EXCELLENCE IN CLINICAL NURSING

NURSING PATHWAYS

KAISER PERMANENTE®

STAFF NURSE III
HH/H III and PCCCM III APPLICATION PACKET
A step on the Nursing Career Ladder

Revised May 2023

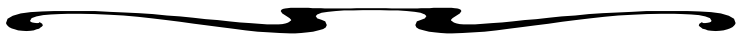
Contents

Definition of Staff Nurse III/IV, and Home Health/Hospice Nurse III/PCCCM III

The Staff Nurse III/IV, HH/H III, PCCCM III programs have been developed to offer recognition and career advancement opportunities for those nurses who have excelled in clinical practice, leadership and professionalism. The Staff Nurse III and IV, HH/H III, PCCCM III roles are designed to enable the clinically expert Staff Nurse to find continuing recognition and rewards in the provision of direct care in his/her area of clinical specialty.

The Staff Nurse III/IV and HH/H III, PCCCM III functions in the clinical setting as an exemplary care giver to patients, a model of proficiency for co-workers, and a colleague to physicians. From years of nursing experience and a continued expansion of clinical knowledge, the Clinical Expert (SN III & IV or HH/H III), PCCCM III is a skilled practitioner who demonstrates leadership by:

1. Identifying, communicating and fulfilling patient needs;
2. Coordinating and utilizing facility and community resources to meet patient needs;
3. Promoting a multi-disciplinary approach to patient care;
4. Assuming a teaching-coaching role with other nurses and health team members, and;
5. Maintaining a flexible approach to resource constraints.



Through an intuitive use of knowledge, fine discretionary judgment, experience and leadership, the Clinical Expert is able to provide the best possible patient care in a safe environment.

Minimum Qualifications

Staff Nurse III

1. Current license to practice as a Registered Nurse in California.
2. Five (5) years of clinical experience as a Registered Nurse.
3. Work in the area of clinical specialty with the Employer for the last two years.
4. Work in the area of clinical specialty with the Employer for an average of 24 hrs/week over the last year. (It is the RN's responsibility to notify the FSC if their hours fall below 24 hours.) See the calculation below.
5. **Current Performance evaluation** based on the applicable performance standards for each year at the midpoint or above on average. Completed or hand signatures are accepted; however, AACC requires hand signatures of RN managers on the evaluation.
   - Performance evaluation must be at mid-point or above on average.
   - **Performance evaluations are found on the HRconnect website:**
     - **Sign on to HRconnect > lefthand side, click on "Performance Management" > righthand side, click on "Acknowledge Review," then in the "Review Period," click on the "dropdown arrow." This link will allow you to print out all of your completed performance evaluations.**
   - **You can view your previous My HR performance documents from 2020 and prior by clicking on the "Legacy My HR" link.**
   - **Legacy document access is for reviews completed in the My HR system, not reviews completed using Word documents.**
   - **Documents are performance reviews, development plans, and performance improvement plans.**
   - **Accessing appears as below:**

View documents in open status	**Documents in open status were active at conversion or the employee acknowledgement was not done to close the document.**
View documents in closed or completed status	**Documents in closed or completed status were employee acknowledged prior to conversion.**

   - All pages of the performance evaluation must be submitted.
6. Fifteen (15) CEUs in her/his area of clinical specialty in the past year.

Home Health/Hospice III only

1. A current license to practice as a Registered Nurse in California.
2. Five (5) years of applicable RN experience within the last five years.
3. Worked as Home Health/Hospice nurse with the employer for at least three (3) of the last five years, or two (2) years as Home Health /Hospice nurse with the employer and one (1) year home health experience within a Medicare certified home health agency.
4. Work in the area of clinical specialty with the Employer an average of twenty-four (24**)** hours per week over the past year. See calculation below.
5. A Public Health Nurse (PHN) certification or serve as a HH/H case manager.
6. Current completed or hand signed performance evaluation at the midpoint or above on average.
7. Fifteen (15) CEUs in her/his area of clinical specialty in the past year.

PCCCM III

1. A current license to practice as a Registered Nurse in California.
2. Five (5) years of applicable RN experience within the last five years.
3. Worked as PCCCM nurse with the employer for at least two (2) of the last five years.
4. Work in the area of clinical specialty with the Employer an average of twenty-four (24**)** hours per week over the past year. See the calculation below.
5. Current completed or hand signed performance evaluation at the midpoint or above on average.
6. Fifteen (15) CEUs in her/his area of clinical specialty in the past year.

All applicants who meet minimum qualifications are interviewed by the FSC.

Hours Worked Calculation

(A) A Registered Nurse hired into a twenty-four (24) hour position or more is exempt from any further calculation to determine paid or unpaid time away from work.

(B) For any Registered Nurse hired into a position of less than twenty-four (24) hours, the following calculations apply:

- Paid time is calculated by determining total paid hours for the year minus the number of vacation hours taken in week blocks.
- This paid time is then divided by number of weeks, which is calculated by taking the fifty-two (52) weeks in a year minus the weeks of vacation blocks minus California Nurses Association option week if taken, minus approved leave of absence up to three (3) months time.
- Paid time divided by number of applicable weeks equals paid hours per week. This number must equal twenty-four (24) hours or more in order for a nurse to meet the hours worked qualification.

(C) For a nurse on disability (UCD) or Workers Compensation integration of the number of weeks will be subtracted from the number of total weeks. The number of sick leave hours paid during this time will be subtracted from the number of hours paid. If the nurse goes on non-paid status (no sick leave) the leave of absence cannot exceed three (3) months.

Application Process

Application packets for Staff Nurse III or HH/H III, PCCCM III are available from the nursing office/staffing office or the https://nursescholars.kaiserpermanente.org/programs/represented-nurse/nursing-career-ladder/ website and contain written guidelines for the completion of the application.

The applicant may contact a member of the Facility Selection Committee to verify completeness of the application prior to submission. Additionally, the applicant must have a Mentor signature on their application to validate that all elements are complete.

