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2010 NURSING ANNUAL REPORT

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This year's Nursing Annual Report puts the spotlight on how nurses at Shawnee Mission Medical Center (SMMC) are working together to create a safer place for healing.

As part of our larger vision of being the best place for our patients to receive care, we have embraced patient safety as a strategic priority. SMMC's nursing strategic plan for patient safety highlights five objectives: creating a culture of safety, designing for safety, using teamwork and communication to enhance safety, promoting evidence to hardwire safety, and using technology to improve safety.

As these five objectives suggest, safety relies on a complementary combination of structure and process. We must provide a physical environment that supports safety. At the same time, we must give nurses the knowledge, tools and resources they need to practice in their environment in the best way possible.

In this report, you will learn how safety concerns influenced the design of our Critical Care Services Expansion. Nurses were involved in planning the physical environment, selecting equipment and developing processes for the delivery of care in this new facility.

This report also highlights a variety of teambuilding and communication strategies that support patient safety, including bedside safety checks and Safety Huddles. As you will see, the power of effective communication within and between teams is especially evident in the progress we have achieved in fall prevention.

You also will learn how realistic simulation drills using a state-of-the-art medical mannequin have given nurses in our Progressive Care and Perinatal units a powerful opportunity to hone in on their skills. In addition to giving individual nurses an opportunity to learn and improve, these drills also are designed to strengthen teamwork and communication.

Every day, nurses must confront an unfortunate paradox: environments devoted to health and healing can often make patients more susceptible to accidents and injury. Those who are ill and injured are inherently vulnerable, and the tools we rely on to cure disease and treat injuries are often accompanied by unique risks. While we can never completely eliminate safety risks, the examples in this report demonstrate that there is much we can do to reduce the potential for harm.

Safety is part of our organizational DNA, and the welfare of our patients is at the heart of everything we do. As we look to the future, the nurses at SMMC will remain committed to finding more ways to improve safety in every aspect of care.

Sincerely,

Sheri Hawkins

Sheri Hawkins, RN, MS, MBA
Vice President and Chief Nursing Officer

TELL ME ABOUT IT

Enhanced communication strategies emphasize safety

"A very high percentage of things that go wrong in hospitals can be traced back to a breakdown in communication," said Patient Safety Officer Suzanne Ginsburg, BSN, RN, MS. "We're always looking for ways to facilitate better communication, whether it's removing a barrier or creating a formal structure for information sharing."

For instance, multidisciplinary rounds ensure that everyone involved in a patient's care is on the same page about safety concerns and risks. In the ICU, for example, rounds are led by a pulmonary care intensivist and include the charge nurse, bedside nurse, critical care nurse specialist, pharmacy, dietary, respiratory specialists, a chaplain and a social worker. All physicians caring for a patient also are invited to attend.

"During rounds, we review critical information about each patient and monitor evidence-based therapies," said ICU Manager Ann Skilton, MSN, RN, CCRN. "This multidisciplinary approach encourages everyone involved in a patient's care to be very intentional and consistent about best practices and safety."

As in many other units at SMMC, nurses in the ICU also focus on safety concerns during Safety Huddles, which are brief meetings where nurses come together early in each shift.

Safety Huddles are also a part of the daily routine on the 40-bed 3-North Medical/Surgical Unit where nurses huddle at around 7:30 a.m. during the day shift and around 11 p.m. during the night shift. The huddles last less than 10 minutes and are very structured.

During the huddles, nurses discuss any patient who is unstable or may be at risk for any reason. Topics vary widely, but may include fall risks, medications, physician concerns, equipment, family situations – anything that affects patient safety.

"Safety Huddles are a great way to give everyone a quick snapshot of what the unit looks like at a point in time," said Peggy Curl, MSN, ARNP, WOCN, Medical/Surgical Nurse Manager. "The huddles also discourage an insular attitude of 'my patient' and 'my tasks' by making all the nurses on the unit aware of issues and threats."

In February 2010, Radiology became the first allied health department to adopt Safety Huddles. With six different modalities at three locations, communication can be particularly challenging.

"Because radiology is so big and spread out over so many locations, the huddles have been very useful," said Tim Edwards, BA, RT (R)(CT), Operations Manager for Radiology. "Not only do we use huddles to assess inpatient and oupatient safety risks, but also use them to identify risks for staff, such as the potential for personal injury because of problems with equipment."

Radiology also offers a great example of the importance of appropriate hand-off communication. Radiology transports up to 150 patients a day, and sharing information about patients – from provider to transporter to provider – plays a critical role in patient safety.

"This had been done informally for years, but we now have a formalized process for patient hand-offs," Edwards said. "This new process insures that nurses share key safety information with transporters so we can be aware of specific conditions and risks that may affect the patient's care while they are in radiology."

