Exemplary Professional Practice

EP13: Describe and demonstrate how nurses have assumed leadership roles in interdisciplinary collaboration.

There are a plethora of interdisciplinary committees, councils, and task forces, listed in OOD15 that demonstrate nursing being at the table to speak to nursing practice and advocate for patients whenever and wherever patient care decisions are being made. Nurses at all levels serve as chairs and co-chairs on these councils/committees and work collaboratively with members of other professional disciplines to address patient care issues and make improvements in patient care structures and processes. York Hospital (YH) has a long, standing tradition of using an interdisciplinary approach in providing the best possible care for its patients. This spirit of collaboration is evident in three major organizational venues; the system level, hospital, and unit levels. Nurses assume leadership roles in interdisciplinary collaboration due to their knowledge, expertise and clinical focus as well as their ability to engage others with the particular group they have been identified to lead. Nurse are identified for these leadership roles formally by appointment of the VPPCS/CNO or other members of the YH OOP or informally based upon word of mouth on projects and other initiatives they have led. Other opportunities come from the clinical director and NM where staff has identified goals for professional development as will be discussed in EP 20. Through our SDM structure, there are multiple groups and sub-teams which are chartered based upon current work and priorities identified within the strategic plan of both nursing, YH and WSH, that offer nursing the opportunity to assume the lead in these interdisciplinary groups.

At YH, a key principle of our PPM is interdisciplinary collaboration. Through these guiding principles, we recognize the value that all health care providers operate as a team, share a mutual responsibility for patient outcomes, and that our ability to communicate and work effectively is essential for delivering quality care to our patients. In addition, our team philosophy is a catalyst for strengthening our employee satisfaction through commitment to co-workers and other health care disciplines. YH Nursing recognized that the most effective way to enhance system or unit practice changes is to incorporate the direct care providers into the decision making process. These direct care providers must be from all levels in the organization, and be empowered to make, recommend, and implement the changes. YH nursing is the backbone of this model, as they serve as members and leaders of councils and committees at all levels of YH and WellSpan Health (WSH). Hence, through our SDM structure, many disciplines have been integrated into the committee and council structure. For example, the SDM Practice Council, by design, consists of representatives from pharmacy, laboratory, imaging, infection control, patient safety and materials management so that these interdisciplinary providers can collaborate to meet the best needs of our patients and families.

YH nursing values the positive working relationships it has developed with interdisciplinary teams and will continue to enhance these relationships to bring about the best possible care for our
patients. Our methodology has been to consistently include nursing at the table for administrative, clinical practice, education, performance improvement and research. Fortunately, our culture is such, that we do not foresee a time that nursing would not be active in such teams as care delivery, safety and quality improvement at the organizational as well as system level, facilities re-design, and budgetary initiatives to name a few. Nursing at all levels is active in interdisciplinary teams throughout YH and seen as essential to provide input to these teams.

Mutual trust between disciplines is paramount for effective patient care realizing that these principles cut across all other disciplines. YH Nursing continually takes the lead in promoting this work:

- The RN has responsibility, authority, accountability to coordinate communication between the patient and family members and the health care team.
- Interdisciplinary collaborative relationships are promoted, nurtured, and sustained. It begins with hiring, continues with learning and developing together and is reinforced over time.
- The work of all professional caregivers is seen as interdependent and collegial.
- Patient-focused care and better patient outcomes are the organizing force behind creating a collaborative environment.

This interdisciplinary approach is readily visible at the system level, through our Clinical Effectiveness Teams (CET) and will be described below. These teams are designed to improve patient care delivery through standardization of practice and protocols throughout our health care system. Many of these teams are led by nurses, who work in various roles across areas affecting patient care at YH. Since 2010, nursing leadership has worked on formalizing the linkage and communication of the information and recommendations developed from the interdisciplinary CETs to our YH Nursing Shared Decision Making Practice Council. Each nurse leader of a specific CET, presents to the practice council on a regularly scheduled time frame to ensure hardwiring of the practice recommendations elicited from the CET.

