As the Vice President of Patient Care Services and the Chief Nursing Officer, it gives me great pleasure to share with you the 2015 Nursing Annual Report. In this report, we highlight the key accomplishments of our entire nursing staff and celebrate the significant contributions they make in our continued focus and commitment to nursing excellence and Magnet designation.

In these pages, you will read about Middlesex Hospital nurses at all levels — serving on our shared governance councils, committees, LEAN teams — and of the significant individual contributions toward our Nursing Department and Hospital-wide strategic goals.

Today, we are confronted with unprecedented changes in health care, increasing fiscal constraints (particularly in Connecticut), and ongoing expectations for superior performance in both quality and patient experience. These changes may seem overwhelming at times, but as nurses at Middlesex, we remain strong in our commitment to outstanding patient care and assuring that we advocate for our patients and their families. Our nurses are committed to advancing the practice of nursing through education, increasing certification, involvement in research and evidenced-based practice projects, participation in shared governance and in their professional organizations.

I would like to thank each nurse at Middlesex Hospital for your dedication, and for providing Care That Makes a Difference every day.

Jackie Calamari, MSN, MS, NEA-BC, CEN
Vice President, Patient Care Services/CNO
Dear Colleagues:

I am very proud to say that the nursing staff at Middlesex Hospital is second to none. You consistently provide the best possible care to our patients and this is clearly evidenced by retaining the prestigious Magnet designation since 2001!

There has been much discussion and research performed over the past few years about the future of nursing. Nurses all over the country have been challenged to continually raise the bar in both clinical and professional areas. I am very pleased to know that our nurses here at Middlesex Hospital continue to not only meet those challenges, but also exceed them, as evidenced in this Annual Report.

As we move forward, there will certainly be new challenges ahead. I am confident that because of your remarkable commitment, talents and dedication, you will rise to meet these challenges with innovative and creative solutions that have become the hallmark of nursing at Middlesex Hospital.

On behalf of the Executive Staff and our Board of Directors, thank you for providing the safest, highest quality care and the best experience possible to our patients every day.

Congratulations on another outstanding year!

Sincerely,

Vincent G. Capece, Jr.
President/CEO
Dear Colleagues:

I would like to thank you for the many contributions you have made to the Professional Practice Council this past year. Shared governance is the driving force for all decisions that affect nursing practice at Middlesex Hospital. Each and every nurse in our organization has a voice, and the Professional Practice Council is the foundation for being heard. We have representation from every nursing area throughout the Middlesex Health System. As professional nurses, we must continue to strive for collaborative, evidence-based practice. Our purpose each day is to deliver high-quality care that makes a difference for our patients and community.

2015 was an exciting year for the Professional Practice Council. The Nursing Strategic Plan for the next three years was approved unanimously. This plan provides the vision and goals that will lead us to our 5th Magnet redesignation. Our clinical advancement program (ATTAIN) evolved with your careful consideration and is off to a great start in 2016. The new ATTAIN will help us fulfill our goals of professional development, while enhancing our practice settings and individual units. We will value your input as we evaluate our Professional Practice Model, “Care that Makes a Difference.”

Taking care of ourselves so that we can take care of others is difficult to balance. We will continue to focus on well-being as the year progresses. Self-care through healthy living and holistic methods will also serve as topics in our meetings, both at the committee and unit levels. In addition, workplace safety and the reduction of patient handling injuries will remain an area of great importance.

Thank you for the wonderful care that you give to every patient and family member who comes to Middlesex Hospital. I am proud to be a member of your team and honored to work with you in making the decisions that affect our nursing practice.

Sincerely,

Meredith Belden, BS, RN-BC, PCCN
Professional Practice Council Chair
CARE THAT MAKES A DIFFERENCE

Nursing Practice
Compassion Advocacy Respect Expertise

Shared Governance
Collaboration Accountability Transparency Inclusion

Care Delivery System
Innovative Patient-Focused Care Collaborative Interdisciplinary Patient-Centered Care

Midsize Health System
Collaborative Managed Health Care High-Quality Affordable Care

CARE THAT MAKES A DIFFERENCE
THE MIDDLESEX HOSPITAL DEPARTMENT OF NURSING
MISSION AND VISION STATEMENT

Mission Statement
Middlesex Hospital nurses provide evidence-based, safe, high quality Care that Makes a Difference for our patients and community.

Vision Statement
As professional nurses, we aspire to promote collaborative practice that embraces innovation across the continuum resulting in excellent outcomes for our patients.

2015—2018 STRATEGIC PILLARS

Enhance Professional Practice
Support an environment of lifelong learning for nurses at all levels and in all settings.

Initiatives:
- Advocate for nurses at all levels to grow professionally
  - Increase % of professional certification to:
    100% Nurse Leaders (12/31/16)
    60% Clinical Nurses (12/31/16)
    62% Clinical Nurses (12/31/18)
  - Increase % of BSN prepared nurses to:
    60% Clinical Nurses (12/31/16)
    70% Clinical Nurses (12/31/18)
- Advocate for Leadership Development
  Implement mentoring and/or succession planning activities for:
  - Clinical Nurses
  - Nurse Managers/Educators
  - Nurse Leaders
  - CNO
- Support growth of our professional practice environment
  Promote involvement of clinical nurses in:
  - Professional organizations
  - Participation in scholarly activities
  - Achievement of ATTAIN
  - Enhancement of Peer Review
  - Re-evaluation of Professional Practice Model

Demonstrate Safety & Quality Outcomes
Provide care in a highly reliable environment that outperforms national benchmarks

Initiatives:
- Outperform national benchmarks for clinical quality and patient satisfaction
  Develop at least one goal for every service unit for every relevant indicator reported (NDNQI, Press Ganey, CMS Core Measures, outpatient measures)
- Strengthen the high reliability environment
  - Evaluate and improve workplace safety for nurses
  - Engage nurses in organization-wide proactive risk assessment/error management
  - Involve clinical nurses in the systematic review of patient safety data at the service/unit level
  - Involve clinical nurses in systematic evaluation of National Patient Safety Goals
- Engage nurses in evaluating service/unit level staffing plans
  Promote awareness of established standards and guidelines for staffing in their practice setting and its relationship to outcomes
Foster a Culture of Pride, Ownership and Accountability

Uphold personal ownership and team accountability to patients peers and the health system community to achieve positive outcomes

Initiatives:

Promote a nursing community that values a collegial environment
- Ensure nurses at all levels model health system core values
- Ensure department wide professional expectations are met

Promote innovation that allows nurses to respond to a changing healthcare environment
- Ensure an effective response to staff satisfaction and employee opinion survey results
- Leverage unit level structures and processes (unit councils, CIT) to solicit innovative ideas

Promote teamwork within the health system community to achieve seamless care transitions
Support staff driven projects that improve team communication, handoffs and improvements to care transitions

Ensure Exemplary, Effective, Efficient Care

Support innovation to strengthen care delivery, care transitions and interprofessional collaboration

Initiatives:

Maximize relationship with Mayo Clinic Care Network (MCCN) to ensure best practices
- Participate in online MCCN nursing practice related learning opportunities
- Encourage clinical nurses to access patient education materials provided in MCCN portal
- Participate in CNO collaboration activities

Include nurses as essential partners in care delivery, technology and workflow design
- Implement care delivery models and technology that improve efficiency
- Implement and evaluate coordinated patient education activities across the continuum

Assure nurses are involved in shared governance at all levels in the organization
Implement staffing models that allow for clinical nurse participation in meetings

Balance fiscal stewardship with excellent patient care delivery
Increase nurses understanding of the financial aspects of patient care delivery
PRESS GANEY OVERALL NURSING SCORES

Falls with Injury
All Reporting Units Combined - Acuity Adjusted

Hospital Acquired Pressure Ulcers (Stage 2 and Above)
All Reporting Units Combined - Acuity Adjusted

Inpatient Units
(Overall Score)

Outpatient Surgery at Middlesex Hospital
(Overall Nursing)

Please note: Means have been standardized to zero; it is desirable to be BELOW zero.
NURSE SATISFACTION SURVEY

Nurse Satisfaction Survey
July 2015

Middlesex Hospital
Press Ganey National Magnet Mean

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TRANSFORMATIONAL LEADERSHIP
Aligning Our Strategic Plan

Nurse leaders have been working diligently as a team to develop, implement, and evaluate the 2015-2018 Nursing Strategic Plan. Starting in early 2014, several nurses participated in Conversation Cafés hosted and facilitated by Gean Brown, MSN, RN, OCN (formerly of the Cancer Center) and Deb Healey, MSN, RN, CPHRM, NEA-BC (Executive Director Homecare & Strategic Planning) in order to build the framework for the 2015-2018 Nursing Strategic Plan. In 2015, each unit council worked with their entire team to develop their goals. A gap analysis, completed at the end of 2015, revealed the need for revisions to the plan, based on both progress and feedback from the units. In addition, nurse leaders worked with the organizational leadership team, in order to ensure the continued alignment with the recently updated Hospital-wide strategic plan. In January 2016, nurse leaders shared the updated plan with each area’s unit council and in various shared governance forums for discussion. This process has laid the foundation for each area to finalize their goals through mentorship and support from nurse leaders Deb Healey, MSN, RN, CPHRM, NEA-BC and Kelly Nicholson, MS, MPH, RN-BC at their unit council meetings throughout 2016. Each unit will have the opportunity to discuss their progress and be mentored in developing goals that reflect the hard work they do every day! Stay tuned as our strategic plan goals come together to demonstrate the many successes and accomplishments of the Department of Nursing!

Advocating for Resources

The Hospice and Palliative Care Team has transitioned their own Deb Potticary, BSN, RN, CHPN into her new role of Palliative Care Coordinator, while working towards completion of her APRN degree. Deb continues to undergo intense training by mentors and experts in the field of palliative care.

The Palliative Care Coordinator role is instrumental in the continued effort to increase understanding by all (lay people and health care professionals) of what palliative care means to patients’ quality of life and its value to the organization. Palliative care is a specialty that may be appropriate for anyone with a serious illness and should not always be associated with care at the end of life. Deb and her team are developing palliative care champions who have had special training to serve as resources to their peers across the continuum of care.