The applicant must:

1. Meet minimum qualifications (see previous page).

2. Submit a complete application portfolio containing the following:
   - **a.** Staff Nurse III or HH/H II, PCCCM III Application Form with a required Mentor's signature.
   - **b.** Verification of Hours Paid form (if applicable).
   - **c.** Signed performance evaluation within the last twelve (12) months of application. Completed or hand signatures are accepted; however, AACC requires hand signatures of RN managers on the evaluation.
   - **d.** Performance evaluation must be at mid-point or above on average.
   - **e.** Performance evaluations are found on the HRconnect > lefthand side, click on "Performance Management" > righthand side, click on "Acknowledge Review," then in the "Review Period," click on the "dropdown arrow." This link will allow you to print out all of your completed performance evaluations.
   - **f.** All pages of the performance evaluation must be submitted.
   - **g.** Three letters of recommendation dated within the last twelve (12) months of application (see required details that follow in this packet).
   - **h.** Documentation of at least fifteen (15) continuing education units in area of specialty (either CEU or CME) that was completed within the last twelve (12) months (see required details that follow in this packet).
   - **i.** Two exemplars that are reflective of events that occurred in the last twenty-four (24) months (see required details that follow in this packet and sample exemplars).
   - **j.** Two (2) professional contributions within the last twelve (12) months (see required details that follow in this packet) Staff Nurse III or HH/H III, PCCCM III Checklist (part of Scoring Guidelines).

   Submitting these materials in the order listed above would be helpful but not required.

3. Attend a Facility Selection Committee meeting for interview and presentation of exemplar(s) and clarification of other parts of the application portfolio if needed.
   - **a.** Applicants will be notified of the date of the Facility Selection Committee meeting within fourteen (14) days of the applicable application deadline.
   - **b.** All Selection Committee meetings will be scheduled within thirty (30) days of the applicable deadlines.
   - **c.** Applicants will be notified of the Committee's decision within ten (10) business days of the interview.
   - **d.** Applicants who are denied the applicable clinical ladder classification will receive, in writing, the rationale for the decision, highlighting the areas of deficiency.
   - **e.** Applicants that meet the minimum qualifications shall be interviewed.
   - **f.** During the interview:
     - Candidates will be asked to answer questions about any aspect of the portfolio contents in a clear, knowledgeable, and succinct fashion.
     - Candidates will be asked to clearly present either one or both exemplars.

Responsibility of Applicants

- Provide the best possible documentation of his/her clinical practice, leadership, and professionalism to the Facility Selection Committee ahead of or before the deadline (March 1, July 1, or November 1).

- Ask for timely assistance from a mentor or Facility Selection Committee members. Attend local workshops for applicants.

- Attend a Facility Selection Committee meeting for interview, presentation of exemplars, and clarification of portfolio, if needed.

- Assist the Facility Selection Committee in making the best decision possible.

- If needed, appeal to the Facility Selection Committee in writing within 30 days of the original decision. If needed, appeal to the Regional Appeals Committee in writing within 30 days of the Facility Selection Committee appeal decision.

- Successful applicants need to become familiar with requirements to maintain their new status including renewal requirements.

- Select a Mentor from the FSC's Mentor list and ensure that your final application is signed by your Mentor.

The Role of Mentors

As an applicant for Staff III/IV, HH/H III and PCCCM III, you must select a **mentor** to assist you in the application process. Choose a mentor from the local FSC mentor list. The Applicant-Mentor relationship is required, and, ideally, the relationship would start at least one month before the application deadline.

A mentor can be either a member of the Facility Selection Committee or a Staff Nurse III/IV, Home Health III, PCCCM III who can offer suggestions to improve the application portfolio of staff prior to submission. **For 2023 all first-time PCCCMII applicants can choose a mentor from the local FSC mentor list.** Names of the Facility Selection Committee Members will be posted on the Association's bulletin board in each facility. The Local Facility Selection Committee will maintain a current listing of Mentors. Ask your manager or your C.N.A. Rep for a list of SN IIIs, SN IVs, HH/H IIIs, or PCCCM III.

The **role of the mentor** is to review your application portfolio for completeness before it is submitted to the committee on March 1, July 1, or November 1. Mentors also offer suggestions to improve the application portfolio prior to submission. Mentors must sign the final application.to validate that all required application elements are complete.

Letters of Recommendation Guidelines

Letters should be legible, brief, indicate the nature and dates of your association, state "I recommend (candidates name) for Staff Nurse III, HH/H III, or PCCCM III" and address the applicant's demonstration of the qualities described in the Staff Nurse III, HH/H III, or PCCCM III definition (reproduced below).

Please submit a letter of recommendation from each of the following parties who are familiar with your practice over the last year. All letters must be dated within 12 months of the application deadline.

- A **RN peer** familiar with your practice
- A **supervisor** (a nursing supervisor familiar with your practice
- Another **health team member** (MD, PT, Social Worker, etc.)

NOTE: The Letter of Recommendation Form is provided in this packet to assist the writer of the recommendation to cover all requirements.

CONCEPTS FOR LETTERS OF RECOMMENDATION

All five (5) of these concepts must be addressed in all three letters of recommendation:

1. **Identifies, communicates, and fulfills patient needs.**
2. **Coordinates and utilizes facility and community resources to meet patient needs.**
3. **Promotes a multi-disciplinary approach to patient care.**
4. **Assumes a teaching/coaching role.**
5. **Maintains a flexible role to resource constraints.**

These concepts may be addressed in letters of recommendation in addition to the five required concepts above:

6. Exemplary caregiver to patients.
7. Model of proficiency for co-workers.
8. Colleague to physicians.
9. Skilled, experienced practitioner.
10. Demonstrates leadership.
11. Intuitive use of knowledge/fine discretionary judgment.
12. Provides best possible patient care.
13. Provides safe environment.

*Letters of recommendation written for charge nurses should address clinical skills and not Charge Nurse Duties.

Additional letters of recommendation may be submitted in case one or more letters do not meet requirements.

Continuing Education Documentation

Applicants must have a minimum of 15 Continuing Education credits in the area of the applicant's clinical specialty. Continuing Education must be within the 12 months before the application deadline.

Courses that are approved by the BRN or the Continuing Medical Education (CME) shall be applicable. ACLS/PALS/NRP counts if it is applicable to the clinical area and NOT a job requirement. Determination of applicability to clinical specialty will be made by the Facility Selection Committee.

Photocopies of CEs, CMEs, college credit certification, need to be included in the portfolio when the application is submitted.