**Clinical Effectiveness Teams (CET’s)**

Clinical Effectiveness Teams have been in operation since 2004 and are WellSpan Health’s organizational structures designed to improve the quality of care and standardize the patient’s treatment plan across the WellSpan entities. These teams are comprised of care providers from a variety of disciplines, (physicians, nurses, pharmacists, and others) who are recognized as having knowledge and expertise regarding a particular clinical condition or disease entity across the WellSpan Health System. Nurse Leaders have been assigned to each of our current 10 Clinical Effectiveness Teams based on their leadership ability and include either Nurse Clinical Specialists or Clinical Directors in this role. The Nurse Leader is the organizer of the team’s activities; helps assure that all necessary tasks are completed in a timely and consistent manner; co-Chairs the Clinical Effectiveness Team meetings; develops agendas with the Facilitator and Physician Leader; helps develop consistent work processes for the team and provides feedback to nursing on implementation of actions. Below is an example of the work of the Stroke CET.

**Stroke CET**

The Stroke Coordinator role is an excellent example of a leadership RN who routinely utilizes interdisciplinary collaboration in a number of ways. Two of the most common ways are facilitating optimal stroke population care and process improvement for the Stroke Program. Stroke patient outcomes directly correlate to the quality and timeliness of the bedside care they receive. A
multidisciplinary team, consisting of nurses, physicians, rehab therapists, care managers, social workers, and other disciplines as needed, formulates overall plan of care for each patient. When rounding, any interventions identified by the team as needing attention are communicated through the Coordinator to any service that needs to be included in the care plan. This not only assures compliance with core measures, but also creates patient-centric care. Additionally, the Stroke Coordinator assures that the evidence-based standards of care are well communicated throughout the institution.

Stroke Programs are created on a framework of protocols and processes that are geared to promote evidence-based care. Such programs are surrounded by a plethora of data management requirements and systems, which provide a means to measure processes and look for opportunities for improvement. The Stroke CET (Clinical Effectiveness Team), led by the Coordinator, identifies areas for improvement and creates ad hoc teams with key stakeholders to attach the problem. The Stroke CET and the ad hoc teams are always interdisciplinary and include frontline nursing to leadership staff.

**Teams**

**Falls Task Force**

Since 2006, the Falls Task Force (FTF) has been evaluating patient falls and making evidence-based recommendations to reduce falls and falls with injury. Success of this task force was impacted by numerous different groups working on reducing falls without one coordinated, clear focus. Leaders from Patient Safety and the Office of the President called for action to reduce this threat to patient safety and knew the FTF would be the group to lead the fall prevention efforts. In order for success of the program, restructuring of the task force was required. From leadership to membership, the committee was restructured in May of 2012. The issue of falls is owned by nursing; however, it takes the attention and commitment of all hospital departments to reduce fall rates and injuries.

One main objective for restructuring the FTF is to have it link to the lead being someone who has a touch point to the direct care nurses. The task force chair role was changed to be clinical nurse specialist, Amy Seitz Cooley MS, RN, ACNS-BC, as she was very passionate about falls and had been a true advocate for performance improvement. Amy took over formal leadership of the FTF in June of 2012, however one of the first things Astrid did as new VPPCS/CNO was begin to present Fall outcome data to the new centralized department of nursing leadership. With the intensity of focus, the trend with Falls (EP13.2) began to move into a positive trajectory and fall below benchmark for the first time in several months as seen in the fall graph below.

**Fall Trend: Hospital Overall**

**FY-12 & FY-13**

**Goal:** < 2.5 falls/1000 patient days

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<tr>
<th>EP13.2 YH Total Falls per 1000/pt days with VHA benchmark</th>
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<tr>
<td>1. Purposeful Rounding Implementation</td>
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<td>Astrid Davis becomes CNO</td>
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<td>2. Falls becomes standing presentation at DON meetings</td>
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<td>3. Restructured FTF</td>
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<td>4. Amy Seitz-Cooley new chair of FTF</td>
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<td>5. Falls Kaizen Event</td>
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<td>6. Daily Huddles and Rounding by FTF Chair</td>
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<td>7. Bedside Handoff and Shift Report Begins</td>
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<td>8. Leadership Rounding</td>
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Oversight for the Fall Prevention program is a leadership sub-team that includes the vice president of patient care services, the director of patient safety, the director of nursing excellence and innovation, the director of risk management, and the FTF chair. The actual Falls Task Force membership includes multiple disciplines: nursing staff and nursing leaders, rehab medicine, pharmacy, physicians, materials management, housekeeping, patient transport, patient safety, and biomedical/maintenance. The membership of the original falls task force was expanded to include more disciplines, more nursing staff and leadership.