Cancer Center clinical manager Camille Servodidio, RN, MPH, OCN, CBCN, CCRP collaborated with Sandy Phillips, Radiology Director to create the position of Breast Imaging Nurse Navigator. Kari Mayorga, BSN, RN, OCN joined the Middlesex Hospital Cancer Center team in June 2015. This role provides a much-needed link to the breast cancer patient population. Kari frequently communicates with patients about what to expect with mammography and other related procedures, such as biopsies, so they can get their questions answered promptly and alleviate as much anxiety as possible. Due to the advanced diagnostic technology, this is a growing patient population to manage. Kari also has the opportunity to meet with the patient right after the biopsy, review discharge instructions, improve patient satisfaction and provide overall coordination of care.

Allocating Resources

Pregnancy & Birth Center clinical nurse Melissa Revicki, MSN, RNC completed her graduate studies in May 2015. The leadership team of Amanda McDonald, BSN, RNC, Sarah Lennon, BSN, RNC and Barbara Thompson, MSN, RN, CNOR successfully reallocated existing resources in order to support the development of a new Nurse Navigator role. In this role, Melissa will significantly impact patient satisfaction scores by providing additional ongoing education to patients in all stages of their childbirth journey. Patients and families will also benefit from more interaction with the Pregnancy & Birth Center before delivery, and will be better informed of what to expect during their labor and postpartum periods. In addition, the role will provide essential support to staff as a liaison to the Center for Professional Development, ensuring that all staff continue to engage in required specialty-specific training, in-service and continuing education.
Advocating for Leadership Development

The ATTAIN Program (Acknowledging the Talents, Accomplishments and Involvement of Nurses) underwent significant revision in 2015, thanks to the thoughtful feedback and ideas from clinical nurses, nurse managers, professional development specialists and nurse leaders in all areas. Led by Deb Warzecha, DNP, RN, NEA-BC, CEN (Director, Emergency Departments & Inpatient Behavioral Health) and Kelly Nicholson, MS, MPH, RN-BC (Director of Professional Practice & Research), the task force met with several nurses including the ATTAIN Review Committee, the original ATTAIN Committee, unit councils, the Professional Practice Council (PPC) and the Unit Council Development Council (UCDC) for their input and feedback as they moved forward with program improvements. All nurses participating in ATTAIN after December 31, 2015 applied to the new program consisting of two levels (instead of three) and selected activities within the four domains of professional development, scholarly practice, clinical expertise and leadership. A major difference between the new and old program is that nurses will now apply after meeting with their manager at least eight months in advance of their performance evaluation date to determine a plan for completion of requirements. Another major difference is the requirement of both a BSN and a Professional Certification for the advanced level. Nurses without a BSN who were current participants in the previous ATTAIN program were offered the opportunity to be grandfathered into the new program.

The ATTAIN Review Committee, now led by Anne Burkhart, BSN, RN-BC, PCCN continues to work diligently every month to review applications. The committee has welcomed a new member, Lauren Boule, MSN, RN-BC (Center for Professional Development) as they bid farewell to Judy Henderson, RN, CNOR retiring from surgical services as both a lifelong clinical expert in surgical services and ATTAIN Review Committee member. The committee is pleased to report that over 120 clinical nurses have submitted their plans for either ATTAIN or ATTAIN ADVANCED, a number that promises to surpass the participation rate in our previous program.

Growing Our Leadership Team: Succession Planning

With an ever-changing healthcare environment and multigenerational workforce, nurse leaders must maintain focus on the leadership needs of their teams well into the future. There are several examples of great succession planning to note at Middlesex for 2015! In Surgical Services, Karen Norton, BSN, RN, CAPA was promoted to Nurse Manager of the Outpatient Services and PACU areas from her previous role as Assistant Nurse Manager. On the North 2 Telemetry Unit, Meredith Belden, BSN, RN-BC, CDE, PCCN was promoted to her role of Nurse Manager also, from her previous role of Assistant Nurse Manager. Susan Grube, MSN, RN, EMT-P, CEN assumed the role of Nurse Manager for the Family Medicine Residency Program from her role as clinical nurse in the Emergency Department. The Operating Room welcomed James “JJ” Brooks, BSN, RN, CNOR as Assistant Nurse Manager to support the evening shift, a need determined after careful consideration by nurse leaders to maximize resources.

Prior to 2015, the two departments had not been involved, but with careful evaluation of both departments clinical nurse roles, they were a perfect fit for the new and improved 2016 ATTAIN program. Deb Pantalena RN OCN (Cancer Center) and Elise Avery BSN RN-BC ACM (Case Management) both paved the way for their peers in successfully submitting their ATTAIN applications for 2016!
As Marylee Oleksiw, BSN, RN, CIC planned her retirement, she collaborated with nurse leaders to ensure a successful handoff prior to her departure. As a result, she mentored Jodi Parisi, MT, CIC as the new Manager of Infection Prevention along with assisting in onboarding Katie Benn, MSN, RN who could further support the team through the transition and beyond.

With the planned departure of Terisa Brainard, BSN, RNC from the Pregnancy & Birth Center team, nurse leaders capitalized on the mentoring and development of Amanda McDonald, BSN, RNC to fill the role of Nurse Manager. Thanks to several years of mentorship by both Terisa and Barb Thompson, MSN, RN, CAPA along with several years as an expert clinical nurses on the unit, Amanda joined the leadership team well prepared. As a result of this transition, the team was pleased to also welcome another P&BC expert clinical nurse, Sarah Lennon, BSN, RNC as their new Assistant Nurse Manager.

Recruiting new members to Middlesex Hospital is an essential element to rounding out the leadership team: Sue Daniels, RN, CHPN and Kim Bergere, BSN, RN-BC joined the South 7 Hospice and Palliative Care team and North 7 Inpatient Psychiatry team (respectively) as Assistant Nurse Managers.

Growing Our Leadership Team: Mentoring
Facilitated by nurse leader Mary Allegra, MSN, RN-BC, Director of the Center for Professional Development, a small cohort of nurse managers and assistant nurse managers participated in an American Organization of Nurse Executives (AONE) Leadership Lab series in the Spring of 2015. Essential topics for the role of nurse manager were presented weekly by AONE speakers through a webinar based curriculum. With several organizations participating across the US, lots of strategies and ideas were shared via web and phone conversations. At the end of each contact-hour worthy session, our cohort benefited from some real-time discussion about their experiences, right here at Middlesex.

AONE Leadership Lab Participants:
Lynne Dakers, MSN, RN-BC, Nurse Manager, North 5 Surgery/Bariatrics
Susan Grube, MSN, RN, EMT-P CEN, Nurse Manager, Family Medicine Program
Cheryl Savakis, BSN, RN, CEN, SANE, Assistant Nurse Manager- Middletown Emergency Department
Karen Norton, BSN, RN, CAPA, Nurse Manager, PACU/OPS
STRUCTURAL EMPOWERMENT
Promoting Continuous Professional Development

The Center for Professional Development (CPD) had a busy and productive year, with many accomplishments to share:

- Streamlined and standardized unit-based clinical orientation to include additional methods for competency validation
- Expanded the redesigned competency assessment process for nurses and PCTs to more areas
- Lynn Jansky, MSN, RN-BC and Larissa Morgenthau, MSN, RN-BC presented the competency redesign project at the National Association for Nurses in Professional Development (ANPD) conference in Las Vegas in July and the October Connecticut Nurses Association meeting
- Created a Medical-Surgical Educational Resource website for clinical nurses
- Reinstated the PCT Pearls education program: education tailored specifically for PCTs on relevant topics for all areas of practice
- Mentored nurses and PCTs in implementing unit-based skills validation processes to increase efficiency and effectiveness
- Welcomed new members for key areas: Rob Blewitt, BSN, RN (Critical Care), Stephanie German, MSN, RN (Emergency Department), Melissa Revicki, MSN, RNC (Pregnancy & Birth Center), and Andrea Armentano (CPD Administrative Assistant)
- Exceeded their goal in mentoring more than 70 clinical nurses in developing ATTAIN plans

RN-to-BSN Cohort

Thanks to collaboration between the Center for Professional Development, Human Resources and nurse leaders, there are now nine Middlesex Hospital clinical nurses participating in an online RN-to-BSN cohort with Chamberlain College of Nursing. Designed to be completed in as little as 12 months, this program moves quickly but has been developed with the needs and preferences of full-time clinical nurses. As a faculty member for Chamberlain College of Nursing, Joann Preece, MSN, RN, CAPA provides the team with additional support and mentorship on site at Middlesex Hospital. Over 20 nurses are enrolled with Chamberlain across all departments at Middlesex!

Cohort Participants:
Mary Ballachino, RN, CNOR (Surgical Services)
Deb Woodcock, RN, CNOR (Surgical Services)
Kate Lee Salerno, RN (Surgical Services)
Jane Martin, RN (Surgical Services)
Toni D’Addeo, RN, CEN (Emergency Department)
Tracy Andrulat, BS, RN, ONC (Orthopedics, South 6)
Tiffany Davis, RN (Surgical Services)
Tammy Hickman, RN-BC (Orthopedics, South 6)
Sheri Sienkiewicz, RN, CEN (Emergency Department)

Engaging with our Professional Organizations
Endoscopy clinical nurse Judy Grippo, BSN, RN, CAPA, CGRN continues to be highly engaged in the local and national organization Society for Gastroenterology Nurses and Associates. As a result of her expertise and experience, she has been invited to serve on the faculty for statewide specialty education courses for other endoscopy (ERCP) clinical nurses.
Operating Room clinical nurse Terisa Pineau, RN and Carol Scierka, BSN, RN (endoscopy) collaborated to develop evidence-based guidelines, designed to assist staff in the prevention of falls for patients in the operating room. Using best practices from the literature and by reviewing guidelines established by the Association of periOperative Registered Nurses (AORN), they created a written resource for staff that includes preoperative and intraoperative risk factors, assessment tools and special considerations.