More than 15 CEUs may be submitted with the application packet in case some CEUs do not meet requirements. Candidates who have taken more CEs/CMEs will be rated higher.

Clinical Practice Exemplars

Historical Background: The SN III/HH/H III, or PCCCM III classification is recognition of excellent clinical nursing practice. Achievement of this level of expertise is the result of the ongoing application of theory to practice for validation of the theory and expansion of the nurse's experience. Experience, as it is used here, does not refer to the mere passage of time. Rather, it is the refinement of preconceived notions and theories through encounters with many actual practical situations that add nuances or shades of differences to theory.*

The work of Patricia Benner, RN, Ph.D., was used as a foundation for the development of the SN III/HH/H III, PCCCM III classification. Benner believes in the situation-based, interpretive approach to identifying and describing knowledge, which is imbedded in everyday clinical practice. Her descriptions and definitions of what nurses do to make a difference, which she calls the "domains' of nursing, were culled from hundreds of narrative examples ("exemplars") submitted by nurses. Benner's seven domains include:

1. THE HELPING ROLE
2. THE TEACHING-COACHING FUNCTION
3. THE DIAGNOSTIC AND MONITORING FUNCTION
4. EFFECTIVE MANAGEMENT OF RAPIDLY CHANGING SITUATIONS
5. ADMINISTERING AND MONITORING THERAPEUTIC INTERVENTIONS AND REGIMENS
6. MONITORING AND ENSURING THE QUALITY OF HEALTH CARE PRACTICES
7. ORGANIZATION AND WORK-ROLE COMPETENCIES.

Benner, Patricia from Novice to Expert, UCSF, 1984, Addison-Wesley Publishing, Menlo Park

Read the material provided titled BENNER'S DOMAIN. Find examples in your individual practice which:

1. **Demonstrate your ability to function in any three of the domains**
2. Write, **in your own words, two (2) narratives** each containing three domains. **Describe clinical situations,** which you believe **positively impacted by your practice.**
3. Include how you felt about the situation, why you think your actions may have differed from someone with less experience**.**
4. **State the domains you are addressing** at the beginning of each exemplar **(see back of this packet for examples of BENNER'S DOMAIN).**

Criteria for Exemplars

To assist you in writing exemplars, the following information pertinent to evaluation of exemplars is offered:

1. Two written exemplars must be submitted for review. The exemplars must be reflective of events that occurred in the last twenty-four (24) months.

2. Type the exemplars in a clear, professional, understandable style.

3. Identify the 3 domains being addressed at the beginning of each exemplar.

4. Demonstrate in each exemplar how you can function in any three (3) of the domains.
- The same domains can be used in both exemplars, or different domains can be used.

5. Exemplars include information about any of the following:
- how you felt about the situation
- why you felt that your actions were important
- why the actions were important
- why the actions may have been different from someone with less experience

6. Describe in the exemplar, a clinical situation that was positively impacted by your practice.

7. Demonstrate excellence in your exemplar, i.e., should result in a positive or rewarding experience for the patient.

8. Describe in the exemplar, how you personally made a difference.

9. Show in your exemplar how you used fine discretionary judgment and/or intuitive use of knowledge.

10. Write the exemplar in your own words. Uniqueness and individuality are important.

The appendix of this packet includes a lengthy description of Benner's Domains and helpful examples of exemplars.

Specific examples of exemplars from your medical center are also available for your review. Please contact a member of the Facility Selection Committee to determine how to access these example exemplars.

Additional exemplars may be submitted in case one or more do not meet requirements.

Professional Contributions

Participation in two (2) of the following within the past twelve (12) months is required.

1. Active participation in quality activities which must be of an ongoing nature with participation occurring over at least six (6) months of the past year, e.g., PPC, Safety Committee, organizationally sanctioned peer group or committee, RNQL.

- Committee work may be hospital or professionally based
- Patient classification system
- PPC
- Performance Improvement
- Policy and Procedure
- Other

The applicant may document the role of the committee (charter), meeting frequency, and your contribution by completing the optional form on committee participation documentation included in this packet.

2. Teaching Activities
Community teaching must be voluntary. Teaching activities are not necessarily ongoing in nature. They may be significant one-time events.

- Formal In-service/Presentation
- Informal In-service/Presentation
- Community Teaching (community teaching must be voluntary)
- Health care related research
- Development and/or presentation of patient education programs.
- Precepting
- Orienting/cross-training
- Other

Examples are: teaching guidelines, new grad preceptor, assisting with a complex skills day or facility-wide training, such as blood borne pathogens.
Examples of health-related community work are: a school demonstration project, involvement in a respite program, active participation in a health fair or health screening, teaching a first aid course. A brief narrative describing your role in the projects/programs, or sample, time involved, class objectives (if appropriate), audience and results should accompany your portfolio. For publications, please enclose a copy of the article you wrote.

3. Leadership Activities

- Hold a Charge Nurse, Chief Nurse Rep, Nurse Rep or other CNA leadership position
- Receive Relief in Higher Classification for Charge Nurse or Supervisor
- Committee or Task Force
- Special Projects/Presentation
- Standardized Care Plan/Clinical Pathway
- Health Related Community Organization/Service (community service must be voluntary)
- Mentor one new graduate RN for up to eighteen (18) months within the last thirty-six (36) months, in accordance with contractual provisions in Section X
- Other

Examples of written standards of nursing care are: the actual writing of a standard or involvement in the annual review of the same; the writing of a policy or procedure. A sample of the standard should be included in the portfolio if possible.

Additional Notes:

- Community work must be health related.
    - Letters that support community service and volunteering require dates and detail of service.
- Patient education must be more than that provided by most Staff Nurse II's on a day-to-day basis; it requires that a patient education program, pamphlet, handout, etc., be developed, revised, and/or taught.
- Candidate must be able to substantiate involvement or participation.

Descriptions of additional professional contributions may be submitted in case one or more do not meet requirements.

