TL8 – The CNO uses various methods to communicate, be visible, and be accessible to nurses throughout the organization.

Example A: Provide one example, with supporting evidence, of communication between the clinical nurse(s) and the CNO that led to a change in the nurse practice environment.

Clinical Nurse Communication

The Chief Nursing Executive (CNE) Advisory Committee was developed by Laurie Round, MS, BSN, RN, NEA-BC, Advocate BroMenn Medical Center’s (ABMC) Vice President of Patient Services and CNE, in an effort to establish a forum that not only allowed, but fostered, communication between clinical nurses and herself. Laurie encourages clinical nurses to attend and present questions or concerns that pertain to current nursing practice and the nurse practice environment. During the CNE Advisory Committee meetings, Laurie takes notes of current questions/concerns and personally tends to items she feels warrant follow-up.

At the CNE Advisory Committee meeting on May 7, 2015, the clinical nurses shared their concerns for patient safety, as clinically unstable patients had been admitted to inpatient beds as direct admissions, resulting in the need for rapid response team assistance (Exhibit TL8.A.1 CNE Advisory minutes). The following nurses attended this CNE Advisory Committee meeting:

- Angie Schoon, MSN, RN-BC, Nurse Clinician II, Invasive Cardiology (clinical nurse)
- Scott Farquhar, RN, Nurse Clinician III-Float, Clinical Resource Unit (clinical nurse)
- Kristin Remmers, BSN, RN, Nurse Clinician III, Medical Oncology Specialty Unit (clinical nurse)
- Sharon Strait, RN, Nurse Clinician II, Operating Room (clinical nurse)
- Lisa Gossmeyer, BSN, RN, Quality Care Coordinator, Quality Resource Management
- Jen Kjeldgaard, RN, Charge Nurse, Critical Care/Cardiovascular Care Units (clinical nurse)
- Stephanie Fuller, BSN, RN, Nurse Clinician II, Intensive Care Unit (clinical nurse)
- Rebekah Lavicka, BSN, RN, CHFN, Heart Failure Nurse, Cardiovascular Service Line
- Ra’Net Bye, BSN, RN, Charge Nurse, Same Day Services (clinical nurse)
- Hallie Cook, BSN, RN, Charge Nurse, Pediatrics/Outpatient Infusion (clinical nurse)
- Ma Benirose McNaught, BSN, RN, Nurse Clinician III, PCU (clinical nurse)
The clinical nurses requested that the direct admission policy include some exclusion criteria for utilizing the direct admission process. The nurses felt the current direct admission process contradicted the Advocate Health Care System’s Be Safe Behaviors and Behaviors of Excellence. The process in place allowed patients to be directly admitted to an area that could not provide the level of care required, which contradicted the Behaviors of Excellence “Be Safe” and “Be Collaborative.” The process also challenged the Be Safe Behaviors as it inhibited the ability to “Handover Effectively”, “Communicate Clearly” and “Have a Questioning Attitude.”

**Nurse Practice Environment Change**

The clinical nurses concern was validated when Laurie evaluated the number of rapid response team calls within six hours of admission to the medical center. As a result of communication between CNE Advisory Committee clinical nurses and Laurie, ABMC’s new Direct Admission Policy was developed with exclusion criteria to identify patients who are not eligible for direct admission ([Exhibit TL8.A.2 Direct Admission Policy](#)). The policy was drafted by Laurie and sent to the CNE Advisory Committee clinical nurses for review on May 12, 2015 ([Exhibit TL8.A.3 Laurie Round’s email](#)). It was created in the Advocate Document System by Lori Harper, MBA, MSN, RN, NE-BC, Nursing Practice and Mother Baby Unit Director, on May 18, 2015 at Laurie’s request. After the CNE Advisory Committee approved it, the policy was sent for leadership review and approval. Following leadership review and approval, Laurie asked to have the policy added to the August 2015 Medical Executive Committee (MEC) agenda. She discussed the policy with Dr. James Nevin, Jr, MD, CPE, FACEP, Vice President of Medical Management, and key physician leaders in advance of the meeting. The policy was then approved by the MEC and published on August 25, 2015 ([Exhibit TL8.A.4 Direct Admit Policy Original Creation/Publication Information](#)). When the policy went into effect, Nursing Operations Nurse Manager, Stacy Barclay BSN, RN, educated those who coordinate direct admissions on the policy change ([Exhibit TL8.A.5 Communication to Patient Placement & Clinical Coordinators](#)).