Clinical Nurses in the Pregnancy & Birth Center have been carefully reviewing their data after implementing the Association of Women’s Health Obstetric and Neonatal Nurses (AWHONN) standard regarding delayed bathing for newborns. Delaying the first bath for newborns has been demonstrated in the literature to have several benefits for baby:

• Reducing heat loss-maintaining body temperature
• Decreased hypoglycemia
• Boosts antimicrobial abilities
• Preserves natural moisturizer
• Related to greater success with breastfeeding
• Decreased stress

Marissa Goodnight, BSN, RN (P&BC Unit Council Chair) and Heather Pickerign, BSN, RN (Clinical Nurse P&BC) have worked closely with the P&BC unit council to implement this practice with careful consideration of nursing workflow and planning for a significant amount of patient and family education. Additionally, the team is collaborating with the Interprofessional Research Council (IRC) to systematically collect their data in order to show off their improved outcomes!

Community Outreach
The Center for Chronic Care Management experts launched CareLink in September 2015. Led by Kit McKinnon, MBA, BSN, RN, CDE, CCM, CareLink is a program that supports our diabetic patient population through technology and enhanced self-management skills. Using automated care calls, patient engagement tools (which measure blood glucose levels, weight and activity levels) and wireless technology (glucometers and Fit Bits), the team can better evaluate and provide feedback to patients in real time and in support of their goals. Care Call response team members assess the patient and establish parameters for check-in and check-up purposes. By enrolling several cohorts of patients, the team will be able to compare and determine the success of various approaches. Patient cohorts are devised according to the following categories:

• Freshman – Inpatient referrals
• Graduates – Recent group class attendees
• Alumnae – Group class ‘post-graduates’, at least a year out
• Home Schooled – Received Medical Nutrition Therapy only
• Non-Matriculated – Patients that do not receive devices-only check-in calls by the Care Call team

Stay tuned for outcomes on this exciting and innovative project!

Caring for our Community while Caring for Ourselves
The 2015 C.H.E.R.I.S.H. (Connected Hearts Empathetically Restoring Intentional Shared Healing) Valentine’s Day event was a success! Practitioners offered massage, reflexology, sound healing, aromatherapy, and hand ‘M’ technique services for $1 per minute to all staff. Donations were provided to St. Luke’s Eldercare of Middletown. A special thanks to the Holistic Care Team co-led by Deb DePasqua, MSN, RN-BC, HNB-BC (Nursing Supervisor) and Cheryl Mohrlein, MSN, RN, OCN, NE-BC (Nurse Manager South 4 & Outpatient Infusion) and support from Catherine Rees MPH for planning this event each year.
Fostering Our Future Generation of Caregivers

Clinical Nurses Rachel Crockett, RN, CEN, Laura Giardullo, MSN, RN, CEN and Joe Pucillo, RN, CEN and their Emergency Nursing teams at the Marlborough Emergency Department and Shoreline Medical Center continue to foster our future nursing and health care team generations by hosting comprehensive Career Day events. Students are given the opportunity to see first-hand the roles and day-to-day work of the interprofessional Emergency Department team.

Maryann Swetz, RN (Shoreline Medical Center) has been instrumental in implementing a student volunteer program, in which high school students interested in health care careers spend several hours supporting the department with various tasks, while gaining valuable insight on their possible career options in the future!

Preparedness for the Changing Environment

Clinical nurses and the interprofessional team in the Middletown Emergency Department have been diligently enhancing their level of preparedness through various mechanisms such as participating in drills with local and statewide partners, training frontline staff in key positions such as those who register our patients and collaborating with our own Infectious Disease Prevention experts Jodi Parisi, MT, CIC and Dr. Rahul Anand. Lesson learned from the EBOLA crisis: We can never be too prepared!

In addition, the staff continues to prepare for and support community-wide initiatives such as the Middletown Half Marathon and large events such as the Durham Fair. Our staff not only provide the highest quality care to our patients but also to our community!

Recognition

In May of 2015, the Middlesex Hospital North 5 team was reaccredited as a comprehensive quality center for bariatric surgery. The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accreditation is bestowed to programs that demonstrate excellence in safe surgical care and favorable outcomes, with a focus on long term results. There is a rigorous evaluation process led by Bariatric Coordinator Patty Marteka, BSN, RN-BC, CBN to achieve the designation. Bariatric surgery accreditation not only promotes uniform standard benchmarks, but also supports continuous improvement. Patient information is entered into a national database at 30 days, 6 months, one year and annually. At quarterly intervals, this national database reports on readmissions, revisional surgeries, morbidity and mortality centers to maintain the highest quality services and make improvements to practice. Obesity is a common and costly health issue that increases the risk of heart disease, Type 2 diabetes and cancers. Middlesex Hospital began performing weight loss surgery in 2001, under the direction of Dr. Jonathan Aranow. First accredited in 2005, the program was based on centers of excellence. Middlesex was again accredited in 2009 under the Center of Excellence standards. In 2012, The American College of Surgeons (ACS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) combined their respective national bariatric surgery accreditation programs into a single unified program to achieve one national accreditation standard for bariatric surgery centers, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

Melanie Cama, MSN, RN, CHPCA, Program Director (Hospice and Palliative Care) was the recipient of the 2015 Hospice and Palliative Care Director of the Year Award from the Hospice and Palliative Care Credentialing Center. Melanie was selected for her contributions to end-of-life care. Melanie received her Certified Hospice and Palliative Care Administrator (CHPCA) certification in 2013 and had Certified Hospice and Palliative Care Nurse (CHPN) certification from 2005-2013. She has served in her current role since 2002 and has worked tirelessly to promote palliative care within the Hospital system. She has also assisted with the development of an evidence-based palliative care tool to identify patients appropriate for a palliative care consult,
called the Decision Aid for Palliative Care Referrals (DAPR). Melanie’s ability and desire to communicate, always remain positive, and to make changes when appropriate, has sustained and improved the program for the organization. She has been recognized not only for her skills as a leader, but also for her emphasis on staff support. Melanie ensures that staff has ample time to reflect on losses, release and vent appropriately, and cherish the work that they do.

Kudos to the Critical Care and IV Therapy teams! It has been FIVE years since the last Central Line Associated Bloodstream Infection (CLABSI) in the Critical Care Unit. This is an impressive accomplishment and a true testament to great insertion technique, great maintenance and commitment to great patient outcomes by both teams.

Congratulations to the Cardiac Rehabilitation team – Laurie Hill, BSN, RN-BC, Mary Mesek, BSN, RN-BC, Cari Noti, BSN, RN, CEN, Denise Slater, RN-BC, Catherine Rich MSN, RN, Edyta McCuin, RN, Pam D’Amato, RN-C and Noreen McQuade who recently achieved the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) program certification – their FIFTH designation! They first became certified in 2003!

Congratulations to the Professional Practice Review Committee (PPRC) who recently reviewed their 100th case! Created in 2011, PPRC was formed to evaluate nursing practice, acknowledge outstanding practice as well as identify areas for practice improvement.

Congratulations to the Center for Chronic Care Management for achieving accreditation from the National Committee for Quality Assurance (NCQA) for the FIFTH time!

Cathy Wade, MHCA, BSN, RN-BC (Nurse Manager, Shoreline Emergency Department) received the Pam Vecchiarino Nursing Leadership Award from the (former) Connecticut Organization of Nurse Executives. Cathy received the award at the annual meeting in January.

Congratulations to the Cancer Center team for earning a full, three-year reaccreditation from the National Accreditation for Breast Centers (NAPBC) in April. With 28 standards executed flawlessly, the team was also recognized for six best practices:

• Patient Navigation
• Nursing
• Support and Rehabilitation
• Genetic Evaluation and Management
• Breast Cancer Survivorship Care
• Education, Prevention and Early Detection programs

These practices were showcased on the NAPBC best practice online repository! Way to go!
Two Middlesex nurse leaders were recognized in Oncology Nursing Society’s publication ONS Connect:

Melanie Cama, MSN, RN, CHPCA in “How Can Palliative Care Discussions Happen Earlier in Patients’ Diagnoses?” and Cheryl Mohrlein, MSN, RN, OCN, NE-BC in “How Did You Overcome Horizontal Violence in the Workplace?”

Congratulations to Terri Savino, MSN, RN, CPHQ for receiving the national Luc R. Pelletier Quality Award from the National Association for Healthcare Quality in October for her contributions to the sepsis initiative.

Congratulations to the following nurses in earning a Great Serve in 2015

- Nancy LaMonica, MHA, MSN, RN, PCCN (Nurse Manager, Observation Unit)
- Joseph Pucillo, RN, CEN (Clinical Nurse, Emergency Department)
- Laura Hanley, BSN, RN, CEN (Clinical Nursing Supervisor)
- Phil Martinez, EdD, ACNP-BC, CCRN-CMC (APRN, Critical Care Unit)
- Jose Lopera, MSN, RN, CEN (Clinical Nursing Supervisor)
- Dan Guilmette, BSN, RN, CEN (Clinical Nurse, Emergency Department)
- Carla Pitarra, RN (Clinical Nurse, Operating Room)
- Teresa Pineau, RN (Clinical Nurse, Operating Room)
- Kate Schultz, BSN, RN-BC (Clinical Nurse, North 4)
- Sue Niedbala, RN, CHPN (Clinical Nurse, Homecare)
NEW KNOWLEDGE, IMPROVEMENTS AND INNOVATIONS
NEW KNOWLEDGE, IMPROVEMENTS AND INNOVATIONS

Developing New Knowledge
The Interprofessional Research Council (IRC) developed a task force in early 2015 led by Betty Molle MSN, RN-BC (Research and Outcomes Specialist) to re-examine models of evidence-based practice, in order to ensure that the team is using the most appropriate model as a guide for projects, and in order to meet organizational needs. In order to conduct a meaningful evaluation of the evidence-based practice model in place at Middlesex, the team reviewed the literature and undertook a thorough evaluation of the components of various models, including the Iowa Model (current model) and arrived at the Johns Hopkins Evidence Based Practice Model for implementation at Middlesex. Several features of the Hopkins model made it a great choice for Middlesex: clinician/user friendliness, level of detail provided, online tools available and tutorials are just a few. The IRC looks forward to supporting evidence-based practice questions through the application of the Johns Hopkins Model!