NURSING PATHWAYS

APPLICATION FORMS

STAFF NURSE III, HH/H III/ / PCCCM III Application

STAFF NURSE III, HH/H III/ PCCCM III APPLICATION FORM

1. Name_____ 2. Date_____

3 Unit/Shift_____Facility_____

4 Mailing Address _____

5. Manager _____Cost Center_____
☐ Manager informed that applicant is applying for SN III or HH/H III**/ PCCCM III.**

6. Phone
(Work)_____ (Home) _____(Other)_____

7. R.N. License Number_____

8. For Home Health Only:
Requirements for HH/H III: _____

I obtained my PHN: In (date) _____

I am a case manager: From (date) _____To (date)_____

9. Area of Clinical Specialty
☐ Ambulatory Care
☐ Home Health/Hospice
☐ Hospital

10. Classification
☐ Regular
☐ Short Hour
☐ Per Diem

11. Average Number of Hours Worked Per Week_____
(Use Verification of Hours Paid form if needed)
(It is the nurse's responsibility to notify the Facility Selection Committee if hours drop below 24 hours)

11. RN clinical nursing experience (See minimum qualifications) Most Recent Listed First * (Include at least the last 5 years).

APPLICATION ONLY:

DATES: FROM - TO	**AREA OF PRACTICE**	**EMPLOYER**
1.		
2.		
3.		
4.		
5.		

STAFF NURSE III, HH/H III/ PCCCM III
SIGNATURE PAGE FOR MENTOR

Mentor's Name_____

Mentor Signature_____

Date _____

STAFF NURSE III, HH/H III/ PCCCM III
RECEIPT OF APPLICATION FORM

Application Submission:

Date application submitted:_____
Time application received:_____
Application received by:_____

Note: please provide applicant with a signed copy of this page as verification of receipt of SN III/ HH/H III/PCCCM III application.

Verification of Hours Paid Form

(This form should be completed for any Registered Nurse who is NOT hired into a twenty-four (24) hour position or more)

1. Name_____ **Date**_____

2. Unit/Shift _____/_____ **Facility**_____

3. Phone: WORK_____ **HOME**_____ **OTHER**_____

4. R.N. License # _____**Expiration Date**_____

5. Area of Clinical Specialty: ☐ **Ambulatory Care** ☐ **Home Health/Hospice** ☐ **Hospital**

6. Classification: ☐ **Regular** ☐ **Short Hour** ☐ **Per Diem**

7. Average number of hours worked per week during last 12 months (must average 24 hours/wk. paid time):

Application:
I year total hours _____**/week. (New Applicants for Staff Nurse III/IV, HH/H III PCCCM III)**

The staffing/payroll office will assist in this calculation if needed.

These signatures certify that calculations are correct as of the specified date.

SIGNATURE (PAYROLL)_____

SIGNATURE OF MANAGER_____

DATE_____

Letter of Recommendation Form

The Staff Nurse III, HH/H III or PCCCM III functions in the clinical setting as an exemplary care giver to patients, a model of proficiency for co-workers, and a colleague to physicians. Part of the application process requires that applicants submit letters of recommendation from peers, supervisors/managers, and other health team members familiar with the applicant's practice over the past year.

Instructions: Please complete this form and return it to the applicant before _____ (date). The form must be legible. Please use additional pages if needed or replicate this format in a separate document.

(Letters of recommendation written for charge nurses should address clinical skills and <u>not</u> Charge Nurse Duties.)

1. Your Name _____Date of Recommendation _____

2. Applicant Name _____

3.Relationship to Applicant:
 RN Peer Supervisor/Manager Health Team Member (MD, PT, Social Worker, etc.)
 Dates: from _____ to _____

Brief description of relationship to applicant:

4. Do you recommend the applicant for SN III, HH/H III or PCCCM III? Yes No

5. Please describe how the applicant identifies, communicates, fulfills patient needs:

6. Please describe how the applicant coordinates and utilizes facility/community resources to meet patient needs:

7. Please describe how the applicant promotes a multi-disciplinary approach to patient care:

8. Please describe how the applicant assumes a teaching/coaching role:

9. Please describe how the applicant maintains a flexible role to resource constraints:

10. Other comments regarding the applicant's clinical practice, leadership, or professionalism:

Signature _____

NURSING PATHWAYS

Committee Participation Documentation Form
Clinical Ladder
Staff Nurse III, HH/H III, and PCCCM III

Committee participation should be ongoing in nature with participation occurring over at least 6 months of the past year.

Name of Committee: _____

Date Joined: _____

Committee Charter/Purpose:

Committee meeting schedule:

- Monthly
- Every other month
- Quarterly
- Other

Individual's contribution to the committee: (Please list how/what you contribute to the committee or how you share the information with your staff.)

As the chairperson of the above committee, I am verifying that
_____(Name)

- attends the committee on a regular basis
- makes an individual contribution

_____Chairpersons signature Date: _____

KAISER PERMANENTE MEDICAL CENTER

STAFF NURSE III/HOME HEALTH III/ PCCCM III FACILITY SELECTION COMMITTEE CHECKLIST

Applicant Name: _____ Date: _____

Unit/Dept/Shift: _____ Facility: _____ ☐ KFH ☐ TPMG

Area of Specialty: ☐ Ambulatory Care ☐ Home Health/Hospice ☐ Hospital

RATING

- A score of at least **100** is required for an applicant to be granted a SN III/HH/H III classification.
- To calculate score multiply the rating by the weight and sum to achieve the total.

ITEM	WEIGHT	RATING	ITEM TOTAL	TOTAL SCORE
Performance Evaluation	15			
Letters of Recommendation	10			
Continuing Education	15			
Exemplars	30			
Professional Participation	20			
Interview	10			

All minimum qualifications & all application requirements must be met for the applicant to advance.

MINIMUM QUALIFICATIONS

☐ Current license to practice as an RN in California.

☐ Five (5) years of clinical experience as a Registered Nurse.

☐ One of the following:

- SN II works in the area of clinical specialty for the employer for the last two (2) years.
- HH/H II - Possesses a PHN certificate or serves as a HH/H case manager
- HH/H II works in Home Health at least 3 years with the employer
- HH/H II works in Home Health at least 2 years with the employer and 1 year HH experience within a Medicare certified home health agency
- PCCCM III- works in the area of clinical specialty for the employer for the last (2) years

☐ Work in the area of clinical specialty for the employer an average of 24 hrs/week over the last year.

☐ Current performance evaluation at the mid-point or above on average.

☐ Fifteen (15) CEUs in area of clinical specialty in the past year.

