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PCU Nursing Considerations for CAR-T Therapy
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FIT Rounds in the PCU
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Igniting Innovation
Melissa Callahan BSN, RN, OCN, Jessica Mathers MSN, RN, CNL, CCRN, Laura Vento MSN, RN, CNL

Case Study: The Ethics of Law Enforcement in the PCU Setting
Daniela Jenkins MSN, RN, CCRN, NEA-BC, Dr. Judy E. Davidson DNP, RN, FCCM, FAAN, Dr. Lynette C. Gedequist, MD

We Acknowledge

Five Magnet Components

Transformational

Leadership Structural

Exemplary

Professional Practice

New Knowledge and Innovation

Empirical Outcomes

Shared Governance committee membership is a great way to become personally involved in the Magnet journey and to help shape the future of nursing at UCSD. For more information go to our nursing website at https://health.ucsd.edu/medinfo/nursing/Pages/nursing-committee-opportunities.aspx

Message from the Chief Clinical Officer

Welcome to the 16th issue of the UC San Diego Health Journal of Nursing. We are proud to produce this year’s journal centered on the topic of progressive care nursing. We asked each of our Progressive Care Units (PCUs) to provide stories about their unit, and received a wide range of material on a variety of topics. In 2016 UCSDH expanded the number and types of patient care units. This was done for many reasons. First, we needed to increase the number of ICU beds available for tertiary care needed by patients transferred from our new affiliations with other health centers. Secondly, as our market-share continues to grow, we needed to provide more patients with treatments that required closer monitoring than can be done on a medical-surgical floor.

You will read about the experience of opening a new PCU, where nurses were often asked to care for new types of patients at a new level of care. Many of these nurses had not expected a change like this in their career. Whole units that were once medical-surgical level of acuity were required closer monitoring than can be done on a medical-surgical floor.

We are proud to produce this year’s UC San Diego Health Journal of Nursing. For more information go to our nursing website at https://health.ucsd.edu/medinfo/nursing/Pages/nursing-committee-opportunities.aspx

With Gratitude,
I wish all of you a wonderful Nurses Week.

Chief Clinical Officer

UC San Diego Health

Margarita Baggett, MSN, RN

Chief Clinical Officer

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Progressive Care Certified Nurse (PCCN): A Specialty Certification

By: Genesis R. Bojorquez, MSN, RN, PCCN

Progressive Care Certified Nurse (PCCN) is a credential granted by the American Association of Critical-Care Nurses (AACN) Certification Corporation and designates certification in adult progressive care nursing. Progressive care is the term used by AACN to collectively describe areas of which acutely ill patients are cared for, such as: intermediate care, direct observation, step-down, telemetry, transitional care, and emergency departments. The acuity of patients admitted to these areas are often transferred from critical care units while still requiring an increased level of vigilant nursing care. National practice analyses of the progressive care environment, patient populations served, and core competencies of progressive care nurses validated these competencies of progressive populations served, and core care environment, patient analyses of the progressive nursing care. National practice

The acuity of patients admitted to these areas of care often requires patients to transfer from critical care units while still requiring an increased level of vigilant nursing care. National practice analyses of the progressive care environment, patient populations served, and core competencies of progressive care nurses validated these competencies. Nurses who have achieved the PCCN certification provide patients and their families with validation that the nurse caring for them has demonstrated experience and knowledge in the complex specialty of progressive care.

PCCN EXAM

Eligibility

Nurses seeking PCCN certification must have a current unencumbered license as an RN or APRN in the U.S. and meet one of the following clinical practice requirement options:

Option 1: Practice as an RN or APRN for 1,750 hours in direct care of acutely ill adult patients during the previous two years, with 875 of those hours accrued in the most recent year preceding application.

Option 2: Practice as an RN or APRN for at least five years with a minimum of 2,000 hours in direct care of acutely ill adult patients, with 144 of those hours accrued in the most recent year preceding application.

Exam Content

The PCCN Exam is 2 1/2-hours and contains 125 questions. 100 questions are scored and 25 are used to gather statistical data on question performance for future exams. The items are based on the AACN Synergy Model for Patient Care, with 80% focusing on Clinical Judgment and 20% focusing on Professional Caring and Ethical Practice. The exam is offered by computer-based testing year-round across the U.S. and the score report becomes available immediately upon completion of the exam. AACN offers an online PCCN review program at: https://www.aacn.org/store/books/pccnrd13/pccnreviewcourses-online

PCCN Renewal

The PCCN certification is recognized for a 3-year period. During the 3-year certification period, the nurse must maintain a current, unencumbered RN or APRN licensure and complete an Examination Recognition Point (CERPs) program outlined by AACN. The CERPs system awards credit for activities that don’t fall into the direct clinical practice category, such as writing articles, serving on committees or being a mentor/preceptor. In addition to CERPs, the nurse must meet the clinical practice requirement of 342 hours in direct care of acutely ill adult patients, with 144 of those hours accrued in the 12-month period prior to the renewal date.

Significance of PCCN Certification

The PCCN certification provides patients and their families with validation that the nurse caring for them has proven specialty knowledge, experience, and clinical judgment of progressive care nursing. Acutely ill patients require intricate care from a team of highly skilled health professionals and as healthcare becomes more complex, nurses are encouraged to validate their knowledge and abilities through certification. As a voluntary process, obtaining a specialty certification points to nurses’ commitment to care development and dedication to patient care. Furthermore, by becoming certified, nurses position themselves for appropriate recognition, advancement, and a sense of confidence and achievement. In progressive care areas, the PCCN is a mark of excellence to patients, their families, employers, and nurses.

Conclusion

PCCN certification promotes continuing excellence in progressive care nursing by assisting registered nurses in maintaining an up-to-date knowledge base of care of acutely ill adult patients. Achieving certification provides nurses with a sense of professional pride and commitment to the progressive care specialty, and reinforces the core competencies, special knowledge, and experiences required for progressive care nursing.

References:

The Evolution of Progressive Care Unit in Acute Care Settings

By: Rachel Lantacon MSN, RN, CCRN and Dorothy Macavinta MSNc, BSN, RN-BC, PCCN

The Progressive Care Unit (PCU), also known as the Intermediate Care Unit (IMU) or Step-down unit, was developed to care for those patients who do not require ICU but need closer monitoring than can be provided with medical-surgical (med-surg) level of care. Table 1 defines the number of PCU units in the UC San Diego Health system, which have evolved throughout the years with the opening of more hospitals and units. Bed capacity has increased with more patients being monitored. PCUs are equipped with telemetry monitoring, continuous pulse oximetry machines, and arterial and central venous pressure monitoring. This technology requires nurse knowledge on a list of educational topics such as vascular access, hemodynamic monitoring, pacemakers, automatic implantable cardiac defibrillators, pharmacologic infusions, advanced cardiac life support, and conscious sedation (Berke & Eckland, 2002). The additional technology and higher acuity of the patients requires education and training, and develops skills for nurses working in this environment (Stacey, 2011).

The evolution of the PCU and the rate that units are opening and being utilized in hospitals today is a testament to how effective they can be, in both cost and care. The American Association of Critical-Care Nurses (AACN, 2010), explains that PCU patients are “moderately stable with less complexity (who) require higher acuity care and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care.” PCU patients can span from med-surg, telemetry, or intermediate care and facilities. The transfers and discharges are also dependent on the rate the patient is recovering or declining. The PCU is able to work with the patient’s individual care plan, promoting the care for a patient with the right technological monitoring and invasive lines with nurses who have the knowledge and familiarity with a wide range of diagnoses and conditions.

Proper education and knowledgeable nurses are necessary in caring for any patient in the hospital. With the extensive range of patients being monitored in the PCU, nurses need to be competent. The completion of the competency based orientation makes the nurse accountable and aware of their responsibilities and scope of practice in their respective floors. According to our professional practice model, teaching and staff development is a core value in the nursing division. Exercising this core value through PCU education courses was essential to prepare nurses for specializing in this select patient population with proper hands-on practice-based learning and the initial PCU courses.

Initially, UCSD Hillcrest started with one PCU originating from the 11th, 9th and 7th floors. This unit previously catered to a variety of patients and diagnoses including but not limited to orthopedic, trauma, transplant surgeries, neuro-critical, medical-surgical staff, and failure. There appeared to be no limitation on patients the unit could accept. Expansion of the Progressive Care Unit occurred as more nurses were cross-trained from the 11th, 9th, and 7th floors to transfer to the new hospitals and units were developed in the months and years following. With the opening of Sulpizio Cardiovascular in 2011 and specialized Trauma Unit in 2012, skills and knowledge were shared amongst these staff from the original PCU. In addition to shadowing with a designated preceptor, further allocation of funds and resources were utilized to ensure that specialty PCUs became highly skilled and knowledgeable in their respective fields. Such distribution of knowledge and training occurred again with the advent of Jacobs Medical Center in 2016. Multiple specialties and divisions arose: Medical, Surgical, Neuro-critical, and Oncology, from which many nurses were hired and trained from the original PCU. Development of specialized units may be advantageous in terms of improving patient outcomes. One example in the literature, in a Respiratory Intermediate Care Unit in the University Hospital of Cattarina, reported a reduction of unanticipated intubations, length of stay and timely transfer to the ICU. Here the nurses specialized in proper utilization of non invasive ventilation, administration of specific medications not normally provided in med-surg care, skills in chest physiotherapy, and arterial gas interpretation. (Conflantoni et al. 2015). It is with these specializations that UCSD can boast expertise. One example is the unique care required to provide care in the highly specialized pulmonary thromboendarterectomy (PTE) patient rate. The UCSD program has been shown to have the most successful PTE outcomes including the lowest post-operative mortality rate worldwide (2019). There is a continuous trend in having multiple med-surg floors converted to PCU floors, allowing for their nurse to work on higher acuity patients. The main goal is to soon have PCU floors of all specialties, thus improving patient flow. The PCU’s evolution was a necessary and important shift in UCSD’s history, allowing more nurses to grow and develop their skills, ensuring patients receive the proper level of monitoring, encouraging appropriate utilization of resources, and aiding with bed capacity throughout the hospital.