Another critical patient hand-off occurs every day during shift changes. To ensure that safety concerns are communicated in a consistent, structured way, units across the hospital have also implemented bedside safety checks.

These checks are a strategy first developed by the Oncology and 3-North Medical/Surgical units as part of Transforming Care at the Bedside (TCAB), which is a national effort to improve bedside care in medical/surgical units commissioned by the Institute on Healthcare Improvement.

"Bedside checks hold each nurse accountable at the end of a shift, even for small things, and that keeps small problems from turning into big problems," said Melanie Tuffley, RN, staff nurse on 3-North. "For instance, if two nurses doing a bedside check discover an infiltrated IV, they can take care of it immediately."

The bedside safety checks work in combination with two other TCAB strategies: shift reports based on the "SBAR" model (Situation, Background, Assessment and Recommendation) and in-room communication boards where providers post information about the patient's status and plan of care.

The bedside safety checks are a simple but powerful tool for promoting patient safety. At the beginning of each shift, the departing and oncoming nurse meet at the patient's bedside for about three minutes to exchange information and check IVs, equipment and wound sites.

The patient is introduced to the new nurse, and the two nurses communicate in front of the patient and family about safety concerns, such as a recent change in medication or if the patient is a fall risk. The patient and family also have the opportunity to ask questions and share information with nurses.

"Doing a bedside check adds another layer of safety to the shift change," said Michelle Foss, RN, staff nurse in the ICU. "It doesn't take the place of the SBAR report or the electronic records, but when you see the patient, it sparks your memory and ensures that you have shared all the important details with the oncoming nurse."

SAFETY TAKES TEAMWORK

Working together to implement best practices

On Nursing Strategic Pillar Planning Day in September 2009, nurses at Shawnee Mission Medical Center (SMMC) engaged in their own version of fantasy football.

"We wanted to make our strategic plan a living, meaningful document for clinical staff," said Susan Stark, MSN, APRN, RN, Director of Evidence-Based Practice at SMMC. "In particular, we wanted to promote the purpose and function of Safety Huddles, and we did that by using a football analogy."

Safety Huddles are five-minute reviews where nurses come together during each shift to share the unique needs and issues of the patients currently on their unit.

"The huddles are a component of Patient Safety and Quality, one of the five pillars of our Nursing Strategic Plan," Stark explained. "Just like a football huddle, a Safety Huddle is a great way for a team of nurses to have a winning game plan for patient safety."

SMMC's game plan for Patient Safety and Quality extends far beyond Safety Huddles. For instance, another strategic planning safety meeting last fall addressed the importance of monitoring medications, especially opioids. Because some patients are less tolerant of opioids, nurse leaders developed and implemented new protocols for assessment and measurement of this class of drugs.

Another planning meeting was devoted to a discussion of restraints, including how to assess when restraints are appropriate and how to document their use.

"In addition to addressing individual safety concerns, we're always trying to pull all the safety initiatives together so that nurses have the information they need, when they need it, as close to the patient as possible," Stark said.

To that end, Safety Notebooks were launched across the hospital in April 2010. The notebooks offer a "one-stop-shopping" approach to essential safety information.

The notebooks are customized to the needs of each unit and include four categories of safety information: priority communications, such as red alerts about medications or equipment; the falls prevention drilldown tool, which is used to report patient falls for analysis by the Falls Prevention Team; restraint guidelines and documentation; and key safety information shared during Safety Huddles.

Just as Safety Huddles and Safety Notebooks allow all nurses on each unit to share key information, bed briefings at the beginning of each shift give nurse leaders house wide – charge nurses, supervisors and nurse managers – an opportunity come together for an overview of the current status of the entire hospital, including system-wide safety concerns.

"Our goal is to keep every patient moving toward the goal line of health and healing," said Sheri Hawkins, RN, MS, MBA, Vice President and Chief Nursing Officer. "To achieve that goal, we seek out every opportunity to create a culture of safety."

CRITICAL CARE: SAFER BY DESIGN

Patient safety was one of the key drivers in the design of the hospital's new Critical Care Services Expansion, which opened in early 2009.

"At every opportunity, we incorporated evidence-based design into the expansion," said Sheri Hawkins, RN, MS, MBA, Vice President and Chief Nursing Officer. "We made specific choices with the knowledge that we could improve patient outcomes."

For instance, the design of the expansion's 28-bed ICU supports patient safety through greater visibility. Alcoves between patient rooms are equipped with a desk, a phone, a monitor showing the EKG readings for all ICU patients and – most importantly – windows into two adjoining rooms.