All applicants that meet minimum qualifications are interviewed unless the applicant withdraws their application **Interview Date** _____

APPLICATION REQUIREMENTS & CHECKLIST

☐ **Application Form:** All sections of application form are filled out completely and accurately.

☐ **Verification of Hours Paid Form** (if applicable)

☐ **Performance Evaluation** within the last 12 months at midpoint or above on average.

☐ **Three letters of recommendation dated within the last 12 months**

- ☐ RN peer familiar with the applicant's practice
- ☐ Nursing supervisor familiar with the applicant's practice
- ☐ Health Team member (MD, PT, Social Worker, etc.) familiar with the applicant's practice

Each letter must meet all of these criteria:
- Indicate nature & dates of association
- Clearly recommend the applicant for SN III
- Address 5 key concepts

☐ **CEU Documentation:** 15 CEUs in clinical specialty in the past year

☐ **Exemplars: Two exemplars reflective of events in the last 24 months**

☐ Exemplar #1 ☐ Exemplar #2

Each exemplar must meet all of these criteria:
- Identify the 3 domains addressed at beginning of exemplar
- Demonstrate how applicant functioned in the identified 3 domains
- Describe any of the following: how applicant felt about situation, why applicant felt actions were important, why applicant's actions were important , why applicant's actions were different from someone with less experience .
- Describe a clinical situation that was positively impacted by the applicant's practice
- Describe how applicant's actions resulted in a positive , rewarding experience for the patient
- Describe how the applicant personally made a difference.
- Shows how applicant used fine discretionary judgment and/or intuitive use of knowledge

☐ **Professional Participation: Two within the last 12 months**

Quality Activities:	Teaching Activities:	Leadership Activities:
		☐ Chief Nurse Rep., Nurse Rep., or other CNA leadership position
☐ PPC	☐ Formal Inservice/Presentation	☐ Hold a Charge Nurse position
☐ Safety	☐ Informal Inservice/Presentation	☐ Relief in Higher Class
☐ Peer Group	☐ Community Teaching	☐ Committee or Task Force, e.g. Patient classification system
☐ Committee	☐ Health care related research	☐ Special Projects/Presentation
☐ RNQL	☐ Development/presentation of pt ed programs	☐ Standardized Care plan/Clinical Pathway
		☐ Mentor one new graduate RN for up to 18 months within the last 36 months
☐ Other	☐ Precepting	☐ Health Related Community Organization/Service
	☐ Orienting/Cross-training	☐ Other
	☐ Other	

Mentor Signature Yes No (circle one)

PERFORMANCE EVALUATION

Rate 1: Met ♦ Performance evaluation rating at mid-point on average.
Rate 2: Proficient ♦ Performance evaluation rating in "proficient" range on average.
Rate 3: Excellent ♦ Performance evaluation rating in "excellent" range on average.

RATE ☐

LETTERS OF RECOMMENDATION

Rate 1: Met
Rate 2: Very Good
Rate 3: Outstanding

♦ Each letter recommends nurse for SN III/HH/H III/**PCCCM III** and addresses 5 out of 5 key concepts.
♦ The Facility Selection Committee may assign higher rates for letters that exceed the minimum requirements.

Peer ☐ **Mgr/Supv** ☐ **Health Team Member** ☐ **RATE** ☐

CONTINUING EDUCATION DOCUMENTATION

Rate 1: Met
♦ 15 CEU's applicable to area of clinical specialty in past year.

Rate 2: Very Good
♦ 16 to 18 hours of CEU's applicable to area of clinical specialty or,
♦ 15 CEU's applicable to area of clinical specialty and additional CEU's in other areas.

Rate 3: Outstanding
♦ 19 or more CEU's applicable to area of clinical specialty or,
♦ 16 to 18 CEU's applicable to area of clinical specialty and additional CEU's in other areas.

Note: Final determination of applicability to area of clinical specialty will be made in the interview. All candidates will be asked "Within the last 12 months what have you done to maintain your clinical competency in your specialty?" (As listed on application form.) If CEU's are not in their area of clinical specialty, ask candidate to discuss how the course related to their nursing practice.

RATE ☐

EXEMPLARS

Rate 1: Met
Rate 2: Very Good
Rate 3: Outstanding

♦ All criteria are met for both exemplars.
♦ The Facility Selection Committee is to assign higher rates for exemplars that display greater levels of fine discretionary judgment and intuitive use of knowledge.

RATE ☐

Exemplar #1 ☐ Exemplar #2 ☐

PROFESSIONAL PARTICIPATION

Rate 1: Met
♦ Involvement & professional participation in 2 categories.

Rate 2: Very Good
♦ Involvement and professional participation in 3 categories.
or involvement in 2 categories but with extensive involvement in at least one of the categories.

Rate 3: Outstanding
♦ Involvement and professional participation in 4 or more categories.
or involvement in 3 categories but with extensive involvement in at least 2 of the categories.

RATE ☐

INTERVIEW

Rate 1: Met
♦ Answers in a clear, knowledgeable, succinct fashion. Clearly presents one or both exemplars. Demonstrates poise. Uses good eye contact. Asks clarifying questions as needed.

Rate 2: Very Good
Rate 3: Outstanding
♦ The Facility Selection Committee may assign higher rates for candidates who more clearly meet the criteria & interview well.

RATE ☐

FACILITY SELECTION COMMITTEE RECOMMENDATION

Facility Selection Committee recommendation ☐ Granted ☐ Denied

Areas of Deficiency: _____

_____

Applicants for SNIII denial will be notified in writing, within 7 days of interview, the rationale for the decision, highlighting the areas of deficiency.

Applicant Notified By: _____ Manager Notified By: _____

Nursing Payroll Adjustment Request By: _____ Applicants Renewal Date: _____

FACILITY SELECTION COMMITTEE VOTING MEMBERS

_____ _____ _____

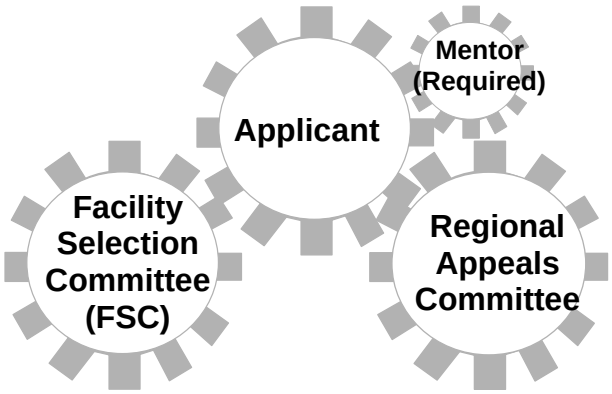
_____ _____ _____

_____ _____ _____

Revised May 2023

Other Useful Information

The RN Clinical Ladder is optimized through a three-way supportive relationship between (a) Applicant, (b) Facility Selection Committee, and (c) Regional Appeals Committee.