Johns Hopkins Nursing Evidence Based Practice Model

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<td>• Experimental</td>
<td>Core Measures</td>
</tr>
<tr>
<td>Equipment/Supplies</td>
<td>• Qualitative</td>
<td>Legislation</td>
</tr>
<tr>
<td>Staffing</td>
<td>• Non-experimental</td>
<td>Licensing</td>
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<td>Effectiveness</td>
<td>• Qualitative</td>
<td>Standards</td>
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<tr>
<td>Standards</td>
<td>• Qualitative</td>
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</tbody>
</table>

Based on a project initiated by Clinical Director Justin Drew, BSN, RN (Homecare), a core group of Homecare clinical nurses and their interprofessional colleagues are leading the way to developing new knowledge around the efficacy of a technique known as Motivational Interviewing (MI) to improve outcomes for their patients in the community. The research study will require that several homecare clinicians become trained in the technique of MI and it will serve as a professional development and team building opportunity as well. The team will collaborate with local experts in the community for more knowledge and skill regarding the implementation of MI and then implement it within the framework of a well-designed research study.

Evaluating Workplace Safety
The Safety When Approaching Aggressive Patients Taskforce (SWAAPT), a subgroup of the Workplace Violence Prevention Committee, reviewed best practices to manage aggressive patients and educational methods to improve staff safety. Led by a collaboration of efforts among Jim Hite (Security Department), Mary Allegra, MSN, RN-BC (Director of Professional Development) and Betty Molle, MSN, RN-BC (Research and Outcomes Specialist), the workplace safety observation study had two parts and then the team carefully reviewed their findings to build recommendations.

Part 1: Research
Using simulation, the Center for Professional Development conducted a research study to explore the question, “Do staff members with training perform better than staff members untrained when approaching aggressive patients?”

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>Sig</th>
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</thead>
<tbody>
<tr>
<td>Negative behaviors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trained</td>
<td>10.5</td>
<td>3.53</td>
<td>(p = .04)</td>
</tr>
<tr>
<td>Not Trained</td>
<td>8.7</td>
<td>2.7</td>
<td>(p = .04)</td>
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<tr>
<td>Positive behaviors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trained</td>
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<td>1.18</td>
<td>(p = .04)</td>
</tr>
<tr>
<td>Not Trained</td>
<td>1.97</td>
<td>1.34</td>
<td>(p = .04)</td>
</tr>
</tbody>
</table>

The data shows that the staff members (RN, PCT, MD) showed more negative behaviors post-training than the staff members who were not trained. Also, staff members who were trained had fewer positive behaviors than those not trained.

Part 2: Identification of aggressive patients Using a valid and reliable tool, SWAAPT conducted a quality improvement initiative to explore the use of an evidence-based tool designed to identify patients at risk for violence on selected medical units along with inpatient psychiatry and the emergency department. In addition, the team asked nurses and PCTs to rate this statement: “I feel confident in my ability to identify at risk patients for violence.” The results showed that an equal percentage of 47% strongly agreed or disagreed.
Staff was also asked to rate these two statements:

“I can identify 10 personal safety steps when approaching an aggressive patient.”

“I can identify 10 environmental steps when approaching an aggressive patient.”

The majority of the respondents agreed with those statements. Patients with a score of 5 had 5x greater likelihood of being physically abusive! The results of this pilot project continue to inform discussion and ongoing education and training efforts. Here are some tips developed by the team:

**Personal Safety Interventions**

- Remove hoop earrings
- Remove stethoscope from neck prior to entering room
- Remove neckwear, including lanyards for ID badges, if not break-away
- Remove any loose items on self to prevent strangulation
- Remain aware of your surroundings at all times
- Hair that is shoulder-length or longer should be fastened out of easy reach
- Stay at least three feet away from the patient unless performing a required task
- Use the buddy system when providing care or confronting the patient
- If a buddy is not available, let a staff member know that you are going into the room before entering
- Never turn your back to the patient
- Have an escape plan; don’t allow the patient to move in between you and the door
- Protect peers/other employees from entering the room if the situation is unsafe
- Be aware of your body language (keep arms at waist level and palms facing out)

**Environmental Interventions**

- Remove barriers between patient and door
- Ensure functionality of alarm systems available to staff (bed/chair alarm, phone)
- Inspect the area for objects that could be used as weapons and remove them
- Inspect the area for objects that could be thrown and remove them
- Keep door open at all times
- Keep a clear path from patient to doorway for a quick exit
- Only close the curtain when patient privacy is necessary
- Consider room placement; move patients closer to nurse’s station; turn bed around for increased visibility, provided necessary items can still be accessible
- Decrease stimulation; reduce shadows and bright lights
- Place ‘blue triangle’ magnet outside the patient room

The Unit Council Development Council (UCDC) co-led by Jessica Poetzsch, BSN, RN-BC and Jennifer Woyner, BSN, RN has also remained focused on improving workplace safety for nurses. The team has been discussing and sharing trends in the workplace such as injuries, exposures and needlesticks, with their units at least twice each year for an in depth discussion at staff meetings or unit council meetings. As a result, several units have gained focus on areas for improvement and have begun to implement strategies to reduce injuries and exposures. For example, ATTAIN clinical nurse Emily Morelli, BSN, RN-BC (float pool) has taken this one step further as part of her ATTAIN plan and begun a review of all areas to determine practices and supplies available related to personal protective equipment. Emily plans to identify what may best assist staff with prevention of splashes and improve adherence to the PPE guidelines developed by Infection Prevention experts Katie Benn, MSN, RN and Mary Lee Oleksiw, BSN, RN, CIC (retired) earlier in 2015.
Improvements: Decreasing Mortality with Technology

Sepsis is a potentially life threatening complication of infection. In the summer of 2013, the Rapid Response Review Committee identified opportunities for reducing delays in identifying sepsis. The impetus for Middlesex Hospital to implement a sepsis improvement initiative was a direct result of the commitment to high reliability science and the identification of Serious Safety Events (SSE). An interprofessional sepsis task force, almost 50% nurses and co-led by Terri Savino, MSN, RN, CPHQ (Quality Department) and Maureen Skowronek, RN-BC (North 5) was appointed to review current literature and implement best practices for sepsis care. Evidence-based practice strategies for sepsis improvements included: Revisions of pathways, physician and nursing education on sepsis (including the components of the sepsis bundles) and implementation of an electronic early warning system. The St. Johns Sepsis Tool was implemented to alert providers and nurses that a patient is at risk or has developed sepsis. Additional enhancements that could be automated included a system-generated repeat lactic acid for elevated levels, an alert for the lab to contact the nurse with increasing level, a pathway-generated, weight-based intravenous fluid order, and an alert for the provider to reassess the patient after receiving fluids for septic shock. In addition, a program was initiated to recognize nurses and providers for exceptional care of septic patients. Awareness, education and technology has resulted in a greater number of accurate, timely sepsis diagnoses and treatments. Baseline SSE data, sepsis mortality data, and length of stay (LOS) significantly improved with clinician sepsis education, modifications in our pathway and implementation of an electronic early warning system. In the first year there was a 67% reduction in reported SSE’s, and sepsis mortality was reduced by 21%! Since 2014, there has been a 29% reduction in sepsis LOS and a 49% increase in sepsis diagnosis. The outcomes of this project were reported at the National Institute for Healthcare Improvement Meeting and in the January edition of Hospital Peer Review.

Patients presenting to the Shoreline Medical Center and Marlborough Emergency Department with symptoms of a stroke can now benefit from the implementation of the Telestroke Program. This program provides patients with faster, more efficient and effective treatment and is a direct result of collaboration between nurses, physicians and nurse leaders. The Telestroke Program brings a board-certified expert neurologist to the bedside ‘virtually’ within minutes through the use of technology. This shortens the period of time that many patients would otherwise have to wait in order to get life-saving, clot-destroying medications when indicated. The program also trains clinical nurses to do focused assessments that identify symptoms sooner. Since implementation in November 2015, patients at both sites benefited from successfully receiving treatment as a result of Telestroke.

Workspace Improvements

2015 was a busy year with improvements made to several units to include renovations and technology designed to improve workflow and surroundings for patients and families. From the development of a brand new Observation Care Unit on North 2 to the brand new North 6, and renovated North 7 – there has been no time for the dust to settle anywhere, as renovations continue throughout the organization.

Taking the feedback and experience from the Critical Care Unit implementation process, led by clinical nurses Ashlee Tedford, BSN, RN and Ann Morgan, BSN, RN, of the Raulands call bell system, Nurse Managers Kelly Haeckel, MSN, RN, Dom Biello, MSN, RN-BC and Nancy LaMonica, MSN, MHA, RN, PCCN collaborated with Karen Kohler, MSN, RN (Director Information Systems), their clinical teams and facilities experts to add the integrated call bell system. The system is designed to improve communication between clinicians and among clinicians and patients by sending alerts directly to staff phones. Additional improvements for North 6 include ceiling mounted lifts to support safe patient handling efforts. Renovations on North 7 have allowed for increased safety for patients, families and staff. With all renovations, input from staff has been, and continues to be, an essential element to the process.
Improving Efficiency
The wound center team, under the leadership of Margo Golas, MSN, RN, CPHQ (Quality Manager) has successfully implemented an electronic medical record, greatly improving efficiency and communication for patients and staff. In addition, the team has transitioned their inpatient-based advanced practice clinical nurse Christina Barrows, ANP-BC, WCC, WCCN to the outpatient wound care setting. This has allowed for a more comprehensive approach to caring for patients in the community. Several wound care certified nurses have been cross-trained to provide continued support to the inpatient population allowing more patients to benefit from wound care expertise. Mary Saunders, BSN, RN, WCC provides evidence-based wound care services in all settings: Homecare, the Outpatient Wound and Ostomy Center, and inpatient areas. This service has proven to be a high patient satisfier.