Table 1: Progressive Care Units at UCSD Health

<table>
<thead>
<tr>
<th>UCSD Medical Center (Hillcrest)</th>
<th>Thomson (La Jolla)</th>
<th>Jacobs Medical Center (La Jolla)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCSD - 1966</td>
<td>2E Surgical 27 beds</td>
<td>4SGH Surgical/Oncology - 36 beds</td>
</tr>
<tr>
<td>5W Trauma 24 beds</td>
<td>2W Surgical 27 beds</td>
<td>3FSG Medicine/Oncology/Palliative Care 24 beds</td>
</tr>
<tr>
<td>7W Medicine 18 beds</td>
<td>3P FU 15 beds</td>
<td>5W Nru 12 beds</td>
</tr>
<tr>
<td>9W Medicine 6 beds</td>
<td>4 A/B PUI 27 beds</td>
<td>5FGH Oncology - 36 beds</td>
</tr>
<tr>
<td>11th Floor Surgical</td>
<td>PCU 36 Beds</td>
<td>PCU 36 Beds</td>
</tr>
</tbody>
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REFERENCES:

Rachel Lantacon, MSN, RN, CCRN

Dorothy Macavinta, MSNc, BSN, RN-BC, PCCN

was hired as new graduate nurse at UC San Diego Health in 2000. She now holds a Master’s degree in Nursing from San Diego State University. In her current role, she serves as the Assistant Nurse Manager in the Medicine PCU in Hillcrest. Rachel Lantacon, MSN, RN, CCRN

Dorothy holds specialty certifications in Medical-Surgical Nursing and Progressive Care Nursing. Dorothy Macavinta, MSNc, BSN, RN-BC, PCCN

bed availability and placement are important factors when assigning patients to a room or unit. There are strict acuity criteria for med-surg and intensive care units. The usage of PCUs helps with quicker and more efficient triage. The PCU is used as a middle ground to monitor patients that may be improving or deteriorating but not yet critically ill. Patients with changing level of care requirements also affect the admission, transfer, and discharge rates. Admissions can come from both med-surg and ICU beds; they can also be admitted directly from the emergency department or transferred from other healthcare settings.

stafing is adjusted according to the patient’s needs. Creating a PCU level of care criteria offers patients who would unnecessarily be kept in the ICU the possibility to be transferred or downgraded to PCU, thus increasing ICU capacity, allowing a bed for a patient who is more critical and could potentially benefit more (Vincent & Rubenfeld, 2015). PCUs are able to use telemetry monitoring devices to monitor cardiac rhythm and continuous oxygen saturation. With adherence to the mandated nurse to patient ratio, the nurse can monitor vital signs and patient condition more frequently. Due to the vast ways patients are able to be monitored, these units are able to manage higher acuity patients and care for a large proportion of inpatient admissions.

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Oh, the Places You Go!
A Glimpse Into the Life of a 2-East PCU nurse

By: Kimberly Noumi MSN, RN and Kimberley Connors-Mabry BSN, RN

Kim started her career at UCSD the year AB 394 passed in the California Legislature, mandating RN staff ratios. The implementation would not take effect until January 1, 2004, so it was still the ‘Wild West’, so to speak. During Kim’s first year at UCSD, 2-East was a senior behavioral health unit, and the IMU occupied 9 beds on 2 West. She had 4-5 patients per shift, the acuity was high, and the unit was always full. Often, the IMU would expand to 12 beds due to patient needs. This precipitated a permanent move to 2 East a few years later due to the growing acuity of the patient population. Kim spent her shifts honing her skills with a mixed medicine-surgical floor.

Kim, what was it like working in the IMU in 1999. Who did you work with?
It was my first IMU experience. There was a big learning curve. I worked with a lot of travelers and a small core group of nurses. We had CCP’s, with one of our night CCP’s, Al, starting a few months after I did. We had 3-4 nurses on each shift, no resource, and the charge RN took patients.

What kind of training did you receive when hired to work on the IMU unit?
We took a critical care symposium with other RN’s in other facilities throughout San Diego. Patty Graham taught the classes (and still does). I learned a lot. We used a large purple critical care textbook. It was intense! Also, we all took ACLS, not the ART we take today.

This was the year the California legislature passed the RN ratio law. It was implemented in 2004. Is there anything back then that sticks out to you as being different when it comes to nursing care compared to now?
Well, we had paper charting that was huge. Our nursing care compared to now?

Kimberley Connors-Mabry, BSN, RN is a California native who has spent most of her life in beautiful sunny southern California. She spent several years in Alabama, where she attended the University of South Alabama for her nursing degree and went through ROTC. She received her commission as an Air Force officer and her nursing degree on the same day. It was truly one of the most special days of her life. She served as a nurse in the Air Force for 4 years in northern California and then returned to southern California. She found her way to UC San Diego Health in late 1999 and has been a part of the IMU ever since. In her free time, she likes to spend time with her husband of 14 years, her 7 1/2 year old son and her Siberian husky. In the rare moments of peace and quiet, you can find her curled up with a good book.

Kimberley Noumi MSN, RN has been with UC San Diego Health for almost 4 years and has been the Assistant Nurse Manager at Thornton 2 East IMU since 2016. She started her career in Massachusetts working at Lahey Clinic in Cardio-thoracic surgery and neurology/trauma, and at Massachusetts General Hospital in their Neuro ICU. Kim has been a nurse for over 9 years, her previous career was in the Hospitality Industry. She earned her BSN from the University of Massachusetts, Boston, a MSN from the University of Arizona, and also has a degree in Psychology/Biology from the University of Massachusetts.

Having such a diverse patient population, do you feel that this was the basis of a good foundation regarding your skills as a nurse?
Yes. I feel that by doing a little bit of everything, it gave me the exposure to feel comfortable with a variety of patients and service lines.

When did you move over to 2 East?
I don’t remember the exact year, but I do remember a situation. We had moved over to 2-East and only had the front half of the unit from Room 206-200 and Room 218-222. Room 200 was still a semi-private like today. We had a WOW workstation on wheels, at the back of the unit, and because we were never full, someone snuck up the back stairwell and stole it. That instance empowered me to become the go-to person when it comes to keeping our equipment safe and accounted for.
Kim’s personal history continues as she marries Pat in 2004. He was the Office Depot delivery man who dropped off supplies to the unit. 2-East was the spot where Kim and Pat met and became soulmates. UCSD continued to grow which resulted in increased admissions, more complex patients, and more buildings to accommodate the growing patient population. As the years pass by, each new day brings a new challenge. This occurs both professionally and in our personal lives. It’s 2014, Kim now has an almost 3 year old son Ben, and her husband Pat, has made some professional changes as well. A little roughhousing with a toddler can sometimes bring your life to a screeching halt. One afternoon when wrestling with Ben, Kim turns into a breast cancer diagnosis by her primary care physician on her 42nd birthday. She was working the day she received the diagnosis. One of her caring oncology patients. Kim states she forgot how physically demanding the job can be on the unit. Once again, she was amazed by the outpouring of support and love she received from the team on 2-East. In November of 2016, 2-East switched service lines again, pivoting to the Cardiovascular service line, specifically congestive heart failure patients with Left Ventricular Assist Devices.

Kim was back working on 2-East in early 2016. At this time, 2 East was a BMT/Oncology Progressive Care Unit (PCU) with complex surgical and medical oncology patients. Kim states she forgot how physically demanding the job can be on the unit. Once again, she was amazed by the outpouring of support and love she received from the team on 2-East. In November of 2016, 2-East switched service lines again, pivoting to the Cardiovascular service line, specifically congestive heart failure patients with Left Ventricular Assist Devices.

Kim, besides the obvious changes in service lines over the years. Is there anything that sticks out as a major change in the caring for people as a nurse in the PCU? 

Yes, service lines have changed. I do miss the smorgasbord of patients. I enjoy helping patients who are very sick when they are admitted and helping them to feel better during their stay motivates me. Cardiac is interesting, but I personally believe that having a diverse patient population with varying diagnoses makes you a better critical thinker. Also technology has changed, some for good, and some not. One of the faults of technology is that it takes you further away from the bedside. That’s the good stuff, being in the moment with your patients and families, following them on their journey. Technology and the business aspect of hospitals has shifted the focus from the personal aspects of nursing. I think it is something that needs to be brought back into nursing.

I agree, Kim, technology is a double-edged sword. Today, if we are not using the most cutting edge technology we lose our relevancy in healthcare. There is a happy medium. What are some of the similarities between early IMU/PCU days and now?

Teamwork and the true caring nature that nurses have for one another and our patients. We are truly one of the most loving dysfunctional families that I am proud to be a part of. Just the other day we had a code at 5:30 pm and we all walked out at 7:30pm, together. We all worked together to stabilize a sick patient, care for the other 25 patients, and got out on time. That is a true testament to the teamwork that has always been on display over the years on 2 East.

The team that surrounds you really can make or break you overall experience on a unit. What do you see in the future when it comes to nursing, your career and what advice do you have for nurses in the future?

For nursing in the future, I see a shift more to outpatient and with the really sick patients’ inpatient, needing more IMU/PCU training for nurses. Unfortunately, I think that with that push to outpatient, the inpatient resources will get scarcer. People are wanting a quality of life that can only be afforded when you are surrounded by things and people that are familiar. Focus on outpatient will be the next wave, and more home care, I think.

Personally for me it is getting harder to be a nurse on the floor. The PCU is a physically taxing unit. My endurance and stamina is not what it used to be. I see myself moving more towards the outpatient arena. I would really like to work in the Breast Clinic here at UCSD. Pay it forward, so to speak. I think that nursing will evolve, but the backbone will always be the camaraderie and teamwork that makes nursing so special.