Facility Selection Committee

Names of the Selection Committee Members will be posted on the Association's bulletin board in each facility.

ABOUT THE FACILITY SELECTION COMMITTEE
The Committee shall be co-chaired by Nurse Executive/DONP or designee and a Staff Nurse III/IV or HH III/ PCCCM III.

The Facility Selection Committee is comprised of:

- Nurse Executive, Director of Nursing Practice (DONP) or designee
- 2 RN managers (appointed by the Nurse Executive/DONP or designee)
- 1 Staff Nurse III (minimum)
- 1 Staff Nurse actively involved in a professional committee
- 2 Staff Nurse IIIs, Staff Nurse IVs, HH/H IIIs or PCCCM III

Alternates: a substitute in the same category to be used as needed. Applicants may request a committee member be replaced by an alternate.

Content experts may be called if the committee has limited knowledge in a specialty area.

Committee members may serve a maximum of 2 years in any single category.

Selection committee vacancies are to be publicized by Nursing Administration and the PPC.

Nominations to the committee to fill vacancies will be made by the Staff Nurse III and IV, Home Health Nurse and PCCCM III peers.

The committee will choose replacement members from the nominees by consensus. Membership will be reviewed by the Nurse Executive/DONP or designee who is charged with ensuring board-based representation over time.

Appeals Process

Any applicant denied the Clinical Expert designation may appeal the decision of the Facility Selection Committee (FSC) as follows:

- A written appeal, clearly stating the basis for the appeal, must be submitted to the FSC that made the original decision no later than thirty (30) days after written notification of denial. The appeal shall not contain any application information that was not submitted with the original application as a justification for the appeal.

- The Facility Selection Committee shall review the appeal and either accept the application or deny the appeal, providing a written explanation of the reasons for the written denial. If the appeal is denied, the nurse may appeal that decision to the Regional Appeals Committee, no later than thirty (30) days after denial of the appeal by the FSC.

- Applicants may request a regional appeal in writing (e-mail is ok) within 30 days of the FSC appeal decision to Matt Boyer, C.N.A., 155 Grand Ave, Oakland, CA 94612, mboyer@calnurses.org AND **Earvin Ledi MSN RN CCRN-CMC**, Kaiser Permanente, Patient Care Services, 1950 Franklin St, 17th Floor, Oakland, CA 94612, Regional-Appeals-Committee-NCAL@kp.org The applicant should include their facility, their mailing address, and the reason for their appeal (clear and convincing evidence of procedural error or bias).

- The Regional Appeals Committee shall be composed of six members and two (2) alternates. Three members, plus one (1) alternate, shall be selected by the California Nurses Association from among Staff Nurse IIIs, Staff Nurse IVs, HH/H IIIs or PCCCM III of different existing Facility Selection Committees (FSCs) who are currently serving on a FSC or who have had past experience as a Staff Nurse IIIs, Staff Nurse IVs, HH/H IIIs or PCCCM III on a FSC. Three members and one (1) alternate shall be selected by the employer from nurse manager representatives from different existing FSCs who are currently serving on a FSC or have previously served on a FSC.

- The Regional Appeals Committee's review shall be limited to a consideration of the same appeal presented to the Facility Selection Committee. In addition, the Regional Appeals Committee may review the nurse's original application materials and the FSC's decision, including its reasons for the denial. This decision shall be provided to the applicant within thirty (30) calendar days after the Regional Appeals Committee's meeting.

- The Regional Appeals Committee may overturn the decision of the FSC only when there is clear and convincing evidence of procedural error or bias that affected the decision to deny movement up the clinical ladder.

- If the decision of the FSC is reversed, the percent increase in pay will be retroactive to the application deadline (March 1, July 1, and November 1).

The FSC will give the Staff Nurse Applicant information about where/who to send Appeals to Region. The decision of the Regional Appeals Committee is final and binding and shall not be subject to the provisions of Article XXXVIII of the Collective Bargaining Agreement.
A regional appeal may not be completed before the next application deadline. The applicant is free to apply at the next deadline regardless of the status of the regional appeal. The results of the new application and the regional appeal will be coordinated appropriately.

Transfers

Transfers to:

1. Nurses who transfer to a similar area of clinical specialty will retain their Staff Nurse IIIs, HH/H IIIs or PCCCM III status.

2. The Staff Nurse III or HH/H Nurse III, PCCCM III will apply for renewal at the end of the three (3) year classification.

3. Transfers to another area of clinical specialty require an application for Staff Nurse III or HH/H Nurse III, PCCCM III in the new area (see minimum qualifications).

APPENDIX

STAFF NURSE III, HH/H III/ PCCCM III Application

BENNER'S DOMAIN

THE HELPING ROLE

- The Healing Relationship: Creating a climate for and establishing a commitment to healing.
- Providing comfort measures and preserving Personhood in the face of pain and extremes.
- Presencing: Being with a patient maximizing the patient's participation and control in his recovery.
- Interpreting kinds of pain and selecting appropriate strategies for pain management and care.
- Providing comfort and communication through touch.
- Providing emotional and information support to patient's families.
- Guiding a patient through emotional and developmental change: providing new options, closing off old ones; channeling, teaching, mediating.
- Acting as psychological and cultural mediator.
- Using goals therapeutically.
- Working to build and maintain a therapeutic community.

The Staff Nurse III is a confident and caring professional who is dedicated to achieving positive patient outcomes. To meet that goal, this nurse successfully integrates experience, technical skills, a base, and an ability to deal with patients, families, and other resource people. This nurse's confidence imparts trust to the patient and the patient's family, who recognize that the Staff Nurse III is a competent advocate. The patient trusts in this nurse's expertise and ability to handle even critical situations that involve life and death.