"This aspect of the design allows us to keep a closer eye on patients at all times," said ICU Manager Ann Skilton, MSN, RN, CCRN. "The alcoves allow nurses to work on charts, make calls and monitor the EKG status of the entire unit while maintaining direct visual contact with two critical patients."

Nurses also were concerned about being isolated from patients and other clinicians during team meetings. To overcome this, two rooms on the ICU feature glass walls. This design element further supports a patient-centered culture of teamwork and transparency, resulting in decreased anxiety and greater confidence among patients and families.

As they prepared for the new unit to open, nurses also worked together to develop processes and select equipment that would support patient safety. Supplies were a key area of concern. Easy access to medical supplies allows nurses to stay close to the bedside and respond quickly to the needs of critically ill patients. At the same time, safety also dictates that supplies can't be stored in patient rooms.

Nurses determined which supplies were most essential when caring for critical patients, and they selected portable supply carts to address the problem of access. The carts are lockable, with a double lock for medications, and can be rolled right up to the bedside. For patients in isolation, carts can be parked right outside the room. Similarly, computers kept on rolling carts allow bedside access to up-to-date patient information.

Patients ***and*** nurses are safer thanks to eight ICU rooms equipped with patient lifts. The lifts can move patients weighing up to 550 pounds, allowing nurses to easily raise a large patient in order to make the bed or reposition the patient. The lifts also can be used to transfer a patient into a chair or to hold up a limb with a sling in order to change a dressing.

"Our goal is always to have patients be as mobile as possible," Skilton said. "However, when critical patients aren't able to lift themselves and their size poses a safety risk, the lifts are a great solution. They are comfortable for patients, and safe and easy for nurses."

POWERFUL PRACTICE

Realistic simulations hone skills and foster teamwork

Over the past few months, dozens of nurses in the Perinatal and Progressive Care units at Shawnee Mission Medical Center (SMMC) have become familiar with an unusual patient named Noelle.

Noelle is a bit of a chameleon. She can have a heart attack one day and a baby the next. In fact, if you want her to, she can have heart attacks and babies every day of the week.

Noelle is a high-tech medical mannequin who visits SMMC through a partnership with the Healthcare Simulation Center at Johnson County Community College. Staff from the Center bring Noelle to the hospital, allowing teams to take part in highly realistic simulated clinical scenarios.

Thanks to sophisticated computer programming and robotics, Noelle is a very convincing stand-in for a real patient. She has vital signs. She breathes. She blinks. She bleeds. She talks.

And yes, she can even deliver a bouncing baby mannequin.

HANDS-ON LEARNING

The Progressive Care Unit (PCU) rolled out simulation drills using Noelle in February 2010, with three to five nurses participating in each one-hour session.

Over three weeks, the PCU was able to provide hands-on training to nearly 60 nurses. Drills were scheduled to allow full participation by both day and night shifts, and the unit manager and professional development staff took turns holding nurses' pagers so they could train in a secluded area and focus on the simulation.

SMMC is accredited as a Chest Pain Center of Excellence by the Society of Chest Pain Centers, and the PCU drills were designed to reinforce competencies in chest pain and identify areas where more training was needed.

During the simulations, each nurse was assigned a specific role, and the case scenario took them through three different diagnoses. Noelle wasn't the only lifelike part of the simulations. Everything was as close to real life as possible.

In addition to observing and talking with the patient, nurses also looked at her chart, called a physician, consulted with the pharmacy, calculated dosages, and even set up a 12-lead EKG.

"During the scenario, we had to stabilize a patient who was experiencing chest pain," said Barbara Gruenenfelder, RN, Charge/Staff Nurse in the PCU. "I found the drill extremely helpful because we were able to practice some important skills we don't use very often and do so in a realistic team environment that required collaboration."

Each drill concluded with a debriefing to analyze and discuss the scenario and how well the team had handled the situation. During these discussions, the nurses learned which objectives the scenario was designed to meet.

"For 90 percent of our nurses, except a handful of younger nurses who practiced on mannequins in nursing school, this was a new way of learning," said Mary Wirtz, RN, Clinical Educator for the PCU. "The nurses found it fun and challenging because it felt like the real thing. As result, they were very engaged and open to learning."

Based on the success of the first round of simulations, the PCU is now looking at other competencies that can be practiced and perfected using mannequins like Noelle.

"It took a lot of coordination and teamwork to pull them off, but the drills were extremely valuable," Wirtz said. "The simulations truly demanded the kind of quick, critical thinking required in the PCU."

BUILDING STRONGER TEAMS

Before Noelle started impersonating a PCU patient, she was already a familiar face in the Perinatal Unit, where she played the part of a pregnant patient in two drills that included doctors as well as nurses.

Just as veteran pilots can benefit from flight simulations, even the most experienced health care professionals can hone in on skills and learn new things during a simulation. As with flight simulations, one of the most powerful aspects of health care simulations is that they require the "flight crew" to practice working together.