For me nursing was a calling, I was always destined to be a nurse. For others entering into this profession, I would tell them that you really need to feel that this profession is a calling. It is a special career to have, with a whole lot more positive experiences that negative. I wouldn’t know what else I could have done when it comes to a career. I am a nurse and my team is my family.
In December of 2016, two units were joined to make the Hillcrest 11th Floor Surgical Progressive Care Unit (PCU). To support this new unit, many medical-surgical (med-surg) nurses made the personal commitment to advance their clinical knowledge. Their dedication and enthusiasm for this challenge has made all the difference. This article will describe the experience of transitioning from a medical surgical to a progressive care unit for both the leadership team and the clinical nurses.

CHAU NGUYEN, BSN, RN

For eighteen years of my nursing career my primary experience was that of med-surg level of care. As a transplant nurse, my role included monitoring the patient, providing specialty care, patient education, and preparing the patient for a safe discharge back to their home and family. I worked with the transplant population for over 10 years and loved it. Although interesting and exciting, the fast pace of the intensive care unit (ICU) and telemetry made me nervous.

My home unit went through a significant change and I knew I would have to adapt. When the day came to start my PCU training, I was nervous and scared. I completed my PCU classes and orientation. Thanks to all my preceptors, I became a brand new PCU nurse. There are many things that I like about PCU nursing care. I like the nurses, the 1:3 patient ratio, automatic vital signs, and the electronic monitoring that helps to preemptively detect a patient’s change in condition or deterioration. After almost a year into the PCU setting, despite my occasional nervousness that patients are sicker and can deteriorate any time, I have more confidence in myself and my PCU skills.

Becoming a PCU nurse afforded me the opportunity to expand my career and potentially transition to an intensive care unit. There may be challenges, but there are always rewards. I am proud to be able to provide safe and excellent patient care as a PCU RN in a Magnet-designated hospital.

ELEANOR G. YOSHISAKI-YUSI MSN, MPH, RN, ONC

Becoming an Assistant Nurse Manager on a surgical PCU was a big challenge. My role as an administrative nurse requires me to be clinically competent on the unit as resource nurse or as charge nurse. It was really important that I learn the necessary skills. PCU patients require vigilance in monitoring because changes in condition could happen in an instant. I was struggling to figure out how I would learn the role of the PCU nurse so that I could provide quality supervision and service to the department.

My solution was to get in the mix of the unit. I learned many new skills, including how to take care of patients on complex and critical medication infusions, reading telemetry rhythms, drawing blood, and care of arterial lines. I started connecting with the nurses by learning their routines and began to understand the risks involved in taking care of patients at the PCU level of care. I now see why attendance to the series of PCU classes, 2-day EKG classes, and annual ART classes are mandatory. They were constructed so that nurses would be equipped with all the knowledge needed to safely and competently care for patients.

The PCU is where specialty-educated and trained nurses combine the knowledge and skills of assessment, surveillance, and provision of complex care. According to the American Association of Critical Care Nurses, every nurse should be provided with specialty education and training to achieve a set of core competencies unique to the PCU (ACCN, 1998). The leadership team at UCSD made sure that requirement was met.

Having attended the PCU series, I am integrating what I have learned and applying it on a regular basis. This helps me better understand what PCU nurses do. I am most grateful for all the support I get from the management team and from all the 11th floor surgical unit that I learned to call my home.

ELEANOR “LEAH” G. YOSHISAKI-YUSI, MSN, MPH, RN, ONC is the Assistant Nurse Manager of the newly formed 11th Floor Surgical PCU unit in Hillcrest. She started her nursing career as a floor nurse in 2006 in 8th floor Orthopedics. Leah holds Bachelor’s degrees in both Medical Technology and Nursing in the Philippines, including her Master of Public Health which she earned from the University of the Philippines. She also earned her Doctor of Medicine from Far Eastern University – Dr. Nicanor Reyes Medical Foundation and was a practicing physician for 10 years. She recently graduated her MSN at San Diego State University with concentration in Leadership and Healthcare. Leah formed the Resource and Charge nurse committee in 11th Floor in an effort to support these nurses in their new and challenging roles. The committee meets every quarterly to discuss expectations on how nurses can support each other and identify peers who are ready to step up and assume charge or resource roles. Leah is currently a member of the National Association of Orthopedic Nurses and Sigma Theta Tau International Honor Society of Nursing.

REFLECTIONS OF 4 NEW-TO-PCU NURSES

Eleanor Yoshisaki-Yusi MSN, MPH, RN, ONC

Chau Nguyen, BSN, RN

Chau Nguyen, BSN, RN, CMSRN

is a Clinical Nurse II on the 11th floor Surgical Progressive Care Unit at UC San Diego Health. She earned her BSN at Texas’s Women University. She has 18 years of experience as a registered nurse. She has been with UC San Diego Health since 2004 and was a recipient of the 11th Floor Nurse of the Year award in 2015. She is a certified medical-surgical nurse. She has been with UC San Diego Health since 2004 and was a recipient of the 11th Floor Nurse of the Year award in 2015. She is a certified medical-surgical nurse. She has been with UC San Diego Health. She earned her BSN at San Diego State University. She is a Clinical Nurse II on the 11th floor Surgical Progressive Care Unit at UC San Diego Health. She earned her BSN at San Diego State University. She is a Clinical Nurse II on the 11th floor Surgical Progressive Care Unit at UC San Diego Health.

Odette Punsalang, MSN, RN, ONC

Laura Lembi – Vitale, MSN-FNP, RN

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My solution was to get in the mix of the unit. I learned many new skills, including how to take care of patients on complex and critical medication infusions, reading telemetry rhythms, drawing blood, and care of arterial lines. I started connecting with the nurses by learning their routines and began to understand the risks involved in taking care of patients at the PCU level of care. I now see why attendance to the series of PCU classes, 2-day EKG classes, and annual ART classes are mandatory. They were constructed so that nurses would be equipped with all the knowledge needed to safely and competently care for patients.

The PCU is where specialty-educated and trained nurses combine the knowledge and skills of assessment, surveillance, and provision of complex nursing processes to provide high-quality patient care. According to the American Association of Critical Care Nurses, every nurse should be provided with specialty education and training to achieve a set of core competencies unique to the PCU (ACCN, 1998). The leadership team at UCSD made sure that requirement was met.

Having attended the PCU series, I am integrating what I have learned and applying it on a regular basis. This helps me better understand what PCU nurses do. I am most grateful for all the support I get from the management team and from all the 11th floor surgical unit that I learned to call my home.

ELEANOR “LEAH” G. YOSHISAKI-YUSI, MSN, MPH, RN, ONC is the Assistant Nurse Manager of the newly formed 11th Floor Surgical PCU unit in Hillcrest. She started her nursing career as a floor nurse in 2006 in 8th floor Orthopedics. Leah holds Bachelor’s degrees in both Medical Technology and Nursing in the Philippines, including her Master of Public Health which she earned from the University of the Philippines. She also earned her Doctor of Medicine from Far Eastern University – Dr. Nicanor Reyes Medical Foundation and was a practicing physician for 10 years. She recently graduated her MSN at San Diego State University with concentration in Leadership and Healthcare. Leah formed the Resource and Charge nurse committee in 11th Floor in an effort to support these nurses in their new and challenging roles. The committee meets every quarterly to discuss expectations on how nurses can support each other and identify peers who are ready to step up and assume charge or resource roles. Leah is currently a member of the National Association of Orthopedic Nurses and Sigma Theta Tau International Honor Society of Nursing.
Financial support for this study was provided by the University of California, San Diego, School of Nursing, and Sigma Theta Tau International Honor Society of Nursing.

Sigma Theta Tau International Honor Society of Nursing.

The differences between med-surg and PCU are subtle but noticeable. The amount of critical thinking going into care plans and proactive communication with the team increases. Patients are higher acuity and less stable, therefore, the nurse needs to be more vigilant. The patients seem to teeter between improving and declining in any instant. Their clinical status can completely change day to day, shift to shift, and it can feel like a roller-coaster ride to both the nurse and the patient.

As the name ‘Progressive Care’ implies, many patients do improve clinically. They are able to downgrade to med-surg and can be taken off continuous cardiac and oximetry monitoring. It is usually a feeling of relief for the patients. Cords can finally be disconnected, they can get out of bed, walk more, and eventually be discharged. Discharging a patient who I’ve had the opportunity to care for and see improve clinically throughout their stay, is one of my most rewarding experiences as a nurse.

Other patients decompensate. Their blood pressure drops, they may become septic, or have respiratory decline. This is when the critical thinking becomes essential and nurses must use all their knowledge, training, and resources. This includes utilizing the resources of the interdisciplinary team members and Rapid Response Team to help think through why the condition is changing and advocate for the appropriate changes to the treatment plan. This teamwork, active contribution to the treatment plan, and prevention of further decompensation is professionally fulfilling.

Working on a progressive care unit has been both challenging and rewarding. For me, transitioning from med-surg to PCU was a smooth and natural transition. I was ready for the challenge and embraced it.

There is a decided trend at UCSD toward a Progressive Care model. There are benefits for patients, staff, and the organization. Many UCSD nurses have been trained in Progressive Care, and many more will be soon. As the stories above illustrate, this transition is difficult and challenging. Some degree of fear and anxiety are inherent in most life changes, and a change in career specialty is significant. Those who find themselves anticipating this change in their career can know their worries were shared by most who have already made the change. They can also be assured there are opportunities and benefits that go along with growing their skill set. As each of these authors have written, the rewards of this growth exceed the challenges they faced.

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AACN Scope and Standards for Acute and Critical Care Nursing Practice.
Thornton 2-West has 27 beds and approximately 70 employees. As part of the UCSD's Mission and Vision and as a Magnet organization, over 90% of the nurses have their BSN and over 30% have an ACCN recognized certification. Thornton 2-West cares for a wide variety of patient populations but not limited to: medicine, general surgery, bariatric surgery, cystic fibrosis, and pre-liver transplant patients. The unit is also designed to care for epilepsy patients requiring 24-hour Video Electroencephalogram (VEEG) monitoring.