The Interventional Radiology nursing team clinical nurses Anne Burkhart, BSN, RN, PCCN and Karen Harvey, RN led an initiative designed to minimize delays for patients as they undergo various procedures through collaboration with the Radiology Department and outpatient services. The team identified strategies for improving daily processes that will ensure the availability of the right staff at the right time in order to avoid delays in addition to other process improvements. The team also reviewed supplies and processes for emergency situations to ensure maximum preparedness.

Dialysis clinical nurse Mary Jo Logan, RN, CNN and Nurse Manager Josh Kekacs, MSN, RN, CEN improved flow for dialysis patients in the Emergency Department through a thorough re-evaluation of resources, patient care policies and education for staff. The improved processes will allow for a more seamless transition of patients from the Emergency Department with dialysis needs.

Under the leadership of Jill Norton, BSN, RN, CCM, the Case Management team undertook an innovative approach to increasing efficiency in accomplishing their daily work – separating specific functions of their role: utilization review and discharge planning. As a team, they will evaluate the results of this trial and continue to work towards the most effective and efficient care delivery.

The Clinical Informatics team successfully implemented Capacity Management in 2015, a Cerner application designed to improve flow, efficiencies and overall operations. Clinical analyst Shauna Lawson, BSN, RN presented the successes of her team at the October Cerner Conference in Kansas City. After completing our first year with Interdisciplinary Plans of Care (IPOCs), Lauren Boule, MSN, RN-BC, Nancy LaMonica, MSN, MHA, RN, PCCN, along with support from Joan Townley, BSN, RN had the opportunity to share their successes at the Cerner Healthcare Conference last October. Being identified as pioneers, the Middlesex team has been active in mentoring other organizations in their journey to implement IPOCs.

The IV Therapy nurses have trialed and then adjusted their schedules to achieve maximum efficiency as a team. The team has also assumed an active role in identifying opportunities for reducing expenses by evaluating new products using their expertise to determine the best option for their patients. They have already saved approximately $20,000 with one suggestion!
Innovations
Asthma continues to pose a large burden to Connecticut’s patients and families, the health care system, as well as society in general. With a higher than normal prevalence in Connecticut than other regions, it’s a longstanding priority for nurses in the Center for Chronic Care Management. Asthma Care Manager Veronica Mansfield, DNP, APRN, AE-C, CCM has been a collaborating partner with the New England Asthma Innovation Collaborative (NEAIC) since 2012 to develop a new care delivery model of asthma care called “Little AIR Home.” The three-year project was developed to deliver asthma care in the home with the goals to reduce emergency department visits, hospitalizations and missed work and school days for children with asthma living in the community. The program involves a model of care that brings nurses and community health workers into patients’ homes to provide asthma education and management of environmental triggers. This innovative model of providing education at home continues to show promising results, with statistically significant decreases in missed work and school days and an improvement in reported quality of life.

With the guidance and support of Clinical Nurse Leader Jess Gabrielle, MSN, RN-BC, CNL, Assistant Nurse Manager Lindsey Downing, BSN, RN, and Nurse Manager Kelly Haeckel, MSN, RN, the North 6 Unit Council embarked on their CIT (Care Innovation and Transformation) journey in the Spring of 2015. By the end of the year, they had generated a full-page of Tests of Change! After learning how to implement the brainstorming concept, the team quickly put it to use developing many ideas for their soon-to-be-renovated patient care area.

The North 2 Telemetry Unit Council launched their own CIT journey in early 2015. All disciplines were invited to join their monthly meetings in order to brainstorm daily practice challenges and generate their own tests of change. The team presented their successful initiative “Ready, Set, Sit” in September, at the CIT meeting in Florida. Also in the Fall, the team began a pilot focused on patient-centered rounding.

NEW KNOWLEDGE, IMPROVEMENTS AND INNOVATIONS

2015 Tests of Change
TOC CIT North 6

- Introduction to brainstorming concept
- Movement of how might we...move to a more visible location
- Identify the heat source nos
- Remove or transfer beat sheet from necessary to click next of receiving
- CIV Board
- Organizing paperless for more
- Reorganizing the intake
- The man is a new environment
- How to improve the environment
- Always to locate things in “OUR” temporary home going from a larger space to smaller

- What might we like to keep in the brand new unit
- Daily weights
- Combining distribution of mobility sheets now, when and how
- Bed side suction stations
- Mainly charged device
- Preparing for patient flow
- R101 rounds for nurses
- Card PCT (personal care team)
- Nurse buddy system
- Secret Santa
- Rescues (left over activities to redistribute)
- Administration in the interim to get patient information: o Patient name, age, going to room, etc. MD, medication, need for suction, transfer, and RN case location
- Suggest for accessory and action plan to address family member care/touch improved patient satisfaction
- Assessment of chemotherapy (including making sure pyogenic value sheet in order)
- Standardize PCT start in/on each shift
- Identify documentation project
- Standardized bed weight scale sheet (moving into the bed in every month)
- Toiletries chart form (moved to clean utility carts)
- Ideas among us recognizing staff for accomplishments and great care
- ERTH Day
EXEMPLARY PROFESSIONAL PRACTICE
Care THAT Makes a Difference – For Patients and Families
Chaired by Judi Satagaj, RN, the Critical Care Unit Council has implemented strategies in order to recognize veterans on their unit. The staff provide bereavement kits for the families of patients that are terminally extubated or pass unexpectedly. Posters are placed throughout the unit to encourage patients to self-identify as veterans. Once identified, they are given a card, an American flag pin and flag placed outside their door. The CCU staff is actively collaborating with informatics specialists to include military status in the EMR so all staff have a mechanism of identifying veterans.

OPS/PACU Clinical Nurse Laura Graham, BSN, RN, CAPA collaborated with the Patient and Family Education Committee to develop an official professionally printed hand out. The purpose of the handout is to better inform visitors about what to expect when they visit their loved ones after surgery.

Enhancing Professional Peer Review
Clinical nurses on North 2 developed their own process for enhancing peer review on their unit. Unit council chairs Kelsey Mansfield, BSN, RN and Renee Antonio, BSN, RN surveyed their peers for input to be used to revise the current process to be more interactive and to promote accountability. The team then developed a shared document for tracking the process and to identify pairs-matching peers to one another. Through quarterly meetings, nurses provide each other with valuable feedback about their practice and the attainment of their goals. The document serves to demonstrate that feedback is shared with one another while keeping the content between clinical nurses, but still meeting the annual requirements for performance evaluation. Each nurse has one goal that pertains to the unit’s strategic plan goals and one that is related to individual professional development goals. Each nurse has the opportunity to consider the feedback for their self-evaluation as evidence of the process being effective, or its reflected on their shared document.

Interprofessional Care: GOT CARE
Led by Millicent Malcolm, DNP, GNP-BC (Nurse Practitioner Primary Care), GOT Care! is an innovative collaborative project improving outcomes for geriatric patients in our community. This project, propelled with national grant funding, brings together a team of clinical geriatric faculty experts and students from the disciplines of nursing, medicine, dental medicine, pharmacy, physical therapy, social work, and public health, to work collaboratively with Middlesex Hospital. A collaboration between Middlesex Hospital Homecare and the University of Connecticut School of Nursing, this comprehensive program provides interactive training for all students on cultural competence, interprofessional collaborative practice (IPCP), evidence-based geriatric care, and focused care for veterans within the traditional health care system. The trained faculty and students form a highly effective and efficient IPCP team, poised to improve outcomes for identified community-dwelling vulnerable older adults with multiple chronic conditions and high emergency department use. Once trained, the IPCP faculty and student team participates in weekly outreach visits to identified vulnerable older adults for in-home IPCP Comprehensive Geriatric Assessment. The team employs IPCP competencies for mutual respect, effective communication, shared problem solving and healthcare coordination. Under the leadership of the nurse, the team provides recommendations to the patient’s primary care provider to reduce risks for hospitalization and institutionalization such as fall risk and prevention, polypharmacy and prescribing issues, cognitive and mental health concerns, physical and functional challenges, and unmet psychosocial needs. An essential feature of this initiative is the development and implementation of an autonomous role for the project’s Geriatric Outreach Nurse Navigator Patricia Coe, BSN, RN, a Homecare clinical nurse, who directs and leads the intervention and provides ongoing care-coordination and support for the patient and project. The IPCP education and practice experiences provided by this initiative are designed to improve several outcomes for local geriatric care, IPCP, and geriatric workforce development.
Interprofessional Care: ERAS
The nurses on North 5 and the entire interprofessional team have implemented ERAS, the Enhanced Recovery after Surgery initiative. Designed for postoperative colorectal patients, ERAS is a multifaceted and evidence-based program designed to improve patient outcomes by reducing length of stay, and incidence of complications, while increasing patient satisfaction. Patricia Ahlquist, RN (Quality Department), Lynne Dakers, MSN, RN-BC, CGRN, Patty Marteka, BSN, RN-BC, CBN and Lynn Jansky, MSN, RN-BC have all had instrumental roles in supporting nurses through this change. Starting in June, the team received several continuing education programs, training days alongside our statewide colleagues and several meetings as an interprofessional team to determine implementation plans. The first patient to undergo colorectal surgery following the ERAS protocol took place in September 2015. The team continues to refine the delivery of care through pathways and nursing documentation for these patients and optimizing their outcomes. ERAS includes strategies for all phases during the process of patients undergoing colorectal surgery: preoperative (risk evaluation, patient education and engagement, fasting of only solid foods), intraoperative (fluid and pain management strategies) and postoperative (early mobilization and feeding, opioid sparing strategies for pain management).