In one of the perinatal simulations, Noelle was losing blood due to complications during

childbirth. The unit had recently initiated a new massive transfusion protocol, so this scenario allowed doctors, nurses and ancillary departments – including staff in the blood bank – to rehearse the new procedures.

At the conclusion of the scenario, the team participated in a debriefing to analyze and discuss how well they had performed and identify areas for improvement.

"People engaged far more than I expected them to, including the physicians," said Nancy Boutte, RN, Perinatal Nurse Educator. "Because doctors work with departments at different hospitals, the drills really helped them better understand how our unit functions and communicates."

Instead of educating nurses and physicians separately, the simulations put everyone in one room at the same time, where they could learn from each other – and learn from the team's mistakes.

"I've been a nurse for 19 years, and very often the most profound learning comes when something goes wrong," Boutte said. "Simulations are a safe place to make mistakes and then learn from those mistakes."

READY FOR THE REAL THING

The ultimate goal of the simulation drills is improved patient safety. The drills provide a safe place to practice, allowing nurses to be better prepared to react quickly and make the best possible decisions when a patient is in trouble.

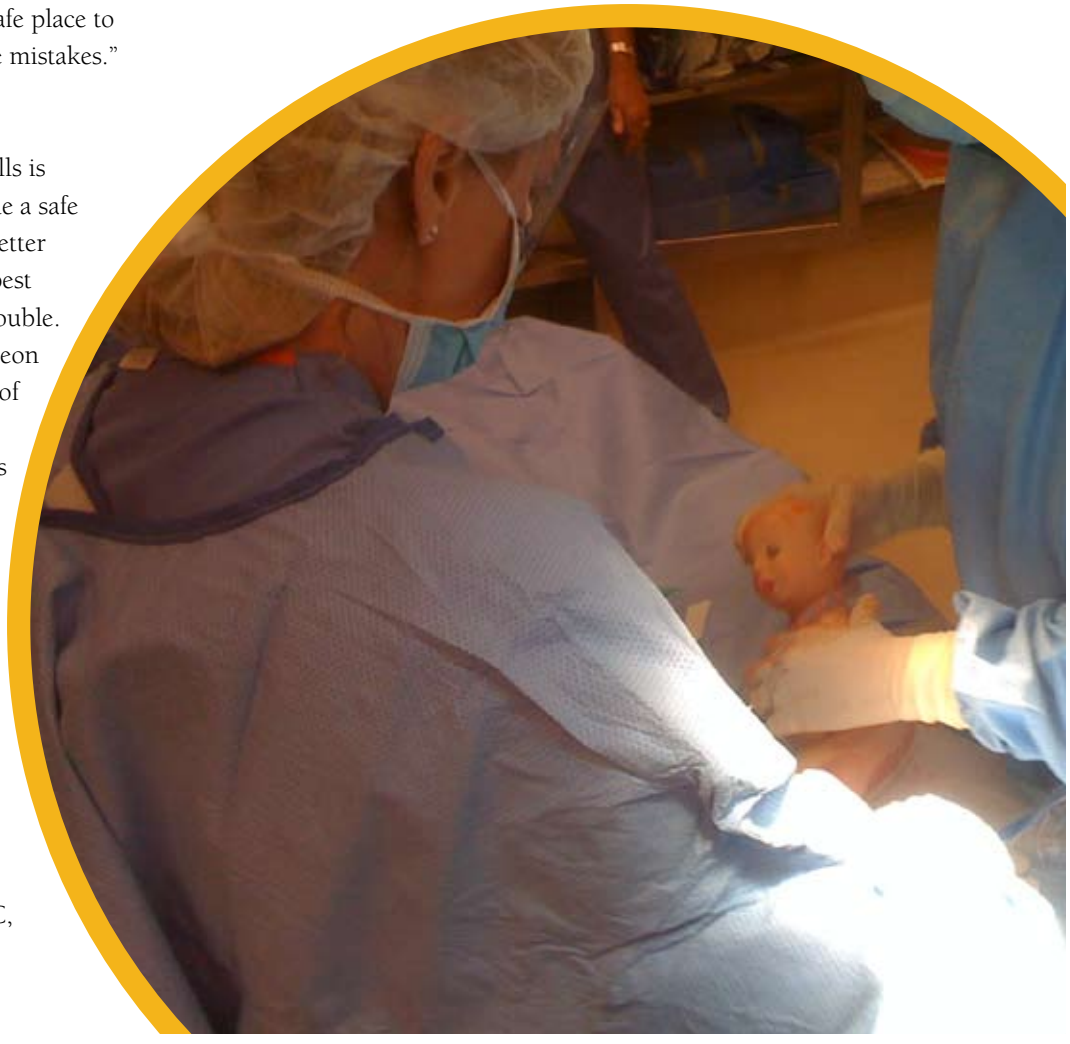
David Zamierowski, MD, a plastic surgeon and founder of the Wound Care Centers of Kansas City, is a major proponent of the benefits of simulated learning. He and his wife, Mary Zamierowski, PhD, helped fund the Healthcare Simulation Center at Johnson County Community College, and he encouraged SMMC to embrace this high-tech, hands-on approach to training.