In Thornton 2-West started as a medical-surgical (med-surg) telemetry unit, however, as the healthcare needs of the community evolved, and as part of our commitment to provide exceptional service to our patients, 2-West transitioned to a progressive care unit (PCU). By definition, this bridges the gap between intensive care units and med-surg units. The PCU level of care reduces transfer of patients because surgical ward and PCU care can be provided in the same unit. The PCU also promotes effective use of ICU beds, and provides patients can be provided in the same unit. Because surgical ward and PCU care can be provided in the same unit. The PCU also promotes effective use of ICU beds, and provides patients needing 24-hour Video Electroencephalogram (VEEG) monitoring.

Cristy Clarete RN began her nursing career at St. Luke’s Hospital in New York on a progressive care unit. Since marrying an active duty military member, she has spent the last 12 years of her travelling across the United States, working at different institutions and different levels of care. Cristy has been a staff nurse on Thornton 2 West for the last 4 years. She is one of the charge nurses on 2 West and one of the first staff to be trained for 2 West’s transition to progressive care. Cristy was Employee of the Quarter for the summer of 2018.

By: Cristy Clarete RN and Cecilia Caronongan MSN, RN, PCCN

PCU Advanced Resuscitation Training (ART), completion of a variety of online nursing modules, as well as hands-on training. Charge and resource nurses received practice-based learning in other PCUs for 2 weeks and developed competencies to operate new equipment. Eventually, those nurses were able to cross-train our core staff and newly hired staff. Currently, 95 percent of nurses on 2-West are PCU trained with the remainder of nurses caring for only surgical patients.

After much rigorous training and preparation, 2-West successfully converted to a PCU in April 2016. While initially, caring for lower acuity IMU patients to help ease the transition, many 2-West nurses’ biggest challenge was the fear of the unknown. The nurses had countless questions regarding adapting to their new level of care, from of setting up a patient on the heart monitor to providing patient care for patients requiring telemetry monitoring. For every new patient encountered, nurses sought out their resources and researched nursing guidelines and nursing policies specific to their patient population. At times, the cumulative effect of these iterative challenges seemed like the learning curve was insurmountable. Some nurses did not find the challenges a good match, and went to pursue other career goals. However, the team members that weathered what felt like a storm are now the backbone of our unit. Together, 2-West has become a stronger unit of highly skilled nurses, proficient in UCSD policies and procedures that govern our nursing care, and are very capable in taking care of high acuity PCU patients. With the guidance and support of the 2-West leadership team, and the amazing support of the Rapid Response Team that held our hands through difficult times, the support of our adjacent unit 2-East, and the interdisciplinary teamwork of every department involved in the care of our patients, 2-West nurses never felt alone. Currently, the 95 percent of 2-West nurses that are PCU trained are now also training nursing nurses from other units such as 3-West in their PCU transition.

Creating the standards and competencies necessary to provide PCU level of care was not easy. It was anticipated that ambivalence and hesitation to change would be a common obstacle towards complete transition into the new role. Factors that stimulate hesitation to change and training include fear of the unknown, fear of greater responsibility that may demand work and training. It is anticipated that ambivalence and hesitation to change would be a common obstacle towards complete transition into the new role. Factors that stimulate hesitation to change and training include fear of the unknown, fear of greater responsibility that may demand work and training. It is anticipated that ambivalence and hesitation to change would be a common obstacle towards complete transition into the new role. Factors that stimulate hesitation to change and training include fear of the unknown, fear of greater responsibility that may demand work and training. It is anticipated that ambivalence and hesitation to change would be a common obstacle towards complete transition into the new role. Factors that stimulate hesitation to change and training include fear of the unknown, fear of greater responsibility that may demand work and training. It is anticipated that ambivalence and hesitation to change would be a common obstacle towards complete transition into the new role. Factors that stimulate hesitation to change and training include fear of the unknown, fear of greater responsibility that may demand work and training.
Neuro Nurses Have All the Brains! Elevating PCU Nurses through Interdisciplinary Collaboration with ICU Counterparts & Neuro Leaders to Promote Continuity of Care for Stroke Patients

By: Dawn Carroll BSN, RN, MS, Abigail Edilloran BSN, RN, CHPN, Christine Wood BS, BSN, RN

There is no other unit like the SH Neuro Progressive Care Unit (PCU). Established in 2016 with the opening of Jacobs Medical Center, the 12-bed SH Neuro PCU was essentially a grassroots project. SH started with five UC San Diego (UCSD) nurses transferring internally to build the unit, along with, approximately, 18 external new hires from various organizations throughout San Diego county and the nation, who brought their expertise from other hospitals and their fresh new perspectives with them. Designed and built from the ground up by frontline staff, SH was the creation of a group of pioneering nurses who utilized their voices and transformational vision to establish UCSD’s first dedicated stroke unit. Furthermore, SH helped pave the way for UCSD’s esteemed neuroscience, who brought with her over 15 years of nursing leadership roles in Neuro-Surgical Intensive Care, Cardiovascular and Cardiac Respiratory Services. Prior to UC San Diego, she served as Director of Nursing/Intensive Care unit and Director of Trauma/Stap Down at Regional Medical Center in Hudson Florida from 2008 to 2013. She was crucial in the development of HCA’s first Trauma Center, where her team was recognized, based on her nomination, in Advance for Nurses for adaptability. Her nomination letter was featured in the May 2013 issue of Advance for Nurses. Dawn also served as nurse manager of the ICUs and Rapid Response teams at Palomar. Dawn is an active member of ACNL, ANA, AQONE and serves on the Rewards and Recognition committee for ACNL. She plans on pursing her DNP in the fall of 2019.

Abby Edilloran, BSN, RN, CHPN is an Assistant Nurse Manager for the Jacobs Medical Center 3F & SH Neuro ICU/PCU team. Abby has been a Registered Nurse for 7 years. As a second degree bachelor's prepared nurse who entered the healthcare profession as a new graduate in the intensive care unit, Abby has witnessed firsthand the complexities of patient care, sparking her determination to not only serve her patients with the best clinical skills possible, but also be their voice and advocate for what they need (and what nurses need) to optimize nursing care and healthcare delivery. Because of this, she has developed a passion for quality improvement and patient and family centered care. She has earned her nursing degree from Azusa Pacific University and holds professional certifications in stroke nursing (Stroke Certified Registered Nurse) and in palliative care (Certified Hospice and Palliative Care Nurse).

Christine Wood, BS, BSN, RN graduated with her BSN from National University in 2014. She is an active, participating member of the Quality Council, Medication Safety Committee, and Stroke Quality Council Meeting. She has diligently devoted herself to creating an atmosphere of open and honest communication between physicians and staff. Being able to care for patients in their darkest hours after a stroke is something that she is very passionate about. The opportunity to be a stroke nurse truly has been a calling and her dream come true.

5H’s neuro nurses engage in rigorous training in order to refine their specialized skill sets, as the medical management of stroke patients relies on the acute assessment skill care providers. Taught by our Stroke Clinical Nurse Specialist, Patricia Graham MS RN CCRN SCRN, and our Neurocritical Care Medical Director, Dr. Navaz Karanjia, each neuro nurse participates in a series of neuro-specific classes (Neuro A, Neuro B, Neuro Bootcamp, Neuropharmacology, Neuro Skills, and more) as a part of their onboarding and annual training. In this rigorous neuro program, our neuro nurses are trained to be experts in stroke care, equipped with the attentive assessment skills needed to identify the subtlest stroke symptoms and to understand the area of the brain affected. Subsequently, the nurses are empowered through their knowledge to advocate for their patients when changes in the treatment plan are indicated. As active participants in their patient’s care, SH nurses spend a day rounding with the neurocritical care team, review various MRI/CT scans during radiology rounds, and have the opportunity shadow during the most complex of neuro cases in the operating room.

SH neuro nurses are transformational, even beyond the bedside. As masters of their own craft, SH neuro nurses often teach their peers across the organization about stroke care and nursing management. Many of SH’s nurses have taught at annual Neuro Skills days, participated in Mock Stroke Codes with the interdisciplinary neuro team, and led educational presentations to prepare nurses and leaders for regulatory visits for our stroke survey. SH neuro nurses are a valuable asset to the stroke program at UCSDH, as they play a role in their patients’ hyper-acute care up until discharge planning and rehab. As a sister unit to their ICU counterpart, the 3F Neuro ICU at Jacobs Medical Center, SH is often called upon to provide expertise in nursing across the continuum.

It is not only because of its highly specialized knowledge regarding stroke care that the SH staff shines in many of the nursing sensitive indicators, but it is also because of the compassion, teamwork, and culture of caring that it demonstrates.
Every day: The unit has not had a single incidence of CAUTI or CLABSI in over a year, and the nurses demonstrate a commitment to nursing excellence through tackling nursing sensitive indicators routinely. Additionally, every day on the unit, nurses find reason for celebration, whether it be a patient’s birthday while they are hospitalized, a patient’s recovery from even the most devastating stroke deficits, or the simple fact that a patient mastered their walk while in our care: a patient’s discharge. 5H is a strong proponent of focusing back to the patient, and we have a tradition to do this each Friday. This practice embodies the ‘I’ in teamwork, retention, and staff morale.

The success of this team is not only due to the relentless spirit of the compassionate group of individuals who are proud to be a part of the 5H team; they can also be attributed to the various team building activities that are conducted to maintain engagement and a healthy work environment. Annually, our neuro family (including both ICU/PCU nurses and all neuro providers) participates in team building retreats to maintain personal wellness, as well as active participation in Stroke Quality Council, have also proven to be valuable in the empowerment and quality of care that 5H neuro nurses deliver. 5H is a driving force in what stroke care looks like at UCSDH.

The successes of this team are not only due to the relentless spirit of the compassionate group of individuals who are proud to be a part of the 5H team; they can also be attributed to the various team building activities that are conducted to maintain engagement and a healthy work environment. Annually, our neuro family (including both ICU/PCU nurses and all neuro providers) participates in team building retreats to maintain personal wellness, as well as active participation in Stroke Quality Council, have also proven to be valuable in the empowerment and quality of care that 5H neuro nurses deliver. 5H is a driving force in what stroke care looks like at UCSDH.