The Staff Nurse III is always present for the patient, using touch and a caring, and sensitive manner. This nurse guides patients through emotional and developmental change. Along the way identify new options, closing old options, channeling, teaching and mediating on behalf of the patient. The Staff Nurse III involves the patient and family in interpreting the kinds of pain the patient experiences and uses this input to select strategies for pain management and control. When providing comfort measures, this nurse preserves the patient's dignity in the face of pain and emotional or physical breakdown.

The Staff Nurse III draws upon the patient, family and significant other as resources. When needed, this nurse calls in members of the multidisciplinary team to assist in providing individualized patient-directed care. Together with other members of the health care team, the patient and the family, the Staff Nurse III initiates the plan of care. This plan might address the next level of care, such as discharge to the home, transfer to another medical unit, or admission to a skilled nursing facility.

At all times, the Staff Nurse III behaves professionally and assertively with an unquestionable commitment to every patient. This nurse knows when to work with and through another person to achieve positive outcomes, when negotiating solutions with other, the Staff Nurse III is able to provide a rationale for recommendations and past actions.

THE TEACHING-COACHING FUNCTION

- Timing: Capturing a patient's readiness to learn.
- Assisting patient to integrate the implications of illness and recovery into their lifestyles.

- Eliciting and understanding the patient's interpretation of his or her illness.
- Providing an interpretation of the patient's condition and giving a rationale for procedures.
- The coaching function: making culturally avoided aspects of an illness approachable and understandable.

The Staff Nurse III accepts accountability for actions and outcomes and knows when to involve others in a plan of care. This nurse makes every effort to assure that all members of the care delivery team share consistent information regarding the patient.

The Staff Nurse III initiates appropriate teaching and coaching of patients and their families. In assessing a patient's readiness to receive information, this nurse incorporates knowledge gained from past experience with other patients. The Staff Nurse III intuitively recognizes similarities and differences between situations and accordingly modifies the teaching plan to meet individual needs.

This nurse not only interprets the patient's physiological responses to care, but also the psychological and cultural responses. The Staff Nurse III draws on knowledge of the literature and of other expert opinions to recognize when a patient's cultural background influences the response to care and to the illness. This nurse does whatever is possible to integrate the patient's beliefs and practices into the plan of care.

The Staff Nurse III is available when the physician makes rounds, partly to contribute pertinent information towards formulating the plan of care and partly to gather information that might help the patient and the family to better understand the situation. Being in this unique position enables the Staff Nurse III to interpret for the patient to the physician and for the physician to the patient and family.

This nurse assists the patient, family and significant others in addressing their particular concerns. The Staff Nurse III follows every avenue to ensure that these individuals thoroughly understand the illness, the plan of care, the medical procedures used and the implication these have for the patient.

THE DIAGNOSTIC AND MONITORING FUNCTION

- Detection and documentation of significant changes in a patient's condition.
- Providing an early warning signal: Anticipating breakdown and deterioration prior to explicit confirming diagnostic signs.
- Anticipating problems: Future think.
- Experiences of an illness: Anticipating patient care needs.
- Assessing the patient's potential for wellness and for responding to various treatment strategies.

The Staff Nurse III uses past experiences as a guide to action when diagnosing and monitoring patients. Yet the Staff Nurse III sees the patient as a whole, unique individual. Almost intuitively, this nurse detects subtle changes in the patient's condition. Whether the patient is not responding to a particular therapy, this nurse has an inquisitive need to search continually for the reasons. The Staff Nurse III, then, draws not only upon past experiences but also upon inquisitiveness, intuition and an organized use of the nursing process to anticipate problems and intervene before the patient's condition deteriorates.

EFFECTIVE MANAGEMENT OF RAPIDLY CHANGING SITUATIONS

- Skilled performance in extreme life-threatening emergencies: Rapid grasp of a problem.

- Contingency management: Rapid matching of demands and resources in emergency situations.
- Identifying and managing a patient crisis until physician assistance is available.

This nurse knows the scope of the Staff Nurse III level of responsibility and with this understanding, acts in the patient's best interest. The Staff Nurse III
s the whole picture and so is in control of the situation, able to create order out of chaos.

The Staff Nurse III relies on past experiences to identify clinical signs and symptoms that predict a possible life-threatening situation. Attempting to avert a crisis, this nurse quickly assesses the magnitude of a problem in order to identify and assign resources that the patient needs. The Staff Nurse III not only notifies appropriately people but also takes immediate action. This action includes continual reassessment to ensure that the demands of the situation are met.

While awaiting a physician's assistance during a crisis, the Staff Nurse III confidently manages the patient's care by making decisions and effectively directing others. Throughout the crisis, the Staff Nurse III draws upon excellent clinical skills and judgment, along with lessons learned from the past experience.

Able to provide leadership in a crisis, the Staff Nurse III transforms chaos into a manageable situation that has a greater likelihood of positive outcomes.

ADMINISTERING AND MONITORING THERAPEUTIC INTERVENTIONS AND REGIMES

- Starting and maintaining intravenous therapy with minimal risks and complications.
- Administering medications accurately and safely: Monitoring untoward effects, reactions, therapeutic responses, toxicity and incompatibilities.
- Combating the hazards of immobility: Preventing and intervening with skin breakdown, ambulating and exercising patients to maximize mobility and rehabilitation, preventing respiratory complications.
- Creating a wound management strategy that fosters healing, comfort and appropriate drainage.

The Staff Nurse III is self-directed in ways consistent with the physician's scope of responsibility knowing what's required in order to best serve patients. The nurse keeps abreast of new medications so as to identify potential errors before they occur. The Staff Nurse III is present when a physician makes rounds, initiates interventions to prevent and treat skin breakdown and wound care and calls upon other resource people as appropriate.

MONITORING AND ENSURING THE QUALITY OF HEALTH CARE PRACTICES

- Providing a back-up system to ensure safe medical and nursing care.
- Assessing the appropriateness of orders*.
- Getting appropriate and timely responses from physician.

To fully understand a patient's condition and situation, the Staff Nurse III draws upon an extensive knowledge base, past experience, information contained in the patient's chart, information gained from interactions with the family and most importantly, information the patient provides.

In addition to handling and monitoring the current situation, this nurse anticipates and plans for potential change in the patient's condition, adapting to the patient's needs as they arise.