Laurie Round exhibited idealized influence as she served as a role model for those she guided by both following and encouraging the compliance with the Behaviors of Excellence and Be Safe behaviors. She also inspirationally motivated the nursing associates by referring to the future of healthcare and this institution with optimism, and reiterated the influence nursing has on patient outcomes and the practice environment. Laurie modeled intellectual stimulation by assessing the problem of inappropriate direct admissions by reframing the policy to ensure a safe practice environment. The new Direct Admission Policy created a positive change in the nursing practice environment, reducing the risk of clinically unstable patients being directly admitted to the inpatient
units. It equipped Patient Placement Coordinators and Clinical Coordinators with guidelines to better identify the proper placement of patients.

As a result of the new direct admission policy ABMC was able to decrease the percentage of rapid response team calls for patients within six hours of admission. Before the new policy implementation, 20% of rapid response team calls were called within six hours of admission (January-June 2015). After implementation, 13% of rapid responses were called within six hours of admission (July-December 2015).

8.23.16 jlm
Positive feedback on text messages and all agreed it should be opened to all nursing staff

**Update on recruitment/staffing:**
The following feedback received regarding why no applicants for positions:
- Each time you go to the job site you get a different view; recently students looked and could not find open positions.
- Reports of problems getting through the HR application process – when calling HR they are not helpful. There are problems/stumbling blocks with the application process.
- “The PEP test is killing us”
- Consider expanding the residency program.
- What about internal options for nursing staff wishing to work in a new area? (older, nearing retirement).

**Working with students:**
- It can be challenging and stressful for nursing staff when they are working with both students and new orientees.
- Sometimes nurses just want to take care of their patients – not share with students
- Hard to know what students can do; clinical instructors should share expectations but this isn’t always communicated.
- Denise Hammer mentioned a card Wesleyan developed for students to hand to the nurse they are working with detailing what they are to do. It is unclear if this is still being used. All thought this was a good idea – maybe Denise can work on this? If not for each student maybe the clinical instructor could develop one for her/his clinical group.
- When there is low census the OR is often contacted at the last minute for student clinical experience – this isn’t always a good experience. There could be wonderful experiences in periop with appropriate planning.
- Would be nice if each unit printed and gave clinical faculty unit specific routines at the beginning of the semester.
Maybe senior leadership students could assist with junior students? This could be a leadership experience.

All thought a regularly scheduled meeting at the start of the year with clinical faculty would be very helpful.

Hospitalists:
Rumor – hospitalists are leaving, is this true?
Concern voiced re: Dr J’s behavior.
In the recruitment process to get more hospitalists at this time - much discussion about those physicians with good clinical practice & citizenship behaviors.
Wondering about maybe having NPs and/or PAs on the team to offer consistency.
There are continued concerns on nights getting orders – not unusual for it to take 5-6 hrs. What can we do to make this better.

Direct Admissions – Experiencing problems with patients being inappropriately “direct admitted” to the hospital (leading to RRTs, etc). Laurie will draft a new direct admit policy that she will share with all.

Advanced Directives - Discussion regarding orders for the chaplain to come talk with patient regarding advance directives on the Mother/Baby Unit – even though nurses enter an order, chaplain vistits are not consistently occuring. This is probably due to different charting systems and no one could answer the question – where does the order go when entered on the OB unit?