Teamwork, Retention, and Staff Morale, 3B Small but Mighty

The University of California San Diego Medical Center consists of three hospitals that operate under one license with a current combined capacity of 808 beds: UC San Diego Medical Center in Hillcrest (390 beds), Jacobs Medical Center (JMC) (364 beds) and Sulpizio Cardiovascular Center (CVC) (54 beds). The Hillcrest unit was then divided into 26 individual nursing units ranging in bed size from JMC 4th and 6th floors, which are the largest at 36 beds each, to our 15 bed unit located in the CVC. When the CVC opened in 2011, the nurses and clinical care partners (CCPs) from Hillcrest moved into this new building that houses 3 units dedicated strictly to cardiac care. The nurses that opened the new building left the units they knew by heart to start a new type of unit in a new facility, and 3B was born.

When first opened, 3B was primarily a unit that served a patient population of patients receiving observation or procedures with overnight stays. The short length of stay resulted in a place that was fast paced with a high patient turnover. Most of the patient population stayed less than 24 hours post cardiac catheterization. Most units can claim fantastic teamwork but when you are admitting and discharging over two-thirds of your unit in a day, great teamwork isn’t just helpful, it’s necessary. Because patients are always coming and going, establishing a rapport with patients is sometimes difficult. On 3B the nurses have developed an expertise in this facet of care, or maybe they are so successful because of their natural abilities for relationship-building. To these nurses patients aren’t a number, but instead they are treated as family. The phrase ‘not my patient’ is just not uttered here, just the opposite, it’s considered taboo. They say there is no ‘I’ in team and here on 3B that statement rings true.

Through the years the patient population has changed. There are less one night stays and more chronic congestive heart failure and post heart surgery patients, but the spirit de corps remains the same. One might say that the teamwork on this unit was born of necessity. While there may be some truth to that, the teamwork here has remained because of the highly skilled and dedicated nurses that call this floor home.

The other things that you will notice if you are ever on 3B is that there always seems to be food. We all know that nurses like to eat! Goodies from families and special treats from management help make us feel appreciated. True to form 3B makes that extra effort. The staff here are always bringing in dishes to share. Cookies, candy, and cuisine from any corner of the globe are always filling the breakroom. If there is one thing that can boost staff morale while running around discharging and admitting patients, it is snacks. So, if you’re hungry swing by and grab a bite, it’s guaranteed to put a smile on your face.

Fifteen; that number is not only significant because of the number of beds on this unit, it is also the average years of nursing expertise on the unit amongst the staff. With one of the lowest staff turnover rates in the hospital it’s no wonder it’s hard to find an open position on 3B.

When the staff were asked why they stay on this unit the common denominator is family. Everyone here is treated like family, patients and staff alike. In retrospect maybe that is why the food is so good here, food tastes better when you eat it with your family.

By: Megan Hagedorn, RN, PN, PCCN and Kathleen Boughanem, BSN, RN

Megan Hagedorn, BSN, RN, PCCN is the Assistant Nurse Manager of the 3B Progressive Care Unit at UC San Diego Health Sulpizio Cardiovascular Center. She earned her BSN from University of North Carolina, Greensboro. Prior to working at UCSD, she started at Mission Hospitals in Asheville, NC. From there, she took on several travel assignments in Washington DC and Maui, Hawaii before finding a home here in San Diego.

Kate Boughanem, BSN, RN graduated from St. Louis University in 1996 with her Bachelor’s in Nursing. She started her career at UC San Diego Health 17 years ago as a Travel Nurse at Thornton ICU. She worked as a Cardiovascular and Heart Transplant Nurse before becoming nurse manager of Sulpizio 3B.

ARTWORK BY: Hannah Saarinen
Evolution of the Specialized Nursing Staff on Sulpizio 4AB

By: Krista O’Brien BSN, RN and Meghan Jones MSN, RN, FNP-C

The University of California, San Diego (UCSD) identified a need to provide expert nursing and medical care for a unique group of patients. In response, the Sulpizio Cardiovascular Center (SCVC) was created to offer specialty care to those with cardiovascular and/or pulmonary diagnoses. This new center included an intensive care unit, a procedural area, and two progressive care units. One of those units, SCVC 4AB Progressive Care Unit (PCU), has evolved over time. As nurses on this unit, we would like to share the history of this evolution to a highly specialized unit with complex patients.

Initially, the Intermediate Unit (IMU) in Thornton Hospital provided care to all types of patients needing a higher level of attention than medical-surgical or telemetry level of care. This included patients with a diverse range of conditions: cystic fibrosis, cardiac problems, pulmonary issues, seizure disorders, as well as the geriatric or bariatric patient. Many nurses from the Thornton IMU transferred to help open the fourth floor PCU in Sulpizio in 2011. These RNs, and those subsequently hired, were able to hone their skills and knowledge to these specific patients and diseases. Since then, our unit has continued to flourish and we take pride in our distinctive and exceptional skill set.

Before the SCVC opened, all of the nurses hired to care for patients in the fourth floor PCU attended a program created by the American Association of Critical Care Nurses (AACN) called the Critical Care Internship Program (CCIP). This comprehensive curriculum extended over twelve days and focused on the physiology and pathophysiology of all of the major body systems. Recently the need for unit-specific education for our specific patient populations arose. The master-prepared SCVC nurse educators created the Cardiac Boot Camp, a four-day series intended for Sulpizio RNs addressing topics relevant to the care of cardiovascular patient in a didactic in-classroom and hands-on setting.

Krista O’Brien, BSN, RN

has been a cardiac nurse for three years. She started as a new grad RN at Sharp Healthcare and after obtaining her BSN in 2017 was thrilled to sign on with UC San Diego Health. Krista plays an active role in committees on her unit and plans to continue to grow in the cardiovascular field after obtaining her MSN and becoming a nurse practitioner.

Meghan Jones, MSN, RN, FNP-C

has been a nurse for 4 years. She began her career as a new grad RN at Sulpizio Cardiovascular Center, on the Progressive Care Unit. She recently completed her master’s degree in nursing and is now a certified family nurse practitioner. She hopes to transition to a nurse practitioner position in cardiovascular care at UC San Diego Health soon.

UC San Diego Health soon.

REFERENCES:

Day One

includes an in-depth review of hemodynamic monitoring, waveform interpretation and vasoactive drugs. The overview of cardiac anatomy is accomplished via pig heart dissection.

Day Two

focuses on postoperative implications for the cardiothoracic patient, oxygen delivery and ABG interpretation, as well as hands-on practice with Flolan, Remodulin and radial artery punctures.

Day Three

provides a review of MI/STEMI care and advanced heart failure. A skills lab reviews arterial compression devices and pericardial drains.

The final day

includes a focused examination of Ventricular Assist Devices (VADs). An additional skills lab emphasizes equipment troubleshooting of the HeartMate, HeartWare and Tandem VADs.

Upon completion of the series and associated competencies, nurses have expressed confidence in their ability to provide safe and competent care for the patients of these advanced specialties.

In 2017, the SCVC intensive care unit opened a second unit with twelve additional beds for a total of twenty-four beds. This increase in capacity helped alleviate the need for beds for the critically ill patient in the intensive care unit (ICU).

However, the PCU patient is very high acuity requiring frequent surveillance and treatments delivered using technology that cannot be provided at a medical-surgical staffing ratio. This created an opportunity for SCVC, PCU to develop into a 27-bed “hybrid” floor. Our patient population expanded to accept and care for ventilated patients and patients with Swan Ganz catheters. At this time, the patient population includes anyone pre- or post-operative cardiovascular or pulmonary disorder. The most common are the heart/lung transplant, pulmonary thromboendarterectomy (PTE), open-heart surgery, general vascular surgery, general surgery and patients with ventricular assist devices. In addition, stroke recovery patients and those with medical conditions such as pulmonary hypertension are admitted to the SCVC PCU.

In order to provide this complex level of care, all nurses have developed knowledge and skills needed to monitor and care for these patients. Among the required skills are continuous telemetry (ECG) monitoring, hemodynamic monitoring (arterial blood pressure, central venous pressure and pulmonary artery pressure), ultraltrifaction, ventilator support, ventricular assist devices (HeartMate and HeartWare) and Prostacyclin therapy.

The process of developing a staff of about seventy nurses to possess the didactic knowledge and clinical skills needed for this complicated population has required significant planning and collaboration. The management team and nurse educators met routinely with the staff to elicit concerns, identify potential problems, and propose solutions. The staff received didactic instruction followed by clinical preceptships in the ICU. The most experienced staff were trained initially. They then assisted in the mentoring of the more neophyte group. As a result, the PCU staff has acquired a distinctive and exceptional skill set. At the same time, the staff continues to incorporate holistic treatments and education for the patients and their family to provide for the most comprehensive healing and supportive patient care.
UC San Diego Health System Thornton 3 West Orthopedic Progressive Care Unit Coming Soon Spring 2019!

UC San Diego Health is ranked among the nation’s top 50 orthopedic programs and Thornton 3-West is the designated inpatient care unit for orthopedic surgery. Thornton 3-West consists of a newly renovated unit with 23 beds and all private rooms. The unit serves patients with joint replacement and arthritis surgery, spine surgery, cartilage restoration and transplantation, foot and ankle surgery, hand and upper extremity surgery, orthopedic trauma, physical medicine, and rehabilitation. Most of the patient population undergoes joint replacements and spine surgery.

The Progressive Care Unit (PCU) conversion journey of Thornton 3-West unfolded in June 2017. We started as a unit overflow of 3-East Medical-Surgical Unit. In the beginning, 3-West was only staffed with 3 RNs and as it gradually became an orthopedic unit, we increased staffing with 43 RNs, 7 clinical care partners and 1-unit secretary. The demand to care for the orthopedic patients that require cardiac monitoring led to the transformation of 3-West into a PCU unit. Currently, the unit is in its final phase of an orthopedic progressive care conversion with a completion date in spring 2019. Thornton 3-West will have 6 IMU beds, 6 telemetry beds, and 11 med-surg beds. The unit currently has 20 PCU trained RNs with an ongoing plan to train the next cohort of nurses. In doing so, the leaders are providing transformational development opportunities for the other med-surg nurses who are eager to learn new skills.