The task force met for an all day Kaizen event on June 13th, 2012. Prior to this all day meeting, the leadership group met to establish the overall program objectives and goals. The objective for the all day meeting was to walk away with a workable fall prevention plan. The group agreed on a goal of eliminating all serious falls with injuries and reducing total fall rate /1000 patient days by 75% by 7/11/2013. The areas of focus for the program are patient assessment, communication, equipment, data management, and staff accountability. The leadership group created broad goals for each group. The task force membership was divided into five sub-teams. There was one team for each of the focus areas. Each sub-team is made up of members from multiple disciplines and has a lead or co-leads. One member of each team is also a nursing leader.

Each group spent the day brainstorming implementation ideas related to their goals. They were given the S.M.A.R.T. goals template to use when forming the goals. There were hourly check-ins with the leadership group to assure that the groups were on task. The entire group reconvened at the end of the day to review each teams work and implementation plans. They turned in S.M.A.R.T. goals worksheets to be compiled into the implementation plan.

The leadership group met twice in the two weeks following the initial working meeting. All of the goals from each team were displayed on Gantt charts. There are short-term and long-term implementation goals. Implementation teams were selected from the initial workgroups. Each implementation team is co-lead by a team member and a nurse manager. The expectation for each team is to organize working meetings and keep minutes. In addition, the nurse manager lead is also responsible to report out the teams’ work each month at the department of nursing weekly meeting. At the first DON following the June 13th meeting, Amy Seitz Cooley presented implementation goals and the Gantt charts.

During the first and second weeks of July, each of the implementation work teams had their initial meetings and the work began. Recommendations made by each of the work groups are brought back to the FTF for discussion and further recommendation. Once approved by the FTF, the recommendations along with the expectations and measures for success are presented to the department of nursing. Implementation for some of the first interventions will begin 8/20/2012. The work of the task force will continue to evolve as we work to meet our goal of eliminating all serious falls with injuries and reducing the total patient fall rate/1000 patient days by 75% by 7/1/2013.

**Accountability Sub-Group**

The Accountability subgroup of the Falls Task force is comprised of 6 members. The Patient Safety Office is represented with 3 members; the other 3 members are Nurse Managers of the Oncology unit, a general Med/Surg unit and the Cardiovascular Step Down unit. The area of focus of this group is to develop levels of accountability of staff to ensure that safety precautions are in place for all of our patients and that this accountability is reported out at a hospital level.
Specifically they have worked on a daily risk report that is printed directly to all nursing units, reporting mechanism of compliance to fall measures, post fall huddle compliance, leadership rounding and role accountabilities using a Just Culture model. The daily risk report contains the names of all patients in each unit that have been assessed to be a fall risk by the RN. This report is reviewed twice daily to ensure that all 5 components of Fall Precautions are in place. This daily data is then inputted into a unit spreadsheet that is located on the Nursing Portal. The compliance results will be reported out to the Nursing Leadership team on a monthly basis. Individual staff members who fail to implement all 5 precautions will be held accountable by their Nurse Manager using a Just Culture model.

After each fall, a post fall huddle will take place within 1 hour. The huddle will be led by either the Nurse Manager or Nursing Supervisor, with the intent of determining if there were factors that could have caused the fall that could be eliminated. This information would then be shared with each staff member on the unit with the intent of preventing similar scenarios in the future. Leadership Rounding will be addressed with the intent of having a consistent method for all hospital Leadership to make meaningful rounds on patients that address their needs.

**Equipment Sub-Group**

The Equipment Work Group is a multidisciplinary group composed of representatives from Biomedical Engineering, Materials and Distribution, Nursing, Purchasing, Physical Medicine, Plant Engineering, and ad hoc members as needed to resolve issues. Goals set by the equipment group include identifying and standardizing equipment in all areas, establishing an inventory list of current equipment available in each department and a desired par level, and developing a process for ordering additional or replacement equipment through the Materials and Distribution department that would be both timely and seamless. In addition, all bed alarms will be checked and staff will be educated to connectivity and use, all beds will have alarm capability and nurse call systems will be standardized.

**Assessment Group**

One of the issues identified by the assessment sub-group was that our current Fall Risk Assessment (Schmid Tool) did not capture all patients who were at risk of falling. Our short-term goal is to revise the "Schmid" fall risk screening tool to correct for identification issues. Our long term goal is to review the literature for a valid and reliable tool that may better capture at risk patients.

Revisions to the Schmid tool included:

1. Addition of more medications to the current medication screen. Medications added were antihypertensive, diuretics, laxatives, and opioids.
2. Medication box would appear on the admission assessment that would populate if any of those medications were ordered.
3. If a patient had fallen within the past year and was recorded by nursing on a previous admission it would auto populate on future admissions.
4. Fall Risk and reason per “Nursing Judgment” were added to the screen. This was added so that our current audit tool would capture patients who were placed on fall precaution as well as to identify reasons.