Meeting with Accelerated students from MCN – ISU on Monday June 8th at 5:00, over dinner
Following nurses volunteered to assist: Kristin, Jen, Hallie, & Crystal

Meditech downtime – on hold until June, after graduation

Cut and paste charting – nurses said they did this sometimes – determine if this should be put on the agenda again for deeper discussion and background on issues.

One nurse asked about learning about litigation – what are the lawsuits we are faced with? Why isn’t there more transparency about lawsuits? Bring this to next meeting – August?

Quality Caring Book – Everyone received a book and expressed interest in an “in person” book club (not a virtual book club). We should start this in August.

FOLLOWUP:
1. Set a date for faculty update in August and plan to do this on an ongoing basis.
2. Send an email to this group with an update about which Hospitalists are leaving.
3. Expand the text option to all nurses.
4. Kudos to Dr. Kindred – he is great! (from nursing staff).
5. Send new direct admit policy to this group to solicit feedback.
6. Follow-up regarding Perfect Serve problems.
7. Follow-up on concerns related to Dr. K, who is either not entering his own orders or entering them with errors. Also follow-up regarding behavior concerns.
I. **PURPOSE**
   To provide safe, systematic guidelines for direct admissions to acute medical, intermediate, critical care and pediatric beds.

II. **POLICY**

   **Exclusionary Criteria:**
   Patients with the following diagnoses/problems are excluded from being directly admitted and must present to the emergency department:
   1. Chest pain/angina
   2. Suspected TIA/CVA
   3. Suspected Sepsis
   4. Suspected PE
   5. Any patient with unstable vital signs, if known
   6. All patients requiring intensive care unless cleared by the Intensivist on duty
   7. A patient will not be accepted as a direct admission if the physician has not seen the patient within 24 hours prior to request for the direct admission.
   8. Physician orders must be received prior to admission. If adequate information is not available to appropriately assess the placement/status of the patient, the patient will be triaged through the Emergency Department.

III. **DEFINITIONS/ABBREVIATIONS**

   **Direct admission:** The formal acceptance of an inpatient, observation patient or outpatient in a bed, requiring continuous nursing services, who is admitted directly from a physician's office, home, outpatient testing area, skilled nursing facility, acute rehabilitation facility, or urgent/immediate care center.

IV. **PROCEDURE**

   The patient's attending physician, or designee calls the Patient Placement Coordinator, with a request to directly admit the patient to the hospital. The caller provides additional information as follows:
   1. Complete name and date of birth of the patient and phone number, if applicable
   2. Diagnosis for inpatient admission or specific symptoms/treatment to be provided for observation or outpatient in a bed

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**Scope:** ☒ System

**Site:** ABMC
3. Date/time the patient was last seen by their primary or consulting physician
4. Level of care to be provided
5. Patient Code Status
6. Isolation needs
7. Presenting symptoms
8. Significant abnormal labs, testing and last set of vital signs, if known
9. The Patient Placement Coordinator completes the Rapid Admission Form.
   a. The PPC arranges bed placement with unit Charge Nurse.
   b. Patient Registration completes the short registration process when patient arrives to room.
10. Based on the description of the patient’s severity of illness or intensity of service required, exclusionary criteria and the availability of inpatient beds, the Patient Placement Coordinator may direct the patient to the Emergency Department or to wait at the present location until an inpatient bed becomes available. Patient Placement Coordinator may direct the patient to the Emergency Department. The Patient Placement Coordinator will make the physician aware if a bed is not readily available and inform the physician of the estimated wait time, if known.
11. Elective and/or direct admissions waiting in Patient Access that become acutely ill and cannot wait for the assigned bed to be available will be registered in the Emergency Department and evaluated and managed by the ED attending staff until an appropriate inpatient bed is available.
12. In the event that a bed is not immediately available, the patient may be taken to the ED to hold until a bed is available. Admission orders may be initiated.
13. If admission to the Intensive Care Unit is requested, the Patient Placement Coordinator or Clinical Coordinator will require direct physician to physician conversation between the Admitting Physician and the Intensivist on duty, in order for the direct admission to be accepted.
14. If a unit receives orders prior to the patient’s arrival, consult with the Clinical Coordinator/ Patient Placement Coordinator.