We are proud of our 3-West staff for many reasons. A core group of the 3-West staff is actively involved in the pre-op joint classes for patients which are offered in Hillcrest and La Jolla. In addition, the staff hosts the Annual Bonafide Orthopedic Nursing Educational Symposium (BONES) going on its 15th year offering continuing education units to all nurses in the community. The theme of last year’s BONES symposium was, “It’s a joint effort” which is the mantra that 3-West staff continue to practice. The whole team promotes a culture of professional collaboration with the physicians, case managers, physical and occupational therapists to help restore function, manage pain, and coordinate resources and services pre and post-operatively for the orthopedic patients.

By: Aldrin Poblete MSN RN, Nelissa Reyes MSN RN ONC, Sherlita Aguilar MSNc RN ONC

Aldrin Milay Poblete, MSN, RN is the Nurse Manager for Thornton 3E Medical Surgical and 3W Orthopedic PCU Unit. He started his nursing career as a new grad on 10 East, transitioned to Assistant Nurse Manager, then became Nurse Manager for 3B PCU Sulipalo Cardiovascular Center in 2012. He graduated from San Diego State University with his MSN in 2017. Aldrin has 12 years of nursing leadership experience and has opened 3 nursing units for UC San Diego Health (11E Surgical Telometry, 3B PCU Sulipalo Cardiovascular Center, and Thornton 3W Orthopedic PCU). He is also currently serving in the military as a flight nurse with US Air Force Reserve 42nd Aeromedical Squadron. He has multiple deployments and combat support missions in the Middle East transporting wounded soldiers out of harm’s way into higher level of care.

Sherlita Aguilar BSN, RN, GilAcm, ONC is the assistant nurse manager for 3E East Medical Surgical Unit and 3 West Orthopedic Medical Surgical, soon to become Progressive Care Unit at UC San Diego Health Thornton Hospital. Her passion is in Orthopedics and Apheresis. She is a Certified Orthopedic Nurse and the first nurse at UC San Diego Health to obtain Qualification in Apheresis (QIA) certification, an international and national credential in Apheresis medicine for nurses and physicians. She is currently enrolled in the MSN program at San Diego State University with a concentration in nursing leadership.

Nelissa Reyes, MSN, RN, ONC is the Assistant Nurse Manager for Thornton 3E Medical Surgical and 3W Orthopedic PCU Unit. She earned her Bachelor’s degree and Master’s degree in Nursing at San Diego State University. She started her nursing career at UC San Diego Health Hillcrest 8th floor (orthopedic/neuro/trauma unit) as a new graduate nurse. Nelissa is the chairman for the BONES Committee and was a past President of National Association of Orthopedic Nursing (NAON) San Diego Local Chapter 37. As a new leader, she had the opportunity to open and hire staff for the new Thornton 3 West Orthopedic PCU unit.

We are excited for the PCU Go Live this spring 2019!
INTRODUCTION: Thornton 2-West Progressive Care Unit (PCU) is home to a Level 4 Comprehensive Epilepsy Monitoring Unit (EMU) that specializes in patients admitted for Video-Electroencephalogram (VEEG) neurodiagnostic monitoring. Thornton 2-West has six beds available for epileptic patients undergoing seizure studies to either diagnose, or rule out, epilepsy. Epilepsy is defined as when two seizures occur at least 24 hours apart or when one seizure occurs with at least 60% probability of recurrence within the next ten years. Seizures are caused by an imbalance between brain cells that excite or inhibit other cells from sending messages, causing too much or too little brain activity. Seizures can manifest as focal (or partial) without loss of awareness, while others are generalized (formerly called grand mal). Seizures are linked with brain structural abnormalities, head injuries, infections, metabolic imbalances, strokes, and genetics.

The National Association of Epilepsy Centers provides guidelines for designating medical institutions from Level 1, the highest level of specialized epilepsy care, to Level 4, primary or emergency care. The UC San Diego EMU is a Level 4 Comprehensive Epilepsy Center due to the neurodiagnostic monitoring capability and advanced treatments including surgical options offered. Our UCSD Comprehensive Epilepsy Center team includes most of the seventy nurses and nursing assistants that work on Thornton 2-West. Staff nurses on Thornton 2-West receive EMU training in New Employee Orientation, EMU VEEG Skills Day, 2-West Skills Day, online learning modules, and a new EMU simulation lab course which was launched this year. Additional EMU staff includes Katie Villarino, RN, the Epilepsy Clinical Nurse Coordinator, Rose Bercow, the Patient Care Coordinator, and several EEG Technicians supervised by Ralph Nowacki, AB, who are trained to read the EEG brainwave tracings. The EMU also includes a group of epileptologists including Medical Director Jerry J. Shih, MD, Vicente Iraguimadoz, MD, Evelyn Tecoma, MD, PhD, Leena Kansal, MD, David J. Lee, MD, PhD, and June Yoshii, MD. The staff of Thornton 2-West and the EMU work together to care for the complex patients through Phase I and Phase II of the seizure study.

PHASE I VEEG MONITORING

UC San Diego EMU is the premier destination in Southern California for individuals with refractory epilepsy seeking medical or surgical management for their seizures. Phase I of the seizure study utilizes Video-Electroencephalogram (VEEG) monitoring at the telemetry level of care, requiring hospitalization from two to ten days, and continuous VEEG monitoring encompassing 24-hour closed-circuit video recording paired with brainwave recordings from an array of external electrodes. The goal of this phase is to determine the seizures’ localization and preferably to localize the point of origin of the seizures. To increase the likelihood of capturing seizure events, patients are exposed to common seizure triggers such as medication tapering, sleep deprivation, flashing light stimulation, hyperventilation, skipping a meal, and even alcohol consumption. Phase I VEEG is also called psychogenic events or pseudoseizures. Non-epileptic events are physical manifestations that mimic seizures but have no corresponding abnormal brain activity. A non-epileptic patient’s epilepsy drugs are generally discontinued after the diagnostic study, and the recommended treatment is cognitive-behavioral therapy.

Throughout Phase I, nursing considerations involve performing a neurological assessment every four hours, vital signs every 4 to 8 hours, maintaining the scalp electrodes, and continuous cardiac and oxygen saturation monitoring, as well as inducing seizures with sleep and caloric deprivation, tailored to the individual patient. The patient and video monitor observer each have a button that sounds an alarm if either suspects that the patient is beginning to have a seizure to alert the nursing staff. While the patient is having the seizure, an EMU nurse assesses the patient to give more information to the epileptologist in determining what area of the brain the seizure is originating from.

Jessica Bajjar, BSN, RN, PHN, PCCN

is a Progressive Care Certified Nurse at Thornton 2-West. She has been with UC San Diego Health since 2007. Jessica earned her Bachelor in Nursing from UCSD Thornton 2-West PCU; especially the Nursing Research & EBPP Council.
nursing assessment includes verifying orientation, sensation, memory, cognition, language capacity, identifying objects, and testing fine and gross motor skills. Additionally, nurses ensure safety equipment is at the bedside and that patients do not form blood clots by encouraging pedicycling and administering lovenox if indicated. Due to the risk of injury from seizure, EMU patients are considered a high fall risk of injury from seizure, EMU lovenox if indicated. Due to the need in a Phase II study. The goal of surgical treatment is to cure or decrease the frequency of seizures and options include: Responsive Neurostimulator (RNS), Vagus Nerve Stimulator (VNS), MRI-guided Laser ablation, or Lobectomy depending on the type and origin of the patient’s seizures. Other complementary therapies include a ketogenic diet and mind-body practices such as meditation and yoga.

**PHASE II INTRACRANIAL MONITORING**

Phase II intracranial monitoring involves invasive electrodes implanted in the brain of patients whose seizure origin was difficult to localize in the Phase I study. The electrodes are placed by neurosurgeons in or around the suspected areas of the brain as discussed at the patient’s surgical case conference. These electrodes allow for seizures to be captured in “high definition” on the electroencephalogram, fine-tuning the identification of seizure origination. The choices for monitoring include Stereo-Electroencephalogram (sEEG), subdural grids, strips, and depth electrodes. sEEG monitors electrical activity from superficial to deep in the brain, as electrodes are threaded through a small hole in the skull. Depth electrodes are usually inserted through burr holes in the skull. Depth electrodes may be placed on the brain’s surface, or may be inserted through burr holes in the skull. Depth electrodes are usually inserted through Burr holes and monitor deep brain structures such as the insula or hippocampus. At the end of the Phase II study, functional brain mapping may be performed to identify eloquent cortex or areas of the brain that if removed would result in neurological deficits. Brain mapping involves sending an electrical current through one of the electrodes while simultaneously testing the patient’s response. For example, when mapping a patient’s somatosensory cortex in the parietal lobe, the provider would brush the patient’s face/arms/legs. If a loss of sensation is experienced, the patient should be counseled on potentially losing sensation in that area if a resection or ablation was performed there. It is imperative for the nurses to have emergency and safety equipment at the bedside because the likelihood of inducing a seizure is high. After the Phase II study electrodes are implanted in the brain, patients spend the first 24 hours when they are most likely to experience complications in the Neuro ICU where they receive frequent neurological assessments. For the remainder of the one to two week seizure study, the patient is downgraded to IMU level of monitoring. Along with the same Phase I nursing safety considerations and equipment management, Phase II study patients require vital signs and neurological assessments every two hours due to the increased risk of injury and complications that come with invasive electrodes. The goal of the Phase II study is to localize the seizure origin point with a high degree of certainty to determine if the patient is a surgical candidate, and what treatment options the physician can offer the patient.

**SUMMARY**

UC San Diego Comprehensive Epilepsy Center is an essential service improving the lives of epilepsy patients who are often isolated and lack independence. UC San Diego’s ability to perform PCU level neurodiagnostic monitoring increases the capacity to diagnose and medically and surgically treat patients at an advanced level. The EUMI’s multidisciplinary team is dedicated to working together to help these complex patients.
PCU Nursing Considerations for CAR-T Therapy

By: Caoilfhionn Mulvey, BSN, RN, OCN

In 2018, the blood and marrow transplant (BMT) team at Jacobs Medical Center completed numerous innovative cellular therapy trials as well as UC San Diego’s first commercial use of a Chimeric Antigen Receptor T-cell therapy (CAR-T). The patient received Yescarta, the second CAR-T cell therapy approved by the FDA. Despite a brief stay in the Intensive Care Unit (ICU), the patient tolerated the infusion and is currently doing well, continuing their follow-up appointments in the outpatient BMT clinic.