Another tool that was added to the Fall Screen was the ABCS Fall Risk for Injury Assessment. This assists the nurse in identifying patients who are at risk for injury if they do fall while hospitalized. The fall risk screen and the ABCS Fall Risk for injury assessment will assist the nurse in developing a plan of care (POC) specific for that patient. The fall injury risk assessment will be done on admission
and will be reviewed with each fall screen in I-view and updated if needed. Future electronic POC will include interventions specific to patients who are at risk for falling and who are at risk for falling with injuries. Follow-up will consist of auditing patient’s records to see if auditor obtains same fall risk and fall injury risk score as the RN.

**Communications Sub-Group**

At the first meeting, the communication subgroup discussed the current communication system for fall risk management. The group comprised representatives from the nursing staff including RN’s and nursing assistant, representative from the transport team, clinical nurse specialist, assistant nurse manager and practice council chair. At the completion of this meeting suggestions were given to the leadership group for communication mechanisms that would allow handoff communication, signage, changes to the SRS tool, and mechanisms of communication of fall events for the staff.

The membership for the subsequent meetings changed to include representation from Gettysburg Hospital. It also includes management, clinical nurse specialist, staff RN’s, and rehab staff. The legal department and patient safety department are ad hoc members. We decided how we would support the overall goal of eliminating all serious fall with injuries and reduce total fall rate/1000 patient days by 75% by 7/1/2013. The following recommendations were given to the leadership group: handoff communication via a handoff communication that includes the following pneumonic: F(falls) A(alarms/assist) C(comfort/cognition/communication) S(stability), safety huddles twice a day on each shift, post fall huddles, real time communication of fall with staff, reporting of fall information at all staff meetings, signage outside each room to communicate what kind of assistance a patient requires, and discussion of fall event with families.

It was decided to use a train the trainer approach for every nursing unit, all rehab staff, and the transport department. These areas would account for the first wave of training with a second wave of training to follow to include other nursing departments such as vascular lab, non invasive cardiology, imaging, IV team, lab, pulmonary, dialysis, GI lab, short stay, PACU, care management, social workers, and pastoral care. A third wave of education would include dietary and housekeeping with information on how they can assist in prevention of falls. Each unit has representatives and a fall champion who will attend an educational session on the fall education bundle. They will then sign an accountability sheet. They are responsible for doing face to face education with all staff on their units. The nurse managers were also given this education and given accountabilities for this education. The members of the communication subgroup are teaching the education sessions. The effectiveness of this education will be demonstrated by a decrease in fall rates.

**Data Sub-Group**

The Data Group is composed of two leaders and one staff member, with Ad-Hoc participation of the Nursing Lead for the Falls Task Force, a CNS. The goal is the development of a “Data Management Plan.” The plan will address input from the Department of Nursing members (managers and directors) on the format and content of data to be specifically depicted for use by all levels of staffing. Additionally, the group will create reports which can be used by the nursing staff to understand fall results.

As a first step in the efforts, a Daily Fall STATs report in the form of an E-mail to the entire Nursing Department was created, which addresses most recent fall events. Some of the specific information about the fall include: age and sex of the patient and location of the fall; current Schmid risk
score; the conduct of a Post-Fall huddle; and contributing factors as derived from the SRS event reports generated with each new fall event. The daily E-mail also contains a tally of all fall events for the month, as well as the current daily census and how many patients are at risk. The next step is to develop a Monthly Summary report from SRS data files including the post-fall data, and trend the results in the form of an audit report.

The goal for completion of the latter is scheduled for September and was dependent upon rollout of the revised SRS event reporting system which was changed to incorporate the post-fall data to start August 1st and planned training related thereto scheduled for August 8th. Other possibilities include tracking of compliance with all elements of the Fall Precautions contained in the Nursing P&P DOC-0909 on Fall Prevention protocols. An Informatics change order was issued to develop a front-end software product to make data capture easier for the nursing staff on every unit, with automatic tallies of the data and some analysis.