Express Registration:
1. Units: Obstetrics Unit (OB), Mental Health Unit (MHU), and Addiction Recovery patients may be express registered following initial assessment.
2. Unit staff obtains consent for treatment and copies of insurance information and forwards to Patient Registration.

V. CROSS REFERENCE
N/A

VI. REFERENCES
Lippincott’s Nursing Procedures and Skills (On-Line):
Admission
Admission to floor, pediatric
VII. RELATED DOCUMENTS/RECORDS
N/A
Document Metadata

In Project Mode

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Approver(s): Round, Laurie
Publisher: HARPER, LORI

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CNE Advisors,

At our last meeting we talked about the draft Direct Admit Policy. I would greatly appreciate your feedback. Thank you Laurie

PS: I need to address physician orders before they hit the floor.

Laurie

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PURPOSE

To provide safe, systematic guidelines for direct admissions to acute medical, intermediate, critical care and pediatric beds.

POLICY

A. Exclusionary Criteria:
   Patients with the following diagnoses/problems are excluded from being directly admitted and must present to the emergency department:
   1. Chest pain/angina
   2. TIA/CVA
   3. Syncope
   4. Sepsis
   5. Any patient with unstable vital signs, if known
   6. All patients requiring intensive care or critical care level of care, unless cleared by the Intensivist on duty
   7. A patient will not be accepted as a direct admission if the physician has not seen the patient within the 12 hours prior to request for the direct admission

DEFINITIONS/ABBREVIATIONS

A direct admission is the formal acceptance of an inpatient, observation patient or outpatient in a bed, requiring continuum of nursing services, who is admitted directly from a physician’s office, home, outpatient testing area, extended care facility, skilled nursing facility, acute rehabilitation facility, long-term care facility, free standing emergency department, or acute care/urgent care center. Express Registration: Allows patient to be transported directly to their room, bypassing Patient Registration

PROCEDURE

The patient’s attending physician, office nurse practitioner (NP), physician assistant (PA), or registered nurse calls the Patient Placement Coordinator, Advocate BroMenn Medical Center (ABMC) or responsible nurse Advocate Eureka Hospital (AEH) with a request to directly admit the patient to the hospital. The caller provides additional information as follows:
1. Complete name and date of birth of the patient and phone number, if applicable
2. Diagnosis for inpatient admission or specific problem/service to be provided for observation or outpatient in a bed
3. Date/time the patient was last seen by their primary or consulting physician
4. Insurance information
5. Level of care to be provided
6. Patient Code Status
7. Isolation needs
8. Presenting symptoms
9. Expected length of stay
10. Significant abnormal labs, testing and last set of vital signs, if known
11. The Patient Placement Coordinator completes the Patient Bed Reservation Form
12. The Patient Placement Coordinator completes the MCG review to determine the correct level of care and makes a recommendation as to the level of care.
   a. Arrange bed placement with unit Charge Nurse.
   b. Complete short registration process when patient arrives to room.
   c. Assist in arranging transport to assigned unit as needed
13. Based on the description of the patient’s severity of illness or intensity of service required, exclusionary criteria and the availability of inpatient beds, the Patient Placement Coordinator may direct the patient to the Emergency Department or to wait at the present location until an inpatient bed becomes available. The Patient Placement Coordinator will make the physician aware if a bed is not readily available and inform the physician of the estimated wait time, if known.
14. Elective and/or direct admissions waiting in Patient Access that become acutely ill and cannot wait for the assigned bed to be available will be registered in the Emergency Department and evaluated and managed by the ED attending staff until an appropriate inpatient bed is available.
15. If admission to the Intensive Care Unit is requested, the Patient Placement Coordinator or Clinical Coordinator will require direct physician to physician conversation between the Admitting Physician and the Intensivist on duty, in order for the direct admission to be accepted.
16. If a unit receives orders prior to the patient’s arrival, consult with the Clinical Coordinator/ Patient Placement Coordinator or responsible nurse regarding patient placement.
17. Patient Registration obtains admission information and general admissions consent, prepares an identification band, and secures patient valuables