In order to provide CAR-T patients with excellent care, the BMT team has formed a multidisciplinary committee to streamline processes and identify specific changes from this therapy. The committee’s objectives include:

- Education of the Progressive Care Unit (PCU) and ICU nurse
- Planning for staffing considerations
- EPIC flow sheet documentation updates, including related grading scales
- Implementation of physician and pharmacy order sets

While it takes numerous members of the healthcare team to facilitate effective care for these patients, a key member of the care team is the PCU nurse. The patient receiving CAR-T requires a high level of skilled nursing care and surveillance, as they can decompensate rapidly and need to be transferred to the ICU. They can experience a rapid onset of toxicities following the infusion, the most common being cytokine release syndrome (CRS) and a neurological toxicity called cytokine release encephalopathy syndrome (CRES). CRS usually occurs within the first 1-14 days after the infusion. CRES can happen concurrently with CRS or onset can be delayed for weeks to months following, making it important for the patient and family to be aware of the signs and symptoms upon discharge (Locke et al., 2018).

The PCU nurse needs to be aware of early recognition of toxicity symptoms and notify the BMT attending physician for further interventions. Although nurses are knowledgeable of the grading scales for symptoms, the nurse does not officially grade the toxicity. Nursing documentation (see figure 1 below) is crucial to ensure that the physician grades the toxicity correctly so that interventions can be initiated rapidly. Additionally, nurses consider the patient’s baseline neurological status into consideration. For example, a patient with a developmental delay or psychiatric history may display different neurological side effects than typically expected.

The Immune Effector Encephalopathy (ICE) assessment is a new and essential tool to help identify the unique neurological deficits that may not have been previously identified with a standard neurological exam. This assessment is completed every eight hours and as needed. A noteworthy part of the ICE assessment (see figure 2 below) is the handwritten portion, in which the nurse directs the patient to write a standard sentence; this exercise can diagnose dysgraphia, one of the first signs of neurotoxicity (McConville, 2018). Nurses need to be aware when to implement seizure and aspiration precautions and monitor patients for symptoms of increased intracranial pressure or cerebral edema. Ultimately, if a patient requires an ICU transfer, designated PCU nurse continues to round on the patient to assess their condition, as they are the expert in providing this type of care. Collaboration between the PCU and ICU nurses is essential to provide patients with excellent care and promote health after the completion of CAR-T therapy.

REFERENCES:
FIT Rounds in the PCU

By: Karen Armenion, MSN RN CMSRN, Sarah Horman, MD, William Frederick, MD, Marianne Delos Santos, MSN RN

It’s time to get FIT! Yes, it is! On our unit you will hear our clinical nurse leaders (CNL) say “It’s time for FIT Rounds.” This would be around 10:30 am on JMC 5F every weekday. We continue FIT Rounds on 5G at 11:20 am every weekday. FIT stands for Focused Interdisciplinary Team Rounds.

A coordinated interdisciplinary rounding is the ideal way to ensure patient safety through accurate, consistent and regular team communication (1). This is especially important in a progressive care environment where treatment interventions evolve with changes in the patient acuity. Interdisciplinary team rounds involve the various disciplines involved in patients and their families/caregivers care.

The FIT rounding program is led by Dr. Sarah Horman and Dr. William Frederick from Hospital Medicine. The FIT “loop” (Figure 1) is a standardized framework of communication; each team member has a designated checklist to maximize exchange of useful information among disciplines. Highlights of this discussion and patient concerns are summarized and addressed at the end of the loop to enhance patient understanding and participation.

The goal of FIT is to create a structure for bedside rounds to improve communication amongst team members, patient experience and operational efficiency.

Jacobs Medical Center 5FG was the pilot unit for FIT Rounds implementation. 5FG is a 24-bed medical oncology and palliative care unit with an average daily census of 23 patients. The unit caters to patients with oncology diagnoses and those with specialized palliative needs. The medical management of the patients is led by Hospital Medicine with Team 4 on 5F and Team 5 on 5G. Hospitallists assign patients to Team 4 and 5 based on location on 5F or 5G respectively;

Karen Armenion, MSN, RN, CMSRN graduated with a BSN from Cebu Normal University in the Philippines in 1999. Since then, she has worked in several organizations as a registered nurse in the acute care setting. She joined UC San Diego Health in 2003 as a clinical nurse II in the HIV/Infectious Disease Unit (6 East). She pursued her Master’s Degree in Nursing and graduated in 2009 from the University of Phoenix. Karen has 13 years of administrative nursing leadership experience and 8 years as an acute care nurse manager. She has been successful in improving operations, work processes, nurse sensitive outcomes and patient experience at the unit, divisional and organizational levels. She has been a mentor for nursing staff in their leadership and clinical advancement. She promotes transformational leadership in her daily interactions with staff and patients. She provided leadership in the opening of Jacobs Medical Center 5FG, the Medical Oncology and Palliative Care Unit. Karen received the Nurse Leader of the Year award for Empirical Outcomes in 2014 and 2018.

Dr. Sarah Horman is a hospitalist at UC San Diego Health. She has helped lead the development and implementation of FIT rounds on JMC 5F and 5G as well as several other units (Thornton 2 East, 2 West, and 3 East and Hillcrest 6 West). As the chair of Patient Experience within the Division of Hospital Medicine, she is passionate about interdisciplinary collaboration to enhance communication amongst staff and patients.

William Frederick III, MD, PhD, is a hospitalist in the Division of Hospital Medicine, Department of Internal Medicine at the University of California, San Diego. He teaches both residents and medical students and has worked on the project to implement Focused Interdisciplinary (FIT) Rounding since its inception.

The same structured process has occurred during the pilot phase and then 1-2x per week after the first 6 months of implementation. Monthly meetings occurred during the pilot phase to review best practices, re-organize scripts and streamline our process. The same structured process has been implemented in Thornton 2East/2West and will be rolled out to other units in Thornton including 3East. Outcomes on each of these FIT units are being monitored after 6 months and after 1 year of geographic cohorting of these patients maximizes the benefit of FIT for these units. Many oncology patients are high acuity with complicated medication regimens and lab monitoring schedules, planned procedures and various consultants at any given time. FIT promotes streamlined communication so that everybody—including the patient—understands the daily care plan and barriers for discharge.

The FIT rounding program is led by Dr. Sarah Horman and Dr. William Frederick from Hospital Medicine. The CNL clinical nurse III Marianne Delos Santos is the project leader for the unit implementation. The teams met several times initially to create the structure for rounds and now have monthly working group meetings with leaders from each discipline. Staff nurses were coached daily in the initial pilot phase. We had mock rounds to practice the script that we created. Go live was July 5, 2017.

The charge nurses create the rounding schedule at the start of the shift. This schedule is given to the CNL and the rest of the team. Patients are rounded in an order that provides minimal disruption to nursing care. The CNL is the rounds coordinator on each pod, keeping rounds at a maximum of 4 minutes per patient. The attending physician leads the rounds in the room and provides each team member time to provide updates, including the patient/family. Patient encounter rounds are maintained at an average of 4 minutes per patient. The nursing management team was available to coach during the initial phase and then 1-2x per week after the first 6 months of implementation. Monthly meetings occurred during the pilot phase to review best practices, re-organize scripts and streamline our process.

The same structured process has been implemented in Thornton 2East/2West and will be rolled out to other units in Thornton including 3East. Outcomes on each of these FIT units are being monitored after 6 months and after 1 year of implementation.

Figure 1. FIT Rounding Loop

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**HCAHPS Patient Survey Results**
(Top Box Percentile Rank, All Press Ganey)

<table>
<thead>
<tr>
<th></th>
<th>Baseline 1/1/17 to 7/4/17</th>
<th>Implementation 7/5/17 to 2/28/18</th>
<th>6 Months Post Implementation 3/1/18 to 6/30/18</th>
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<tr>
<td>Likelihood to Recommend</td>
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<td>91 (n=42)</td>
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<td>Communication with Nurses</td>
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<td>Communication with Doctors</td>
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<td>Communication about Medicines</td>
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<tr>
<td>Discharge Information</td>
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<td>86 (n=74)</td>
<td>78 (n=42)</td>
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<tr>
<td>Care Transitions</td>
<td>83 (n=80)</td>
<td>94 (n=82)</td>
<td>88 (n=43)</td>
</tr>
</tbody>
</table>

Table 1. JMC 5FG Patient Satisfaction Survey Results

**REFERENCES:**
Laura Vento, MSN, RN, CNL is Nurse Manager of the Surgical Oncology Progressive Care Unit at UC San Diego Health Jacobs Medical Center. She earned her BS from James Madison University and her MSN from the University of Virginia. Prior to working at UC San Diego Health, she was a Peace Corps rural health extension volunteer. In East Timor, Laura has been at UC San Diego Health since graduating with her MSN in 2008. She began her career in the HIV/AIDS unit, and is also experienced in Abdominal Transplant and Surgical Oncology patient populations. Laura was the recipient of the 2011 Nurse of the Year and the 2013 Nurse Leader of the Year. Laura has certification as a Clinical Nurse Leader (CNL) and is a member of the American Association of Critical Care Nurses (AACN) and the Association of California Nurse Leaders (ACNL).

The rate at which solutions are identified. Furthermore, the quantity of issues presented has decreased significantly over the course of implementation. Once a process issue is recognized by staff and communicated to leadership, it is added to a color-coded spreadsheet (green=done, yellow= in progress, and red= cannot complete at this time), and emailed weekly with status updates to all staff. In evaluation of the spreadsheet, improvements that were a product of the PRRAISE process, and thus led by team members, are highlighted.