Total Joint Center
Did you know that Middlesex Hospital is one of only nine hospitals in Connecticut to achieve disease specific certification as a Total Joint Center? Since earning this distinction in 2014, an interprofessional team of experts including the clinical nurses on South 6 Orthopedics and Nurse Navigator Tracy Andrulat, BS, RN, ONC have continued to demonstrate their ability to deliver high-quality patient care. With the use of evidence based guidelines, high reliability and protocols in place, the team continues to enhance the patient experience and deliver the best possible care. Lots of news to report for 2015:

- Close to 500 patients received joint replacements in 2015, benefiting from the multifaceted program in place
- Utilizing a patient-centered approach, the team uses resources such as the newly established role of Pain Management Coordinator Gail Mancuso BS, RN-BC, ONC and multidisciplinary rounds to ensure patient needs are met during their stay. Prior to surgery, patients are given educational resources in their doctors office, invited to attend an informational class taught by an orthopedic clinical nurse as well as a visit with the APRN in the PEAC clinic
- Tracy began leading the effort to examine their functional outcomes several months after discharge to determine opportunities for improvements through collaboration with Betty Molle, MS, MSN, RN-BC and the Interprofessional Research Council
- Patients began benefiting from a new, evidence-based technology to deliver pain medication, the OnQ Pump, group physical therapy and more time with an occupational therapist on a daily basis
- Patients are at least sitting up ‘dangling’ on day of surgery and many are out of bed!
- Most importantly, several patient outcomes, including infections, are trending in a very positive direction!
Supporting Patients Across the Continuum

Classes offered by the **Cardiac Rehabilitation team** provide an essential element of support to patients, as they work towards meeting their rehabilitation goals: encouragement from each other. In addition, the team is always seeking to improve their practice and recently welcomed a graduate student focused on exercise physiology. Danielle (pictured) provided some great recommendations to the team that enhance patients’ abilities to succeed with their program. To celebrate graduation for patients completing their rehabilitation journey, patients receive signed, heart-shaped pillows and wear gowns to highlight and recognize patients for their achievements in the program!

![Left to right: Mary Mesek, BSN, RN-BC; Laurie Hill, BSN, RN, BC; Cari Noti, BSN, RN, CEN; Terri Dipietro MBA OTR/L and Danielle Watters, UCONN Student in Exercise Science](image)

Homecare supervisors, **Nicholle Boles, BSN, RN** and **Alice Jain, BSN, RN, WCWN** work collaboratively to follow patients through the health system by attending the Frequent Admission Inpatient Reduction Committee (FAIR) committee meetings and working with inpatient team members to individualize care plans to optimize care that keeps patients in their homes and reduces readmissions.

![Improving Patient Safety: Infection Prevention](image)

**South 4** staff has been diligently working on improving handwashing compliance through an innovative approach to using technology. The GOJO system electronically monitors the percentage of time that staff wash their hands through the use of sensors placed on the unit near sinks and sanitizer dispensers. Their efforts are paying off as they move closer and closer to their goal. Stay tuned for more updates on handwashing improvements as GOJO comes to more departments soon!

![The housewide CAUTI prevention team co-chaired by Jodi Parisi, MT, CIC (Infection Prevention Manager) and Kate Schultz, BSN, RN-BC (North 4 Clinical Nurse) successfully met their 2015 goal of less than 2 CAUTIs per quarter. They exceeded this goal in the last two quarters with just two CAUTIs over six months. Joining forces with the Critical Care Unit CAUTI prevention committee led by Michelle Pallas, BSN, RN PCCN, the housewide committee employed several strategies to impact rates across all units. Aside from learning from the successes and innovations from the Critical Care Team, committee members worked with vendors to assist with clinical observations to identify areas for improvements of insertion technique and advocated for equipment and supplies such as securement devices and kits](image)
designed to support the prevention of infections. Calculations used to determine reimbursement by CMS demonstrated that CAUTIs at Middlesex were improved significantly, by as much as 67%! Middlesex is also ahead of its CT peers for both CAUTI and device utilization:

<table>
<thead>
<tr>
<th>FY 2015</th>
<th>CAUTI rate</th>
<th>Device utilization</th>
</tr>
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<tbody>
<tr>
<td>MH</td>
<td>1.28</td>
<td>0.14</td>
</tr>
<tr>
<td>CT</td>
<td>1.56</td>
<td>0.22</td>
</tr>
</tbody>
</table>

Great work by this team!

An interprofessional task force comprised of Rebecca Burrell MS, CCC/SLP (Rehabilitation Supervisor), Betty Molle, MS, MSN, RN-BC (Research and Outcomes Specialist), Larissa Morgenthau, MSN, RN-BC (Center for Professional Development) and Kelly Nicholson, MS, MPH, RN-BC devised a plan to re-energize the I-COUGH Campaign in order to reduce hospital (non-ventilator associated) acquired pneumonia. The campaign involved two approaches: the first involving clinical nurses in various areas participated in simulated exercises to experience what patients feel with pneumonia and the second is a creative video designed to remind clinical nurses about the essential elements of pneumonia prevention.

**Improving Patient Safety through Handoff**

Operating Room clinical nurses Kathy Hickey, BSN, RN, CNOR, Mary Ballachino, RN, CNOR collaborated with Outpatient Services clinical nurses Wendy Elia, BSN, RN, CAPA and Kim Lee, RN, CAPA to develop a form for handoff between the preoperative nurses and the operating room nurses.

Based on the results of the 2014 Safety Culture Survey, it was determined that handoffs between patient care areas rated lowest. An organization-level task force was co-chaired by Jackie Calamari, MSN, MS, NEA-BC, CEN (Vice President for Patient Care Services/CNO) and Jesse Wagner MD SFHM (Vice President Quality and Safety) to standardize the handoff process. Meeting weekly for a year, the committee reviewed pre- and post-survey responses from staff to develop an online, standardized nursing handoff tool entitled CHAIN. Several nurses participated in this patient safety initiative: Josh Kekacs, MSN, RN, CEN (Nurse Manager, Emergency Department). Jennifer Caveland, BSN, RN (Clinical Nurse, Observation Unit), Cathy Powers, MSN, RN (Director, Inpatient Units and Critical Care), Claire Davis, MSN, RN, CPHQ (Director, Quality Department), Judi Satagaj, RN (Clinical Nurse, Critical Care Unit), Lynne Dakers, MSN, RN-BC (Nurse Manager, North 5), and Kayleigh Phillips, BSN, RN (Clinical Nurse Orthopedics).

**Maintain the CHAIN of Care for Patients**

Provide a complete report to inpatient staff

<table>
<thead>
<tr>
<th>C</th>
<th>Chief Complaint</th>
<th>Name</th>
<th>Sex, Age</th>
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<tbody>
<tr>
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<td>History</td>
<td>Events leading to admission/transfer</td>
<td>Relevant medical history</td>
<td>Allergies</td>
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<tr>
<td>A</td>
<td>Assessment</td>
<td>LOC/Orientation</td>
<td>Assessment Variances</td>
<td>Ex: Alterations in vital signs, head to toe assessment, skin integrity, significant test results</td>
</tr>
<tr>
<td>I</td>
<td>Interventions</td>
<td>Care/treatments provided</td>
<td>-Abx, medications ***confirm Med History/eMar is complete</td>
<td>-I/O’s</td>
</tr>
<tr>
<td>N</td>
<td>Needs</td>
<td>Isolation status</td>
<td>Pending medications</td>
<td>Pending tests</td>
</tr>
</tbody>
</table>

**Reducing Readmissions: Through Securing Discharge Appointments**

Assistant Nurse Managers Lindsey Downing, BSN, RN and Renee Hastings, BSN, RN-BC collaborated with Quality Improvement Project Manager Buffi DePierro to utilize a LEAN approach in improving processes that ensure patients on North 4 and North 6 have post-discharge follow-up appointments with their physicians. An important component to reducing readmissions, post-discharge appointments can provide patients with the link to meeting critical needs after hospitalization. These appointments ensure a safer transition to the community and provide...
much-needed follow-up care. Prior to this initiative, the organization lacked a standardized and consistent process for scheduling follow-up appointments. Patients lacking timely follow with their physician are as much as ten times more likely to be readmitted. Before the project started, less than 50% of patients discharged to home had follow-up appointments. The objectives included arranging appointments for patients prior to their discharge and, as a result, the team was successful in meeting their goal of 95%.

Reducing Readmissions: Through Our Community of Care

Middlesex Hospital developed a “Community of Care” (CCT) in February of 2010 to reduce Hospital readmissions for patients with a diagnosis in heart failure. Led by Terri Savino, MSN, RN, CPHQ (Core Measures Specialist) Middlesex Hospital began collaborating with three local skilled nursing facilities and two home care agencies. Currently called TIME to ACT (Transitions into Medical Excellence All Communities Together), this group meets monthly with 54 community partners working to improve care transitions for all of our patients. Our community consists of skilled nursing facilities, homecare agencies, assisted living and long-term care facilities, pharmacies, and physician offices, among several other settings.

The meetings focus on improving care transitions across the continuum; discussing patients who are readmitted and possible opportunities for improving care transitions and educating members. Patient educational material is shared so that the patients and families are taught with the same materials and tools across the continuum. In 2015, a subcommittee of the Community of Care was developed to take a closer look at fall prevention across the continuum, entitled the Frailty Task Force. Additional members include: Patty Marteka, BSN, RN-BC, CBN, Tracy Andrulat, BS, RN, ONC and Jill Norton, BSN, RN, CCM. Several improvements are a direct result of feedback and collaboration with our skilled nursing facility and home care agencies such as RN-to-RN report from Hospital to SNF, improvements of fluid management, improvements in mobility and patient education “zones.” Our team continues to be recognized by Qualidigm as one of the best collaborative Community of Cares in the state!