Express Registration:
1. Units: Obstetrics Unit (OB), Mental Health Unit (MHU), and Addictions Recovery patients may be express registered following initial assessment.
2. Unit staff obtains consent for treatment and copies of insurance information and forwards to Patient Registration.
I. CROSS REFERENCE
[Include references to documents within the AHC System.]

II. REFERENCES
Lippincott’s Nursing Procedures and Skills (On-Line):
Admission
Admission to floor, pediatric

III. RELATED DOCUMENTS/RECORDS
Include list of attachments such as related forms, templates, or charts and records.]
Direct Admission

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Subject: clinical coordinator/ PPC updates
Importance: High

Please see attached for the clinical coordinator and PPC updates for August. I will be hanging a copy of the new direct admit policy in the clinical coordinator office. I am requesting a read receipt on the updates. Thank you to all of you for all of your hard work. I know what you do is not an easy job. Thanks Stacy

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Clin Coord/ PPC updates August 2015

Welcome to our new hires. Kalina Adams is a new grad that began orientation on August 24th. She will be working in the new grad residency on MOSU and 6 West. Kelly Johanson (Hood) is a nurse clin II joining float pool and she began orientation on August 24th as well. Please join me in helping them to feel welcome.

Kathy Brown has updated the competency sheets. On the sheets the nurse residents are clearly delineated and what areas they are able to float to. Remember for the nurse residents they only go to their two units and no others.

1. There will be an upcoming audit as part of a system evaluation of Nursing knowledge regarding the ABCS assessment to identify patients at risk for a serious injury should they fall.

This is just a friendly reminder that review of the attached SBAR regarding the ABCS assessment and acknowledgement in Healthstream were due August 17th. If you have not already done so, please review the attached SBAR and then log into your Healthstream account to complete the acknowledgement.

2. Hand Hygiene- An effort has been made to increase hand hygiene audits. We have found many areas of opportunities all across the house. So to review, hand hygiene is required:
   - Before entering/as you enter a patient room every time
   - Upon exiting a room every time
   - “Gel in Gel out” is the motto – no exceptions!
   - It does not matter what level of interaction you intend to have with the patient (i.e. no plan to touch them!) you still must do hand hygiene
   - A powerful visual message is seen by patient and families/visitors when every caregiver performs hand hygiene at entry
   - Hand hygiene is required after removing gloves
   - If soap and water is preferred, go directly to a sink and wash your hands. Do not touch anything until that is complete.

So what themes are we seeing? These are examples seen on more than 1 unit and more than 3 times in the last 2 weeks:
   - Passing meds, pushing COW into room. No hand hygiene
   - Passing meds, pushing COW out of room. No hand hygiene
   - Taking isolation PPE off, and no hand hygiene after glove removal
• Leaving room to get a supply and returning moments later with that supply – lack of hygiene both times

As part of our safety journey, hand hygiene should be hard wired by all staff in all areas. We need to serve as one another’s wingmen and remind each other.

3. **Falls**

   We have heard in the Falls Committee that there are still instances across the house where patients are placed in the bathroom with the door closed.

   *our policy is high fall risk patients must be within arms’ reach while up in the bathroom or when ambulating, and if there is a door between the staff member and the patient or the patient is left alone and ‘trustworthy’ to call before getting up, this is not considered within arms’ reach*

   *Also please remember every time you exit the room (tech or nurse or clinical coordinator) to make sure all fall precautions are in place and the bed and chair alarms are on!*

4. **ON call** - When you are placed on call it is the expectation that you have your phone by you where you can hear the phone. It is also the expectation that you are here and ready to work within 1 hour of the time you got called. For those of you who live out of town or have special child care needs you will need to make special arrangements when placed on call. Not that you guys really get put on call but I wanted you to know what was put out to the staff.