The PRRAISE process has directly increased staff satisfaction and communication. It has produced an accountability structure for leadership and as a result increased transparency. It provides insight for staff as they witness the multiple steps necessary to fix a process issue and gives staff real-time updates. For example, if an opportunity for improvement or clarification is identified within an ancillary department, the leadership team contacts the leadership of that department to review and discuss next steps. Historically, this communication would occur without staff knowledge or input in the process. Furthermore, staff generally had limited access to the exact status or actions of leadership without inquiring directly. Due to PRRAISE, staff can access updates on the shared database in real time. Over the course of nine months, 22 issues have been identified and solved through this process. Additionally, the integration of this model has led to an increase in interdisciplinary collaboration as many departments have presented at the unit based practice council meeting.

The second structure introduced to the microsystem was the Idea Team Collaborative. After completing Kim Scott’s Radical Candor within a summer leadership book club, Jacobs 4th floor implemented a process inspired by their reading that supported innovation led by bedside team members. Scott discusses her structure within the text in which ideas are critically evaluated: “The idea team had to commit to listening to any idea that anyone brought to them, to explain clearly why they rejected the ideas they rejected, and help people implement ideas that the idea team deemed worthwhile.” Radical Candor

The Idea Team methodology was born from the notion that those at the frontline are the most capable of identifying inefficient processes and thus have the greatest ability to make meaningful change. While the PRRAISE framework catalogues daily operational system issues and aims to correct these identified deficits quickly, the Idea Team standardizes the quality improvement process on a larger scale and develops projects over time. This collaborative now serves as the platform for all project development and implementation under the oversight of Jacobs 4th Floor’s Unit Based Practice Council. Every member of the collaborative is encouraged to critically think and appraise idea proposals. The collaborative considers the project objective in terms of whether it is applicable now, later, or perhaps never and if it will yield outcomes that are in alignment with the professional practice model and Magnet. The collaborative does not merely say “yes” to every proposal. The structure of the collaborative is conducive to stimulating constructive feedback and purposeful discussion. The process for a team member with a project idea is as follows:

- Idea is emailed to leadership team
- Leadership teams responds via email with attached PowerPoint template for presentation to the Ideas Team and schedules date for presentation
- All project proposal presentations occur within the first hour of the two hour meeting
- Implementation plan developed and objective statement honed collaboratively directly after team decides if proposal is approved
- Monthly check in and update of implementation plan from all team leaders of ongoing projects
- Process supported by weekly “Office Hours”. Leadership team devotes 1.5 hours to mentoring, answering questions, and identifying next steps for in-progress projects.

The outcomes associated with the implementation of the collaborative have been an expedited clinical advancement of three nurses to Clinical Nurse III, an elevation in peer oversight and comprehension of evidence based practice and research, and a significant improvement in manager efficiency. Additionally, bedside team members are able to refine their public speaking skills and their ability to speak directly to quality outcomes. Those with active projects are encouraged to bundle their identified needs to discuss during Office Hours or during the meeting time. Ongoing tracking of project status is simple with up to date implementation plans housed in a shared database.

Effective communication, standardization of processes, outcomes and expedited innovation, and peer oversight are the core foundation of both PRRAISE, the Ideas Team Collaborative. Nurses are able to identify process improvement opportunities, classify them appropriately, and succinctly identify solutions. Additionally, tier 1 staff satisfaction was achieved on Jacobs 4th floor, outperforming benchmark (see Figure 2). The paradigm has slowly shifted and now, frontline staff are empowered to lead innovation with the support of leadership.
CASE STUDY
A middle-aged man presented to the emergency department with a gunshot wound to the face. He underwent a significant facial reconstruction surgery. During his recovery, a police officer came to the unit and notified nursing staff that the patient was a felon. The officer stated that the police department did not have the funds to keep the patient in custody while the patient was hospitalized, but that nursing staff were obligated to notify the police department when the patient was discharged, to facilitate his arrest. The nurse directed the officer to the hospital’s security department, but the officer continued to come to the unit and call the unit repeatedly. According to hospital policy, no patient information was released to the officer.

During numerous encounters, the police officer informed nursing staff that the patient was “very dangerous” and that not providing updates on the patient’s condition was “interfering with law enforcement.” Given the extent of his wounds and medical needs, safe discharge directly to an incarcerated status could not be coordinated. Medical staff attempted to confer, but discussions of his discharge home with family for extended antibiotic therapy, care of the oral mucosal wall graft, and continued adjustment of the jaw wires. As the patient neared discharge, police officers arrived on the unit and proceeded to arrest the patient. Medical staff reiterated that the patient was not cleared to discharge to a custody setting. The officer removed the patient from the ward and took him to the emergency department, presumably for medical clearance. The patient was not seen again.

On reviewing the case with the privacy office, it was ascertained that the hospital did not have a clear process to address this situation. It was suggested by the privacy office that, because reported lack of funding prohibits law enforcement from placing inpatients in custody, it should be the nurses’ responsibility to notify law enforcement of impending discharges to facilitate arrests. Those involved felt that to expect nurses to participate in the guarding and reporting of alleged criminals for the purpose of arrest upon discharge constituted an ethical dilemma. The lack of structured guidance and expectations of nurses’ interactions and collaboration with law enforcement complicated the issue. Because the patient had continued an healthcare need and the team did not have the opportunity to ensure that the receiving providers were prepared for his needs, there was a potential patient safety issue. Clinician safety and the safety of the other patients on the ward were also concerns. Those involved felt that the tension between obligations to care nonjudgmentally versus acting as agents of the law conflicted with the established nursing code of ethics.

ETHICS ANALYSIS
BACKGROUND
Caring for accused and convicted criminals is an inherent duty in trauma care. While law enforcement and custodial institutions operate within rigid and clear guidelines, their normal operations become convoluted in the inpatient healthcare setting. Because of law enforcement budget cuts, patients who previously had an officer posted at the bedside are now arrested upon discharge. The goals of law enforcement and those of nurses in this situation are at odds. There is an inherent dissonance between the culture of custody in prison versus the culture of caring in healthcare. Moral and ethical dilemmas can be expected when seemingly incompatible cultures such as these coexist.

Further, it may be construed that, because imprisonment is an act of punishment, there is an intention of deliberate harm in being imprisoned, whereas the intention of healthcare is to optimize wellbeing and prevent pain. In the worldview of healthcare clinicians, liberty is a positive construct and optimal health includes freedom from physical and existential pain. These juxtaposed intentions function in ethical opposition to each other and are likely to produce dilemmas where the intentions collide.

Where law enforcement officers see a criminal, nurses see a patient, and the nurse’s duty remains unchanged. When asking a nurse to mentally and emotionally act on a patient’s alleged crimes, care can be affected. Disclosing details of the potential prisoner-patient’s alleged crimes presents an opportunity for clinicians to make judgments regarding the case, thereby transforming these clinicians into an arm of the law. In turn, caregivers can become directly involved in the process of punishment. On the contrary, nurses are educated and expected by their own code of ethics to eliminate biases to optimize development of a respectful, caring, nurse-patient relationship, which in itself is part of the healing process. A community assessment was conducted, which found that other local hospitals experienced similar situations and had the same difficulties in devising an effective, safe, and ethical means to handle the requirements of law enforcement. Attempting to solve the problem through the security department and privacy office alone were ineffective. It was not until the ethics team was consulted and all parties subsequently met together that a solution was reached.

The ethics team was consulted to assess the organizational ethics of this case, under the assumption that the situation would occur again in the future. While the process of a formalized policy was underway, it was determined that the ethics committee, nursing division, privacy office, and security department would come together to create a process that would remove the primary nurse from responsibility for calling for the arrest of patients. In this unique situation, both the law and ethics needed to be considered equally.

It was ultimately determined that all law enforcement inquiries would be directed to the security department, and strict adherence to HIPAA and state and federal information release guidelines would be followed. In situations in which it was confirmed that an in-hospital arrest would be likely, it was determined through the creation of an algorithm that an emergency huddle with unit leadership, the security department, and the clinician would take place to determine the interventions necessary to maintain the safety of all involved. It was agreed that the security department, privacy office, and ethics team would be available and would participate as appropriate. Patients would not be arrested in a multi-bed ward. The arrest would need to be timed so that the discharge plan could include communication with the receiving healthcare team before transfer, to ensure patient safety.

Establishing therapeutic and trusting relationships is at the core of ethical practice. Health centers are safe havens in which all patients have the right to receive unbiased care. Clinicians must continue to assess for and advocate against impeding societal and structural forces that could negatively impact their ability to provide holistic care.

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3. Gadow S. Restorative nursing: toward ethical practice. Health centers are safe havens in which all patients have the right to receive unbiased care. Clinicians must continue to assess for and advocate against impeding societal and structural forces that could negatively impact their ability to provide holistic care.

By: Danisha Jenkins MSN, RN, CCRN, NEA-BC; Dr. Judy E. Davidson DNP, RN, FCCM, FAAN; Dr. Lynette C. Cederquist, MD

Danisha Jenkins MSN, RN, CCRN, NEA-BC is the Nurse Manager for the SW Trauma PCU at UC San Diego Health. Hillcrest. Danisha is also a PhD student at UCI and is passionate about advocacy for nurses and their care of vulnerable populations.

Dr. Judy E. Davidson DNP RN FCCM FAAN serves University of California San Diego Health as a nurse scientist supporting nurses with project development, presentation and publication. She hosts an appointment as a Research Scientist in the UCSD School of Medicine, Department of Psychiatry, Dr. Davidson is also an editor of the Journal of Nursing Management.

Lynette Cederquist, M.D. is a Clinical Professor of Medicine at UCSD in the Division of General Internal Medicine and is the Director of Clinical Ethics for UC San Diego Health. She is Board Certified in Hospice and Palliative Medicine. Dr. Cederquist’s clinical practice is focused on chronic pain management within the Division of Internal Medicine. As Director of Clinical Ethics, she runs the Ethics consult service, the in-dyin program, and chairs the hospital Ethics Committee. In addition, she teaches in the medical school’s Primary Care Course, and is Director of the Internal Medicine Chronic Pain elective.

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