Reducing Readmissions: Through Collaboration Across the Continuum

Homecare clinical nurse Trish Coe, BSN, RN and Outpatient Behavioral Health Director Terri DiPietro MBA OTR/L began discussion in mid-2015 about the need to collaborate on shared patients between the outpatient psychiatric programs and Homecare services. In April 2015, the CBH-HC Interprofessional Practice team had their first monthly meeting with the goal of improving access and coordination of care in order to reduce hospitalizations for their shared patient population. This team includes several expert clinicians including clinical nurses Trish Coe, BSN, RN (Homecare Clinical Nurse), Renee Lajoie, BSN, RN (Homecare Clinical Nurse) and Jill Nagy, BSN, RN (Manager Community Behavioral Health).
Taking Feedback to Heart: Improving Mobility Outcomes

The Community of Care Team, comprised of representatives from Middlesex Hospital and our community of care partners reported a trend of deconditioning and functional decline experienced by patients after being discharged. To address this community problem, the nurse residents led by Nurse Residency Program and Professional Development Specialist Lauren Boule, MSN, RN-BC went to the literature in order to develop a mobility guideline. To collect preliminary data, North 6 RN and PCT medical/surgical staff was surveyed regarding their current mobility practices and a baseline level of mobility was tracked for one week. Driven by the baseline survey results and the Bedside Mobility Assessment Tool, an ambulation guideline was designed to help staff assess the patient’s baseline mobility status, develop a plan for safe ambulation, and reassess mobility status throughout the patient’s stay. A one-month pilot study was conducted on a medical/surgical unit, using the PDSA quality improvement model. The goal of the study was to ambulate the patient three times per day and assist the patient to a chair for all meals. Prior to the pilot study, 17% of N6 patients ambulated during their Hospital stay. During the pilot, 60% of the patients successfully ambulated three times per day in the hallway. At baseline, 43% of patients were out of bed for meals, but with the advent of the pilot, 59% of patients sat in a chair during mealtime. The project has identified the need to improve activity orders, improve documentation to capture patients mobility, and promote additional education on “safe moves” equipment for direct care staff. The project is currently being worked on by the Safe Patient Handling Committee and the North 6 CIT Team, in order to ensure implementation across the organization. The North 6 team has embraced this initiative and even presented their successes in a poster presentation at a CIT meeting in Florida.

EMPIRICAL OUTCOMES

Left to right: Carol Drag, BSN, RN (Clinical Nurse North 6), Jess Gabriele, MSN, RN-BC, CNL (Clinical Nurse Leader), Jennifer Woyner, BSN, RN (Clinical Nurse North 6), Jenna Pitruzzello, BSN, RN (Clinical Nurse North 6), Kelly Haeckel, MSN, RN (Nurse Manager North 4 and North 6)
**Center for Chronic Care: Expanding their Reach**

Nurses at the Center for Chronic Care Management (CCCM) launched their newest program targeting patients with Chronic Obstructive Pulmonary Disease (COPD). This marks the sixth patient population for which the team provides care, in addition to diabetes, congestive heart failure, asthma, smoking cessation and Fit for Kids. This program, overseen by Veronica Mansfield, DNP, APRN, AE-C, CCM and Beth Finn, BSN, RN, will reach another vulnerable population in our community as well as assist in responding to the recently enacted readmission penalty tied to this disease state. CCCM embraced the chance to become the Middlesex Health System-wide COPD champions with the goal of reducing COPD 30-day readmissions.

The COPD inpatient program launched in January of 2015 by offering bedside consultation and promoting safer discharges by providing "survival skills" training to patients at the bedside before their transition from one care setting to another. To supplement this program, outpatient COPD patient visits became available at CCCM at all three sites for additional follow-up care and education.

CCCM has worked diligently to develop the concept of “wrap-around care” for these patients. This can be described as identifying extra care that assists with meeting needs that potentially will reduce future readmissions by helping to manage signs and symptoms at home or other non-hospital settings. Strategies developed include:

- Implementing the Homecare telemonitoring program for a full 60 days
- Applying criteria for referral to the frequent admissions inpatient review (FAIR) and/or the Community of Care Team (CCT) committees
- Collaboration with the outpatient behavioral health team for patients with behavioral health comorbidities where appropriate
- Collaboration with outpatient pulmonary rehab and smoking cessation experts where appropriate
- Implementing disease management focused care calls for live support when needed

The team looks forward to demonstrating improved outcomes for this vulnerable population.
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<tr>
<th>Name</th>
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<tr>
<td>Jennifer Ackerman</td>
<td>MSN, RN-OB</td>
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<td>Cindy Adams</td>
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<td>Paula Agogliati</td>
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<td>Patricia Ahlquist</td>
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<td>Kathleen Alexander</td>
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<td>Jill Frey</td>
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<td>Renee Frost</td>
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SELECTED PRESENTATIONS & PUBLICATIONS

Presentations - Podium

Shauna Lawson BSN RN (Clinical Informatics)
October; Missouri

Lauren Boule MSN RN-BC (Center for Professional Development), Nancy LaMonica MSN MHA RN PCN (Nurse Manager Observation Unit) and Joan Townley BSN RN CCRN (Clinical Informatics)
“IPOC Implementation and Lessons Learned” at the Cerner Conference.
October; Missouri

Lauren Boule MSN RN-BC (Center for Professional Development) & Nurse Residents (Shannon Brown BSN RN; Maura Calamari BSN RN; Jennifer Cleaveland BSN RN; Kaela Dolezel BSN RN; Ryan Hunt BSN RN; Elizabeth Minikowski BSN RN; Rebecca Palmer BSN RN; Jenna Piruzzello BSN RN; Megan Sirag BSN RN; Stephanie Swanson BSN RN)
“Don’t Wait, Ambulate!” at the 19th Annual Evidence-Based Practice Conference.
October; Connecticut

Camille Servodidio MPH, RN, OCN, CBCN, CCRP (Clinical Manager, Cancer Center), Susanna Hong MD (Hematology/Oncology), Andrea Malon MD (General Surgery) and Kathleen Gould-Mitchell RHIA CTR(Cancer Center)
“Compliance of Bone Density Testing for Patients Who are Prescribed Aromatase Inhibitors in One Private Practice” at the 19th Annual Evidence-Based Practice Conference.
October; Connecticut

Judy Bahr MSN RN-BC CIC (Center for Professional Development)
“A Community of Hospitals Coming Together to Make a Difference in the Care of their Older Adult Patients,” at the NICHE Conference.
April; Florida

Gean Brown MSN RN OCN (Cancer Center)
“The Role of the Oncology Nurse in Lung Cancer Screening,” at the 40th annual Oncology Nursing Society Congress.
April; Florida

Presentations - Poster

Cheryl Mohrlein MSN RN OCN NE-BC (Nurse Manager South 4 & Outpatient Infusion) and Judy Bahr MSN RN-BC CIC (Center for Professional Development)
“United We Stand, Divided We Fall - How Through Interdepartmental Collaboration One Hospital Decreased Falls by 43% in Two Years,” winning third place at the 19th Annual Evidence-Based Practice Conference.
October; Connecticut

Betty Molle MS RN BC and Kelly Nicholson MS MPH RN BC
“Psychometric Testing of the Decision Aid for Palliative Care Referral Instrument” at the Eastern Nursing Research Society Meeting.
April; Washington DC

Nancy LaMonica MSN MHA RN PCN (Nurse Manager Observation Unit); Melanie Cama MSN, RN, CHPCA (Hospice and Palliative Care Program Director); Nancy Dennehy BSN MHA RN-BC (Nurse Manager South 6 Orthopedics); Pamela Duncan BSN RN-BC (Outpatient Behavioral Health); Amanda McDonald BSN RNC (Nurse Manager Pregnancy and Birth); Cheryl Mohrlein MSN RN OCN NE-BC (Nurse Manager South 4 and Outpatient Infusion); Karen Norton BSN RN CAPA (Nurse Manager OPS/PACU); Deborah Potticary BSN RN CHPN (Palliative Care Coordinator)
“How Did You Overcome Horizontal Violence in the Workplace?” ONS Connect News Magazine - Another Perspective, June 2015

Justin Drew BSN RN-BC (Homecare Clinical Director) and Judy Bahr MSN RN-BC CIC (Center for Professional Development)
“Employing Innovative VOIP Technology to Connect Families with Their Loved Ones” NICHE Network News, April 2015

Betty Molle MS RN BC and Mary Allegra MSN RN-BC
“Behavioral Characteristics of Staff Approaching Aggressive Patients: an Interprofessional Study” at the Eastern Nursing Research Society Meeting.
April; Washington DC

Publications

Nancy LaMonica MSN MHA RN PCN (Nurse Manager Observation Unit); Melanie Cama MSN, RN, CHPCA (Hospice and Palliative Care Program Director); Nancy Dennehy BSN MHA RN-BC (Nurse Manager South 6 Orthopedics); Pamela Duncan BSN RN-BC (Outpatient Behavioral Health); Amanda McDonald BSN RNC (Nurse Manager Pregnancy and Birth); Cheryl Mohrlein MSN RN OCN NE-BC (Nurse Manager South 4 and Outpatient Infusion); Karen Norton BSN RN CAPA (Nurse Manager OPS/PACU); Deborah Potticary BSN RN CHPN (Palliative Care Coordinator)
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“Employing Innovative VOIP Technology to Connect Families with Their Loved Ones” NICHE Network News, April 2015

Gean Brown MSN RN OCN (Cancer Center) Megin Iacarino
BSN RN OCN (Nurse Navigator Cancer Center)
“Low-Dose CT Lung Cancer Screening” Nurse Navigator, January 2015
### New Degrees in 2015

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<td>Nicole Amato</td>
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<td>Renee Antonio</td>
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<td>Meredith Belden</td>
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<td>Katie Benn</td>
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<td>Stephanie German</td>
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<td>Phillip Hawley</td>
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<td>Robin Zemienieski</td>
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As we continue to learn and improve our practices, I’d like to share another amazing story... At 3 p.m., a call was received that a 24-weeker was coming to our unit in pain. The Pregnancy & Birth Center team quickly prepared a room for the patient, as she had a history of a prior C-section. The patient walked in and was quickly placed into a wheelchair and taken to her room for evaluation by the physician, and immediate action by the nursing team. She was an insulin-dependent diabetic with her own automatic insulin pump. The team conducted a bedside ultrasound, evaluated her cervix, placed IV access, drew labs and obtained a blood glucose. The patient reported having a previous 32-week emergency delivery where she had a similar headache and subsequent seizure. Her actual due date reflected a 22 and a half week pregnancy. As the RN was giving pain medication, the patient began experiencing dizziness and a worsening headache. The head of her bed was lowered and she was placed on oxygen for added comfort. Shortly thereafter, she began to seize and the nurses immediately turned her on her side to protect her airway, pressed the emergency bell, and called a RRT. Lots of support arrived, including the supervisor! The nurses kept the patient safe during the seizure, while constantly reassuring her that she wasn’t alone. Two nurses stood by the patient, one RN on each side, both consoling her. Between the seizures, I asked her if I could contact her family. She gave me her cell phone, that was hidden and tucked into her bra. I was able to call her sister and ask her to come to the Hospital immediately. She also was able to show the RNs how her insulin pump continuously reports her blood sugars. The physicians were working on collaborating with others at a higher-level facility for her transfer. She continued to seize a total of three times. Each time, she was given more medications. She was prepared for transport to another hospital. Staff maintained her airway the entire time and her vital signs were stable while transport was arranged. In between seizures, the patient would be responsive to stimuli. She opened her eyes and said, “I want to stay here with you.” The same two nurses stood by her side the entire time. She was comforted by our presence. Her family was notified and they were able to see her just before she was transported. The entire team worked flawlessly together. I couldn’t be more proud of the quality of care this patient received. I was thankful that she was on our unit. The nursing care of the patient was rooted in compassion. A relationship with the patient was built in a very short period of time. Our care delivery was efficient and effective. As the patient had no history here at this Hospital, the physicians had excellent collaboration with the other hospital to which she was being transferred. Our physicians were extremely supportive and remained at the bedside until the patients was transported. Our management was also present and available for additional support. Reflecting on this event, I appreciate the importance of standing by one another. I am proud of the professional nursing practice at Middlesex Hospital’s Pregnancy & Birth Center. We stand by each other for support in these difficult situations. We remember to always stand by our patients and give them the reassurance they need at the most vulnerable times in their lives. We make a difference and impact lives every day!