"We're very fortunate to have access to Noelle and the college's expertise in simulation. Because the mannequin is so lifelike, the scenarios require realistic application of science and protocol," said Janet Ahlstrom, RN, MSN, ACNS-BC, Director of Professional Advancement. "The drills also focus on situations that require effective team communication, which is a huge component of patient safety."

As nurses in the PCU and Perinatal Unit can attest, simulation drills are ideally suited to adult learners and to the unique demands of nursing, where textbook learning can never substitute for hands-on experience.

Jamie DeLong, RN, BSN, is a Labor and Delivery nurse who has been with SMMC for 11 years. In addition to participating in one of the obstetrics drills, she also provided the voice of Noelle during many of the simulations.

"The drills are very intense and dynamic, just like a real medical emergency, so all your experience and training kick in," DeLong said. "Then you are able to discuss what happened and make sure everyone on the team is ready for the real thing."



ONE STEP AT A TIME

Focusing on fall prevention

Falls are a common cause of injury among patients, and preventing falls poses an ongoing challenge for health care organizations.

Hospital patients must navigate a strange environment and many are already unsteady due to health conditions and age. Patients of all ages can be at risk, but the likelihood of falls is higher for older patients. About 50 percent of patients at Shawnee Mission Medical Center (SMMC) are over age 65 – a percentage that increases if you take obstetrics patients out of the equation.

Various aspects of treatment, including IVs and medications, can further diminish strength, balance and mobility. All these factors combine to create high-risk situations for falls, making the prevention of falls and fall-related injuries a top priority.

"When a patient is injured or suffers a setback due to a fall, it's deeply frustrating for the patient and the patient's family, as well as for caregivers," said Janet Ahlstrom, RN, MSN, ACNS-BC, Director of Professional Advancement and a member of the SMMC Falls Prevention Team.

REDUCING THE RISK

Over the years, the Falls Prevention Program at SMMC has used a variety of strategies to make sure nurses and other staff are aware of those patients at risk for falling, including color-coded wristbands, magnets on the outside of patients' doors and stickers on charts.

Other ammunition in the fight against falls has included clear pathways, good lighting, bed alarms and putting at-risk patients closer to nursing stations.

Despite these safeguards, some patients were still experiencing falls. The Falls Prevention Team saw room for improvement and their recent efforts have had a significant impact.

The number of falls fluctuates from month to month, but the overall trend during the last two years has been downward. In summer 2008, SMMC averaged approximately six falls per 1,000 patient days. In fall 2009, that average had decreased to approximately three falls per

thousand patient days.

The Falls Prevention Team includes representatives from multiple departments, including nursing, pharmacy, physical therapy, supplies, quality and risk management. This multidisciplinary approach reflects the fact that falls are 'everybody's business' – that every team member in every department has a role to play in identifying fall risks and communicating within and across teams to prevent falls.

SMMC's intensified focus on falls prevention is aligned with national efforts to address this universal challenge. Falls prevention is one of the National Patient Safety Goals established by the Joint Commission on Accreditation of Healthcare Organizations, and reducing patient injury from falls is one of the ongoing aims of Transforming Care at the Bedside, a national effort commissioned by the Institute on Healthcare Improvement to improve bedside care in medical/surgical units.

MORE EYES, MORE EARS, MORE TOOLS

One of the most visible and effective strategies that SMMC has implemented is the use of bright yellow identifiers. Nationally, yellow has recently been designated as the standard wristband color for fall risks.

At SMMC, in addition to bright yellow wristbands, at-risk patients also wear yellow slippers and yellow lap blankets when they are being transported. These yellow items provide a powerful visual cue, allowing staff to know immediately if a patient is at risk for falling. In addition, whenever a patient is moved, a paper form detailing why the patient is at risk is handed off from provider to transporter to provider.

"One of our biggest accomplishments is heightening everyone's awareness of at-risk patients through yellow identifiers," explained Grace Hagemann, RN, BSN, CMSRN, staff nurse on 3-South and Chair-Elect of the Falls Prevention Team. "It's been exciting to implement this idea and see the positive impact it has had on our patients."