Interdisciplinary Chemotherapy Council

An oncology patient is treated by a team that values interdisciplinary evidence based seamless patient care across the continuum. One of the goals as a service line is to establish programs that embrace shared decision making in an atmosphere of pride, passion, and professionalism. The Interdisciplinary Chemotherapy Council (ICC) is a best practice initiative formed after evaluating staff concerns surrounding chemotherapy administration. They have involved private medical oncology practices, the inpatient and outpatient pharmacists, outpatient infusion room nurses from Apple Hill and Adams County Infusion Center and the YH inpatient oncology nurses from 7 South in deciding evidence based initiatives for safer chemotherapy administration. The Council meets 3-4 times a year and evaluates regulatory standards, chemotherapy related medication errors, new chemotherapeutic agents, and current chemotherapy administration and practice initiatives. Since April of 2010, they have implemented a chemotherapy safety zone, chemotherapy education involving the simulation lab, a designated pharmacist who answers chemotherapy related questions, improved communication between the nurses and the physician office practices and a standard chemotherapy administration checklist.

The council has demonstrated a reduction in medications errors (EP13.3), improved physician/nurse collaboration, and increased awareness of patient education in relation to chemotherapy side effects. We are changing our culture from a passive, static environment to an active envisioned staff empowered for the future.
Nurses provide leadership in many ways within YH. Through the nursing process, nurses have identified barriers that impede optimal outcomes for our patients and organization. Through interdisciplinary collaboration, these problems can be further delineated and acted upon to improve patient and organizational goals. Nurses, as part of the interdisciplinary team, are also utilized in a proactive manner, in planning, implementing, and evaluating new programs and technologies. It is not uncommon for nurses to lead collaborative efforts.

Policy and Procedures

Policies, protocols, guidelines, and even nursing standards must evolve to remain relevant and evidence based. Policy development and policy review are facilitated through our strong SDM model. All of our hospital wide councils participate in policy development, review, revision and implementation. The house wide clinical policies are owned by the clinical nurse specialists and nurse educators assigned according to their individual specialty. The owners review their policies annually, update and make changes based on evidence-based findings and a review of the current literature. References are updated, stakeholders are contacted and then the policy is taken to the specific council, for final approval. Through our council structure, major changes in policies and procedures are communicated to the service line councils and then to the unit-based councils.(EP13.4)

The YH SDM Practice Council is the council specifically charged with the evaluation of nursing standards. This hospital wide group is comprised of staff nurses, clinical nurse specialists, nursing directors, and clinical nurse educators. Furthermore, other members of the interdisciplinary team (pharmacy, patient safety, infection control, materials management, etc.) are directly involved on this council on a regular basis. This approach is a core tenet of the YH Professional Practice Model. This council is empowered to be the formal mechanism to make changes in how we deliver patient care.

Also, individual nurses, being the coordinators of the patient’s care, have the responsibility, accountability and authority, and autonomy to collaborate with other members of the health care team on patient care issues. In addition to CETs, policy development has always occurred as a collaborative effort for many members of the health care team. Interdisciplinary collaboration is evident in both policy formulation and policy approval at YH. YH recognizes that best healthcare providers to evaluate nursing standards, are the nurses themselves. Although nursing expertise runs deep, nurses know that
collaborating with other disciplines makes nursing better and has tremendous positive effect on patient outcomes. As improvements in technology evolve and more nurses become involved in evidence based practice and research, they recognize that periodically they must reevaluate what they actually do.

Collaboration with Physicians

PPP (Preoperative Preparation of Patient) Pilot

Because of an incident that occurred with a surgical patient, a Perioperative Preparation of Patient’s Task Force was chartered. This task force consisted of anesthesiologists, medical physicians, surgeons, Clinical Director for Perioperative Services, Dee Carbaugh BSN, RN (nurse manager for PHAS-Pre-hospital Assessment Services) and staff nurses. Through this interdepartmental endeavor, a manual was written which contains the PPP (Preoperative Preparation of Patient’s) guidelines. Anesthesia set up a listing of surgeries performed and put them into categories of low, intermediate and high risk based on 100 most common procedures in 2009 for the York Hospital operating room. They provided the preoperative testing guidelines for intermediate and high risk surgeries per ASA standards. Dr. Whitney, (acting Chairman for Dept. of Medicine) with Dr. Arbittier (Medical Director of Perioperative Services and Chairman for Dept. of Anesthesia) gave recommendations for the preoperative triage guide for a medical consult and what it should contain. This information was compiled and is listed as a link on the PHAS portal on the Inet so all disciplines involved with the patient’s preparation for surgery can view it. Also it is available for the inpatient units to view if they have questions regarding preparing their patient’s for surgery.