— Melissa Revicki, MSN, RN-C
As nurses, we are aware of the ever-changing climate in health care. We all face overwhelming peripheral challenges — computer documentation, changes in technology, budgetary constraints, working short staffed — to name a few. One thing that remains consistent is that patients and caregivers are human beings, and every human being needs to be acknowledged, accepted, understood, and nurtured, especially when they are not well. Recently, I brought a patient with a laceration to her hand into the Emergency Department. I will call her Heather. She was chatting a mile a minute about her anaphylactic reaction to latex and said she very concerned regarding a latex-free environment. I assured her that our environment is latex-free, but she was going on about the EPI pen that she carries and how frightening her anaphylactic reaction had been. I said “Are you a nurse?” “Yes” she replied. I made her comfortable on the bed, checked her lacerated hand, obtained vital signs; making small talk, Heather was calming down. I asked her where she worked. She replied “Hospice.” I am not sure how it happened, but we started talking about our experiences as nurses and sharing stories, each saying to each other that we would never be able to switch roles. Heather told me that she views her role as a Hospice nurse as a privilege. She said “I am given a small window in time to make a difference. We enter a patient’s, family and friends’ lives at a very crucial time. After this experience, they do not want to see us again, but perhaps we have said or done something to make a difference. It is such a small window in time.”

I shared with Heather that my brother, Tim, age 44, died in Hospice in 2005. I told her that the nurses working there are angels. They are so intuitive; they know what to say, when to say it, and when to remain silent and present in the moment. I said “One day I stepped outside of Tim’s room and totally fell apart. A nurse came over to me and said “It is very difficult to be the sibling.” I melted into her arms. The nurse acknowledged my pain and I will never forget that moment.” Heather went on to say “I have to tell you that when caring for dying children, they all say similar things. “Mommy’s eyes are all red and she is so sad. Please tell her that I am fine. A man came to see me and told me that everything will be fine.” Heather shared one more story. “I was caring for a patient who had been catatonic since the death of his son. One day he clearly said, “I have to go with Kevin.” The patient’s sister told me “Kevin is his son who died.” Heather and I both agreed that our paths were meant to cross on that particular day. In discussing end-of-life experiences with Heather, we agreed that changing the negative, harsh “Do Not Resuscitate” to “Allow Natural Death” aligns much more appropriately with the peace, quiet, and gentleness that accompanies the final moments.

— Sally Marzi, RN, CEN

A 67-year-old gentleman was admitted to Middlesex Hospital Homecare following an admission for COPD exacerbation, new onset diabetes mellitus, and non-obstructive CAD. The patient was a retired contractor and lived in the home he built with his wife. His COPD was end stage and he was sent home on continuous oxygen therapy, multiple medications, and diet restrictions. Nursing and therapy services were initiated and a referral was made for telemonitoring to assist the patient with symptom management. The patient would become very short of breath with any activity and had severe anxiety related to his chronic lung disease. The Homecare team immediately put a plan in place that included multiple visits each week by nursing and occupational therapy to assist
with daily exercises that would improve endurance and control breathing. Nursing worked with the patient and his spouse to create a diabetes management plan that including a shopping list, daily food tracker, and meal planner. A diabetes dietitian visited the patient and provided additional education and assistance. The telemonitoring team contacted the patient daily to discuss symptom complaints, reinforce symptom management strategies, review steroid dosing, and contact the physician when needed. The phone conversations alleviated the patient's anxiety and provided the opportunity for teach back. By the end of the skilled episode, the patient was able to verbalize the strategies he used to alleviate his symptoms and improve his "daily numbers," including using a red balloon to relieve dyspnea and strengthen his lungs. The patient was transitioned to the COPD telehealth program after nursing and therapy were completed. The patient completed the program without readmission to the Hospital, and continues to live the rest of his days in his own home. The Homecare team worked tirelessly to establish a strong relationship based on trust, respect, and autonomy. The patient and his spouse were active participants in the entire care process and this was evident by their ability to prepare diabetic meals, interpret blood glucose results, manage daily medications, and recognize respiratory symptoms that required action. The team used their skill and expertise to create an individualized plan that empowered the patient to care for himself at home. The common goal for this patient was to remain in his home safely and comfortably surrounded by his family for the rest of his days. The Homecare team uses creativity and critical thinking every day to reach patients and improve health in our community. There are so many challenges and barriers in our patients lives. I am proud to be part of this team!

— Allison Giove, RN

4 Telehealth is a greatly underappreciated and unrecognized service by those making payor decisions. Currently, Telehealth is a non-billable service. An additional and often unrecognized benefit of Telehealth is the potential it holds to reduce re-hospitalizations. We are paving the road towards future reimbursement by our constant showcasing of the value that telehealth brings to health care. I have worked in Homecare for the past seven years in the Telehealth Department. When I tell people where I work now, they say, “What is telehealth?” Telehealth is the use of technology to remotely deliver health care and health care information. I have what you might call a “desk job.” I interpret transmitted data from our patients and call our patients to discuss their vital signs transmission, as well as any other concerns they may have at the time. But telehealth is much more than that. I may not necessarily physically connect with our patients, but my relationships are multifaceted, I connect with them on a much deeper level. A patient spends an average of 60 days on this service and, on occasion, I may be the only contact to the outside world for that patient, for that day. My call lessens their feelings of isolation, They look forward to hearing from me, and some share personal stories and interests. One example was a patient who enjoyed watching the Boston Red Sox. I too, am a fan of this team. When I would call him to discuss his vitals, we would also discuss the previous day’s game. Even after being discharged, he would call into Telehealth to provide me with any Boston Red Sox updates. Patients learn to respect our telehealth team and nursing judgement. The ultimate goal for Homecare is to empower the patient to manage and be accountable for their own health issues. We are advocates for them while they are on service. We connect them to supportive services as needed in collaboration with other members of the health system. We find out through daily conversations that they may not be managing their insulin correctly, or overdosing on diuretics. We suggest to their case manager that they refer the patient for further education from additional resources or their physician.
One of our telehealth patients has been on service for over a year. She was first seen by the Homecare staff and was referred to telehealth for additional symptom management. When the discharge process began, she decided to transition to a private pay for telehealth because she felt that she was still too ill and not ready to take total control of her health care needs. Her spouse at the time was in a nursing home and was terminal. It was difficult at first to make a connection with this patient; she was always hurried and never returned any of our calls. In time, we learned that she was going for daily visits to the nursing home to see her spouse. They were married over 50 years, and he eventually passed away in hospice care. The patient was grieving, and she has other family members, but did not want to be a burden to them. Telehealth become her support. We are a constant reminder to her that there is an outside entity with unconditional benefits. We are compassionate, respectful and empowering her to safely manage her own health care. Currently, she is slowly weaning off the telemonitor. The patient sends transmissions three to four times a week now, instead of every day. We are her remote support system and a very important part of her life. There are not many days when we don’t speak to her about a health concern, doctor’s appointment or the occasional episode of Dancing with the Stars. I know when I hang up that she is smiling and so am I. So yes, I have a desk job and I love it and in some ways, it is more rewarding than all the years I spent as a bedside nurse.

— Sue Carmichael, RN

Care That Makes A Difference — During my first few days of orientation on the floor, I had a 24-year-old female patient who had been suffering from multiple health issues, including Crohn’s disease, Lyme disease, multiple sclerosis, electrolyte imbalances, and alcohol and drug abuse. This patient was being admitted this time around to have her appendix removed. Upon having a casual conversation with her during my shift assessment and asking her about other aspects of her life not related to her medical illnesses, my preceptor and I determined that this patient could possibly have an undiagnosed psychological disorder. We decided that it definitely was not safe to discharge her back to her home, as it was found out she was being physically and mentally abused by her boyfriend at the time. My preceptor and I notified other members of the interdisciplinary team that had shared governance for this patient. The patient was diagnosed with severe depression and anxiety. We were able to accomplish getting the right consults and treatments for this patient, which greatly improved her outcome. Through collaboration with our discharge planner, we were able to ensure that this young lady had a safe place to be discharged to and that all of the proper follow-up appointments were put into place. In nursing practice, especially at Middlesex Hospital, we deliver nursing care to our patients that goes beyond just their medical diagnoses. Listening to our patients and advocating for them is something you see here at Middlesex everyday. This patient previously received care at another hospital in the area, and she stated that the nursing care she received at Middlesex was much different. She felt that she had been heard and respected, not judged as she was at the previous hospital. She stated that for once, she felt better coming out of the hospital than she did going in.

— Brandon Kulak, BSN, RN
Special thanks to the Middlesex Hospital Medical Staff for sponsoring this year’s Nursing Annual Report.