Patients who are at risk for falling also are identified and discussed during Safety Huddles, which are quick meetings where all the nurses on a unit come together during each shift to share safety concerns. This ensures that everyone on the unit is aware of fall risks and ready to be extra vigilant about potential falls.

"The Falls Prevention Team has done a phenomenal job of designing a great fall-risk protocol," said Susan Stark, MSN, RN, APRN-BC, Director of Evidence-Based Practice. "This includes making everyone aware of the tools they can use to prevent falls, as well as devices that can help prevent injury when patients do fall."

Those tools include improved bed alarms that alert nurses when an at-risk patient is trying to get out of bed unassisted, chair alarms and beds that can be lowered closer to the floor.

"Many cancer patients are at risk for falling because they have epidurals or are taking medications that make them groggy," said Simonna Smolich, Clinical Associate and Information Associate in the Oncology Unit. "The option to use high-low beds give us another way to protect patients who are at risk."

Another injury-prevention device the team has successfully promoted is the use of hip pads. Hip fractures can be devastating in older patients, and the pads reduce the likelihood of a fracture if a patient does experience a fall.

RAISING THE BAR

The overall reduction in falls is rewarding, but for the Falls Prevention Team, every incident is an opportunity to learn and improve. The team is constantly reassessing its efforts and looking for more ways to protect patients.

One way they do this is through post-fall drilldowns. Any time a patient falls, a report is filled out by the nurse and unit leadership, describing what happened and identifying the contributing factors. Once a month, the team analyzes and categorizes these reports to identify what could be done to prevent similar falls in the future and how to better protect patients if they do suffer a fall.

For instance, the most common location for patient falls is in the bathroom. As of January 2010, an analysis of falls at SMMC showed that 40 percent were related to elimination. Improved awareness during hourly rounding and vigilance about meeting the elimination needs of patients resulted in a 20 percent reduction in this type of fall, a decrease that was achieved in just two months.

Falls continue to be a major concern after patients are discharged, and the team recently received a small grant to work on developing a program to educate patients on how to avoid falls after they leave the hospital.

The team's impact also reaches beyond SMMC and its patients. Sheri Hawkins, RN, MS, MBA, Vice President and Chief Nursing Officer, chairs the Falls Prevention Committee for the Adventist Health System.

"I'm very proud of the role our nurses have played in reducing falls and fall-related injuries," Hawkins said. "I'm excited to see how what we have learned can contribute to best practices for this crucial aspect of patient safety."

NURSING SHOWCASE

Individual Nursing Accomplishments, May 2009-April 2010

The following nurses are acknowledged for the achievements each has contributed to the nursing profession during the past year.

AWARDS

Roberta Anson, Short Stay Unit
Step Up Award, SMMC

Beth Baker, ECT/Behavioral Health
Membership Omicron Delta Chapter
Sigma Theta Tau International Nursing Honor Society

Ann Daniels, Labor and Delivery
Caring Collaborator Award, SMMC

Ashley Duncanson, Short Stay Unit
Newcomer Award, SMMC

Jane Eggleston, Oncology
Step Up Award, SMMC

Michelle Foss, Intensive Care Unit
Step Up Award, SMMC

Meg Holloway, Breast Center
Heart of Gold Award Nominee
Cancer Action Kansas City

Mary Jackson, Critical Care Unit
Newcomer Award, SMMC

Chiquita Jones, Progressive Care Unit
Newcomer Award, SMMC

Kelly Kearns, Critical Care Unit
Pathfinder Award, SMMC

Ellen Ladner, NICU
Pathfinder Award, SMMC

Marla Landreth, PACU
Step Up Award, SMMC

Dawn Linneman, Breast Center
Caring Collaborator Award, SMMC

Natalie Lowery, Professional Development
Newcomer Award, SMMC

Melissa Strief, PACU
Newcomer Award, SMMC

Julia Thrasher, Float Pool
Caring Collaborator Award, SMMC

Armida Torres, Professional Development
Step Up Award, SMMC

Erin Walden, Critical Care Unit
Step Up Award, SMMC

James Wright, Behavioral Health
Caring Collaborator Award, SMMC

NEW CERTIFICATIONS

Diana Faltermeier, Emergency Department
Certified Emergency Nurse
Emergency Nurses Association

Emily Fox, Labor and Delivery
Sexual Assault Nurse Examiner
Office for Victims of Crime

Monica Grosdidier, Women's and Children's Services
Certified Breastfeeding Educator
Lactation Consultant Services

Kristi Henderson, TEAMworks
Critical Care Registered Nurse
Certification in Critical Care Nursing

Ruth Milberger, Oncology
End of Life Nursing Education Consortium
American Association of Colleges of Nursing

Armida Olson, Diabetes Education
Certified Diabetes Educator
American Nurses Credentialing Center