Through these guidelines, an innovative concept for preparing patients for surgery was developed as a pilot program. With this process, the realization occurred that with the health care reform, bundling and ACO’s (Accountable Care Organization’s) influencing how we practice this initiative would be one of the steps toward meeting that goal for our Wellspan Surgical Care Clinical Effectiveness Team (CET). Dr. Krzeminski (neurosurgeon) was approached and agreed to have his patients be part of this 8 week pilot. To be effective, several areas were consulted for their expertise. All of the above areas plus: Bryan Taylor (Quality Management), Jim Stambaugh (Project Knowledge Office), Mike Cogliano (Gettysburg Hospital Director Operations), Virginia Wesner (Manager Research Surgical Service Line at Y.H.), Ronda Sanders (Office Clinical Coordinator for neurosurgeons office), Ellen Portz (Dr.Krzeminski’s office scheduler), Amy Collins (Wellspan surgery scheduler), Sue Holtzinger (administrative assistant for anesthesia), Stephanie Bish, RN (staff nurse PHAS) and Robin McCullister, RN (staff nurse PHAS) were involved in this process.

Several meetings were needed for discussion as to how it would alter scheduling a patient for surgery. After this was decided, then the scheduling form was faxed to PHAS and care management so that the nurse in PHAS could obtain some preliminary information on the patient. The patient was instructed to call PHAS within 48 hours of leaving the office so a nursing assessment could be performed. If the patient didn’t make that phone call, they were instructed that their surgery may be delayed or cancelled. If the PHAS RN did not receive a call from the patient, the nurse would initiate the call after 72 hours.

After doing the nursing assessment, the nurse would order preoperative testing based on the PPP guidelines. Asking the patient where they normally had testing preformed was the next step in the equation. The request would be faxed to that annex and the patient was instructed to go as soon as possible. After completing the assessment, preoperative instructions and postoperative teaching the nurse would suggest to the patient that they be connected to registration so preregistration for the
surgery and testing could be done. This used to be a separate process, with the pilot trying to minimize contacts. This would increase satisfaction for patients with one less automated phone call.

Once the testing results are available, the nurse reviews the results and notifies the surgeon and anesthesia if anything is abnormal according to the PPP guidelines. Also, if the nurse wants an opinion on findings or something the patient relayed during the assessment made her feel uncomfortable, the nurse may consult anesthesia. It was decided that the PHAS nurse will notify the administrative assistant for anesthesia regarding abnormal testing or findings. She would then notify the point physician for the day (rotates between Dr. Arbittier, Dr. Whitney, Dr. McGuinn, Dr. Applefeld) to review results, nursing assessment and any medical history available. If recommendation is for medical consult, the nurse notifies the administrative assistant who then contacts the patient and schedules them for medical consultation. If cardiology consult is needed the medical physician will order. Consults are obtained and attached to the chart so anesthesia has concise and optimized picture of the patient on day of surgery.

Jim Stambaugh has set up a flow sheet to track when PHAS receives the chart, patient calls for the assessment, when the patient goes for preop testing and nurse reviews testing for abnormal values. The positives for this pilot are the personal touch of having one nurse setting up that close nurse to patient relationship. PHAS is 1 year into RBC and this pilot is a terrific example of Relationship Based Care. The PHAS RN always gives the patient the PHAS phone number so if they have any questions they can call. A nurse is assessing the patient prior to preoperative testing so unnecessary testing is eliminated.

This provides a step towards health reform with each surgical case that is assessed by PHAS. A quality management team is analyzing data showing the saving of money for pilot patients versus non-pilot with their preoperative testing. It avoids cancellation of surgery when patients get to the Short Stay Unit. If cancellation occurs it creates stress for the patient and family and doesn’t provide a very satisfying experience. We have this unique method of communicating with anesthesia or Dr. Whitney to get an opinion regarding patient’s medical history problems. Dr. Arbittier, Dr. Whitney and Dr. McGuinn shadowed several PHAS nurses to get an idea of our work process prior to the start of the pilot. The pilot shifts testing responsibility to the more qualified and prepared registered nurse. It provides a one stop shop with an easy button. A preoperative testing tool has been set up that will eventually populate over to the preoperative testing requisition based on the assessment information we gather on the patient. That form is then right faxed to the annex of choice. Dr. Krzeminski wants to continue the process with his patients and several other surgeons are interested in the program.

**Summary**

Whether it be a large group such as a system wide CET or an YH based program and sub team, nursing is often seen at the go-to level for leading the initiative. We seek to put pre and post monitoring structures in place so that nursing not only provides leadership, but demonstrates effectiveness at the organizational level.