACLS (the American Heart Association’s Advanced Cardiac Life Support) manual. LaRee thought: what if you could see through the grid? She combined all three ideas and developed two transparent grids: one for 12-lead EKGs that EMS personnel could use in the field and one that nursing staff could use for EKGs done in inpatient units. The templates are color-coded and include notes to help EMS personnel gather essential information, which they can then communicate to the hospital Emergency Department. Nurses use the template to identify a STEMI occurring to a patient in the hospital. The notes on the templates are treatment reminders, such as MONA for morphine, oxygen, nitroglycerin, and aspirin. In both EMS and inpatient settings, physician order sets allow treatment to begin immediately once the STEMI is identified.

EMS and nursing staff simply lay the transparent grid over the patient’s EKG strip, and look for the hallmark signs of a STEMI. Below is a smaller version of the transparent grid used by nurses. Underneath the transparent grid is an example showing the grid laid over an actual EKG.

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Riverside Medical Center
12 Lead Transparency Grid
For use with full size 12 lead EKG
Lay over 12 lead to help assess location of injury/ischemia

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<table>
<thead>
<tr>
<th>I</th>
<th>aVR</th>
<th>V1</th>
<th>V4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral</td>
<td></td>
<td>Septal</td>
<td>Anterior</td>
</tr>
<tr>
<td>II</td>
<td>aVL</td>
<td>V2</td>
<td>V5</td>
</tr>
<tr>
<td>------</td>
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<td>----</td>
<td>------</td>
</tr>
<tr>
<td>Inferior</td>
<td>Lateral</td>
<td>Septal</td>
<td>Lateral</td>
</tr>
<tr>
<td>III</td>
<td>aVF</td>
<td>V3</td>
<td>V6</td>
</tr>
<tr>
<td>Inferior</td>
<td>Inferior</td>
<td>Anterior</td>
<td>Lateral</td>
</tr>
</tbody>
</table>

Triage:
- Risk factors
- MONA
- Remember goal times!

Grid fits inpatient EKG printed from standard machine

Accreditation surveyors from the Society of Chest Pain Centers were so impressed with LaRee’s grid, they asked LaRee for a copy to take back to their offices. This was just the beginning of the EMS education. All area EMS providers who deliver patients to Riverside’s Emergency Department are educated on our expectations for cardiac care. Education of area EMS personnel is crucial to maintaining the success of our Code
STEMI program and keeping average D2B times at less than 90 minutes. LaRee continues to go on site visits to educate the EMS providers on assessment skills and encourages them to assertively embrace the Code STEMI program.

Another innovation in Code STEMI education is our quarterly Code STEMI Lunch and Learn. Any employees or students who are interested or involved in any way with the Code STEMI program may attend. During the Lunch and Learn, a Riverside Code STEMI case is presented. All staff who were involved with that particular Code STEMI event receives a personalized invitation to attend the Lunch and Learn. The case is presented and then discussed, giving attendees an opportunity to identify successes, areas for improvement, and recommendations to change practice or policies. These educational sessions have been well attended by EMS and hospital staff.

Opportunities for improving the Code STEMI program are encouraged. For example, staff nurses in the Cardiac Cat Lab believed they could design a better Code STEMI Worksheet to streamline preparation and assessment of STEMI patients coming to the Cath Lab from E.D. or a nursing unit for treatment. They believed the previous form was cumbersome and time was being wasted while Cath Lab staff searched for important information. Cath Lab staff redesigned the worksheet so it is easier to follow and faster to complete. This allows them to spend more time with the patient. Our commitment to optimizing patient outcomes is demonstrated in our efforts to continually educate all staff, monitor our outcomes, and make changes that improve patient outcomes.

From January to October of 2009, we had 28 Code STEMI patients. Six of those 28 patients were in their 40’s. The average patient age was 59 years. Stress, lack of exercise, poor nutrition, and heredity are factors in developing cardiac disease, and are most likely factors, which have attributed to our seeing Code STEMI patients who relatively are young. More details about the Code STEMI development and quantitative outcomes are included in source of evidence EP15.

Summary

The nursing staff and nursing leaders at Riverside Medical Center embrace innovative ways of addressing problems, improving structures and processes, and optimizing outcomes. Our Vigilance Professional Nursing Practice Model, itself an innovation, provides the structure and processes that support and encourage nurses to share and implement innovative ideas and projects. Nurses at every level have been involved in a number of innovations, such as our implementation of variable shift times, which were based on our nurses’ needs; our Weekend Program; and our use of the 3M2QUILT to disseminate and enculturate expectations for avoiding use of unsafe abbreviations. Our critical care clinical nurse specialist, LaRee Shule, created an innovative tool for EMS providers and nurses so they could more easily recognize normal, abnormal, or emergent EKG readings. Riverside nurses at all levels support and welcome innovative practices and tools.

References