Debbie Patane, Oncology
End of Life Nursing Education Consortium
American Association of Colleges of Nursing

Malinda Stern, NICU
RNC Low Risk Neonatal
Academy of Women's Health Obstetrical and Neonatal Nurses

Lori K. Swope, Infection Control
Certification in Infection Control
Certification Board of Infection Control and Epidemiology

Armida Torres, Professional Development
Critical Care Registered Nurse
Certification in Critical Care Nursing

Candy Woelk, Surgery Center
Certified Nurse periOperating Room
Association of periOperating Room Nurses

RENEWAL OF CERTIFICATION

Janet Beger, Labor and Delivery
Inpatient Obstetric Nursing
National Certification Corporation

Debbie Dower, Joint and Spine Care Center
Orthopedic Certified Nurse
Orthopedic Nurses Certification Board

Jill Greig, Infection Control
Certification in Infection Control
Certification Board of Infection Control and Epidemiology

Kathy Jensen, Heart and Vascular Center
Critical Care Nurse Specialist
American Association of Critical Care Nurses

Sally Jordan, Labor and Delivery
Inpatient Obstetric Nursing
National Certification Corporation

Linda Kissinger, Endoscopy
Certified Gastroenterology Registered Nurse
Society of Gastroenterology Nurses Association

Cindy Ladner, Surgery Center
Certified Ambulatory PeriAnesthesia Nurse
American Society of PeriAnesthesia Nurses

Carol Maisch, Surgery Center
Certified Ambulatory PeriAnesthesia Nurse
American Society of PeriAnesthesia Nurses

Monica Powers, Surgical Services
Certified Nurse Operation Room
Competency and Credentialing Institute

Kim Sherman, Oncology
Oncology Certified Nurse
Oncology Nursing Certification Corporation

Deborah Stout, Prairie Star Surgery Center
Certified Ambulatory Perianesthesia Nurse
American Society of Perianesthesia Nurses

Charlene Wallace, Breast Center
Oncology Certified Nurse
Oncology Nursing Society

DEGREES/CERTIFICATES

Beth Baker, ECT/Behavioral Health
Master of Science in Nursing; Master of Healthcare Administration
University of Phoenix

Kathy Barbay, Bariatric Program Coordinator
Master of Science in Nursing
University of Kansas

Maggie Barnidge, Labor and Delivery
Master of Bioethics
Kansas City University of Medicine and Biosciences

Adrianne Brinker, NICU
Bachelor of Science in Nursing
University of Kansas

Amber Delphia, Mother/Baby
Bachelor of Science in Nursing
Mid-America Nazarene University

Kristin Graybar, Progressive Care Unit
Associate Degree in Nursing
Johnson County Community College

Erica Hedge, 3-North
Bachelor of Science in Nursing
University of Kansas

Topaze Langford, Progressive Care Unit
Bachelor of Science
University of Missouri-Kansas City

Cathy Lauridsen, Progressive Care Unit
Nurse Refresher Program
State of Kansas

Nicole Lawrence, 3-North
Associate Degree
Johnson County Community College

Dawn Linneman, Breast Center
Bachelor of Science in Nursing
University of Missouri-Kansas City

Kimberly Shepard, 3-North
Bachelor of Science in Nursing
Baker University

Katy Stangl, Progressive Care Unit
Associate Degree in Nursing
Johnson County Community College

Lori K. Swope, Infection Control
Master of Health Administration
Webster University

Jami Weichert, 3-North
Associate Degree
Johnson County Community College

Kebedu Yimam, Progressive Care Unit
Associate Degree in Nursing
Kansas City Kansas Community College

PRESENTATIONS

Nancy Boutte, Labor and Delivery
OB Simulation Drills
"Shoulder Dystocia, Emergency C/S, Hemorrhage, Pregnancy-Induced Hypertension"
Labor and Delivery

Catherine Castelli, Professional Practice
Oral
"Pain/Palliative Care"
Greater Kansas City Medical-Surgical Consortium Review Course

Oral
"Oncologic Emergencies"
Greater Kansas City Chapter of Oncology Nursing Society, OCN Review Course

Jill Greig, Infection Control
Oral
"Norovirus Outbreak Investigation"
Ban the Bug Conference, Association for Professionals in Infection Control and Epidemiology

Peggy Hohendorf, Surgical Services
Oral
"Eating Healthy"
Epsilon Sigma Alpha Sorority

Candy Marx, Intensive Care Unit
Oral
"Data Aggregation using the Apache System and Business Objects"
Cerner World Headquarters

Jen Ogden and Diana McCully, Surgical Services
Webinar
"Blue Wrap Recycling – From Dream to Reality in Less than a Year"
Practice Greenhealth