5. **Associate engagement survey** is coming up in September. We would like to take a moment to encourage you to not only take the survey but when filling out the survey to remember all of the changes that we have tried to make over the past year in response to your concerns. Please see attached document that outlines for associates the feedback we heard from them the Associate Engagement Survey, and steps we have taken as a result.

6. **ISO/DNV** - As you are all well aware DNV will be here soon. Please make sure you are aware of the information in your blue book. If you can’t find your blue book please see me as I have extras. Also I have placed an ISO 9001 Review card on the bulletin board in the office. Please make sure you are confident in this information as well. All Health stream and Alex should be current. If you feel like you want extra review the “I know ISO” Jeopardy game is still available on the intranet.

7. **Town Hall Meetings**: On September 15^{th} BroMenn will be hosting town hall meetings with the executive team. The meetings will be in the conference center down by the
cafeteria. I encourage all of you to attend as Colleen and Tony will be sharing our new approach to evaluating employee performance. The times are 0730, 10 am and 2pm.

8. **Accommodation codes**— We continue to struggle with the accommodation codes. Please remind charge nurses at the 11am staff meeting to speak with their nurses regarding patient status and to obtain the appropriate order. Remind them also to bring the completed sheet filled out to the 1600 bed meeting. Prior to the clinical coordinator faxing the sheets make sure they are filled out correctly. Accommodation codes should be intermediate, crit care, med/ sur or med/surg with tele., not the unit listed where they are at.

9. **Bed Meetings**— At the end of each bed meeting (day and Night shift) you should be recapping the bed meeting. There seems to be discrepancy at times between what the clinical coordinator believes and what the charge nurses believe. For example: the other day MOSU very upset as they said they had no idea there were two nurses on call when they felt like they were working short. I know it is very hard to get everyone on the same page but the recap does seem to help if everyone is paying attention. It is ok to ask them to pay attention.

10. **Communication**— Communication continues to be an area of opportunity for all of us. Please take the extra minute to explain to charge nurses why there is a delay in getting another nurse, why their patient needs held in ED, Why they need to take the patient right away, why you assigned a dirty bed etc… The list goes on and on as you know. If we take a moment to explain some of these things the first time around I think you will see that this will help prevent more phone calls later. I also feel it will help with unit to unit relationships if we can help them see what is going on from the other unit’s perspective.

11. **Cath Lab**— Cath lab is experiencing some staffing issues at this time. Typically they are staffed with 6 nurses currently they have 3 nurses. These 3 nurses are covering the shifts Monday through Friday and are also the call team. Due to this staffing crunch it is a struggle for them to stay late to recover patients as they are likely the one on call also. This is making very long days and short nights for them. In the interest of patient and staff safety please make every attempt to help them find a recover and discharge unit for their patients being discharged later in the day. We do not want to move a patient up to the unit if they have an hour or less of recovery time left. This being said cath lab also understands that there are times that ICU/ CVCU and SDS are full and can’t help them and they will need to stay late. They do have a nurse in orientation and she should be done in the next 2 months. Once she is off orientation that will certainly help their situation but not solve it.

   Chest pain Rule out patients— On day shift when CVCU and ICU are full and the ER is busy, cath lab holding has stated on an as needed basis that they can help with these patients. It will depend on the situation and their staffing but is something to explore when in these situations.
12. Direct Admit Policy - Please see the attached direct admit policy. This goes into effect immediately. It is important for us to ask all of the questions. I know it is super hard to get information but do the best you can. Look over the policy and let me know if you have any questions. We are really trying to prevent those direct admits that immediately require a rapid response or a code. We do not want to put any patient or staff member at a safety risk. If you have concern always error on the side of caution and send them to the ER. You have leadership support on this. The direct admit policy was taken to the physicians and they have signed off on this policy.