Susan Stark, Professional Practice
Oral
"Neurological Diseases and Nursing Care"
Med/Surg Consortium, St. Joseph Medical Center

Oral
"Second Annual Stroke Forum: Victim to Victor"
Johnson County Community College

Oral
"Core Measures, Outcomes, Evidence-Based Practice: What does it Mean?"
Bi-State Stroke Consortium

PUBLICATIONS

Kathy Barbay, Bariatric Program Coordinator
Research Evidence for the use of Preoperative Exercise in Patients Preparing for Total Hip or Total Knee Arthroplasty
Orthopaedic Nursing, May/June 2009

Meg Holloway, Breast Center
Contributing Author – Women's Health and Reproductive Systems, Cardiovascular System, Musculoskeletal System, Nervous System
LaFleur Brooks, Myrna. *Basic Medical Language, 3e.* Mosby Elsevier, 2010.

Joyce Lasseter, Intensive Care Unit
Chronic Fatigue: Tired of Being Tired
Home Health Care Management and Practice, December 2009

GRANTS

Dallas Purkeypile and Camela Noonan-Green, Emergency Department
$571
Older Adult Fall Prevention Mini Grant
Northeast Regional Trauma Council, Kansas Department of Health and Environment

PROFESSIONAL LEADERSHIP

Janet Ahlstrom, Professional Development
Member Content Expert Panel
American Nurses Credentialing Center, American Nurses Association

Member Community Council
Gift of Life Foundation

Sandie Anderson, Diabetes Education
Chair, Diabetes Education Recognition Program
American Diabetes Association

Julie Baker, Prairie Star Surgery Center
President-Elect
Metro KC PeriAnesthesia Nurses Association

Catherine Castelli, Professional Practice
Treasurer
Clinical Nurse Specialists, Greater KC Chapter

Jill Greig, Infection Control
Member of Healthcare Associated Infection Advisory Stakeholder Committee
Kansas Department of Health and Environment

Member of Bylaws Committee
Association for Professionals in Infection Control and Epidemiology

Cathy Haymaker, Intensive Care Unit
Educator
Midwest Association for Administrative Supervisors

Cindy Ladner, Surgery Center
Missouri Kansas Representative Assembly Delegate
Missouri Kansas PeriAnesthesia Nurses Association

Susan Stark, Professional Practice
Co-Chair
Bi-State Stroke Consortium

Lori K. Swope, Infection Control
Chair of Membership Committee
Association for Professionals in Infection Control and Epidemiology

Linda Van Hoecke, Infection Control
Member of Program Committee
Association for Professionals in Infection Control and Epidemiology

FRONTLINE LEADERSHIP ACADEMY

Janet Ahlstrom, Professional Development
Coach

Roberta Anson, Short Stay Unit
"Nursing Teams for Reduced Admission Time"

Beth Armstrong, PSC/ACC/PACU
Coach

Jan Babcock, Progressive Care Unit
"Create E-mail Accounts for Progressive Care Unit Associates"

Marcia Becker, Surgery Center
"Increase Computer Use in Pre-Surgery Interviews"

Jenny Chambers, Short Stay Unit
Coach

Lynda Dowling, Clinical Informatics
Coach

Kristin James, Progressive Care Unit
"Chart Check Education"

Kimberly Keyser, Intensive Care Unit
"Protecting Their Privacy – Patient Confidentiality Code"

Laura Monty, Pulmonary and Respiratory Therapy
"Evaluating Short Notice Discharge Orders for Ancillary Departments"

Jennifer Moore, Rehabilitation Services
"Evaluating Short Notice Discharge Orders for Ancillary Departments"

Meredith Mullen, 3-South
"Protecting Their Privacy – Patient Confidentiality Code"

Deb Ohnoutka, Women's and Children's Services
Coach

Nadine Paegel, Progressive Care Unit
"Chart Check Education"

Debbie Pahura, Women's and Children's Services
Coach

Pam Richey, Nursing Resources
Coach

Cindy Sadewhite, Surgery Center
"Increase Computer Use in Pre-Surgery Interviews"

Jennifer Smith, ASK-A-NURSE
Coach

Jamie Todd, Progressive Care Unit
"Chart Check Education"

Armida Torres, Professional Development
Coach

Kasindra Van Meter, Progressive Care Unit
"Protecting Their Privacy – Patient Confidentiality Code"

Duane Warkentin, Progressive Care Unit
"Protecting Their Privacy – Patient Confidentiality Code"

Theresa Wehrly, Dietician
"Evaluating Short Notice Discharge Orders for Ancillary Departments"

Alisha Westervelt, Endoscopy
"Reducing the Number of Nurses Transporting Patients Between the Hours of 7-9 a.m."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