As a self-directed professional, this nurse is confident and well prepared. The Staff Nurse III uses judgment to assess the appropriateness of physician's orders. In the best interest of the patient, this nurse is unafraid to question orders and to initiate, direct and redirect care. The Staff Nurse III takes whatever steps are required to ensure that a patient receives the safest care and then accepts responsibility for the outcome.

The Staff Nurse III commands the respect of colleagues on the medical staff. This nurse can expect physicians to respond in a timely manner, whether they are called upon to change or provide written orders, or to discuss possible changes in standing policies.

ORGANIZATION AND WORK-ROLE COMPETENCIES

- Coordinating, ordering and meeting multiple patients' needs and requests: Setting priorities.
- Building and maintaining a therapeutic team to provide optimum therapy.
- Coping with staff shortage and high turnover.
    - Contingency planning.
    - Anticipating and preventing periods of extreme work overload within a shift.
    - Gaining social support from other nurses.
    - Maintaining a caring attitude towards patients even in the absence of close and frequent contact.
    - Maintaining a flexible stance toward patients, technology and bureaucracy.

The Staff Nurse III is an experienced nurse who effectively organizes plans and coordinates the simultaneous needs and request of many patients. This nurse anticipates the future, develops a plan of what to accomplish for each patient during a shift, monitors each patient's progress and adjust individual plans to meet changing needs in the patient population. Committed to each patient's progress, this nurse creates order from chaos by making the right choices and by knowing when to reshuffle patient priorities in an environment where patient needs may fluctuate from moment-to-moment. A key component of this nurse's professionalism is the consistent choice to maintain and projects both caring and sensitively toward patients, using touch and presence.

An important and influential member of the therapeutic team, the Staff Nurse III possesses a positive attitude that is infectious. This nurse takes responsibility for the team itself by building and nurturing it. Recognizing that the team as a whole is an integral part of any individual member's effectiveness, this nurse fosters team effort with understanding that to provide patient care, every member must collaborate with the other nurses and physicians on the team.

The Staff Nurse III raises the level of practice by effectively using whatever resources exist and by functioning as a dependable expert readily available to other team members. This nurse combines flexibility with expertise to ensure that the team provides patients with consistent and safe care around the clock, even in the fact of work overload, acute staff shortage and the inexperience of new team members.

In this exemplar I used the following Benner's domains of nursing practice:

1. **The helping role**
2. **The teaching- Coaching function**
3. **The diagnostic and monitoring function**
4. **Effective management of rapidly changing situations**
5. **Monitoring and Ensuring the Quality Of health Care Practices**

Exemplar #1

In one evening I received a call on the Spanish line. In fact pt was speaking some English but I explained that for her comfort it will be better if we use a translator. She agreed. While I was waiting for an interpreter I was looking in CIPS to find some information about 49 years old, Mrs. C.. I noticed that there were no visits, meds and labs in her file and I concluded that she was new to Kaiser. With the help of a translator I found out that she lost her insurance about 6 yrs ago. She just got a new job and she has insurance now with Kaiser. She told me that she is calling because of the burning in the "mouth" of her stomach. With the translators' help I understood that she has epigastric pain. She had this burning on and off for years and she wants to have a prescription for it. When she had insurance she had one and it worked for her. She couldn't remember the name of it. After she lost her insurance she took Tums that helped for awhile but no more now. She could take up to 10 at once with no relief. I asked if she has other symptoms and she said no, just the burning.

A less experienced nurse will triage her under the Acid reflux/GERD protocol and in the absence of other symptoms she would give advice for home care. In our Purple Book the home treatment advice presents a list of food that should be avoided (we all know that Mexican food is mostly spicy) and explains in detail about meal timing and positioning when sleeping to avoid acid reflux. Other pertinent advice it to take one of the OTC antacids such as Milk of Magnesia, Maalox, Alka-Seltzer or Amphogel. There are a group of H2 blockers that block acid production in the stomach and they are also OTC: Pepcid AC (Famotidine), Cimetidine (Tagamet HB) Ranitidine (Zantag 75).

Based on her symptoms and her story (takes Tums with no help) an advice to try taking one the antacids first was appropriate. H2 blockers can be used if symptoms don't subside but they cannot be used more than 2 weeks. Omeprazole (Prilosec) can be prescribed by a doctor if symptoms don't subside. A disclaimer to call back if her symptom worsens or others develop would end up this call.

I know that all drugs included OTC have side effects (antacids can cause constipation or diarrhea, can elevate Ca levels in the blood leading to kidney failure or if taking in large amount there is risk of Ca loss leading to Osteoporosis). Antacids can interact with a number of drugs in the intestines by reducing their absorption. These drugs include some ATB, Propranolol, Captopril and H2 blockers.

I couldn't advise patients to take any of these drugs without having her past history. So I continued to ask more questions. I asked if the symptoms are related to meals, if she has them at night and how often.

She told me that for about a week she cannot sleep because the burning wakes her up. She feels hot and thirsty. She takes 4 or 5 Tums, drinks plenty of water and she goes to sleep. Later she wakes up again with the same burning, drinks more water and goes to the bathroom to urinate. She is not able to rest because of the burning and going to the bathroom. She doesn't know what else to do. I asked if any of her family members have diabetes. She said no. She got impatient about too many questions. She just called to have prescription.

I implored her to be patient and answer a few more questions. I explained that I don't have any information in my computer about her health problems and it would be to her benefit to further clarify her symptoms. She agreed. I asked her for how long she is having this pain today. She told me that after she had breakfast the burning started again. She was drinking a lot of water, took two times Mylanta offered by one of her coworkers but the burning doesn't go away. She needs medication ASAP.

I asked her if she has any other symptoms associated with that burning feeling. She noticed that since morning her L arm is achy but she was mopping floors all day long. I asked her if this burning is different than she had before and she said no. Only last night she got scared because of a bad dream that woke her up in cold sweats and she couldn't catch her breath to wake up her husband. By the time he was awake she was just fine. By now I knew that I have to ask questions. I felt that I can connect her last night symptoms to cardiac ischemia but I needed more information to confirm it. Because I showed interest in her symptoms and patience to listen to her story, Mrs. C. seemed more willing to talk.

As I didn't have any information in CIPS I asked her if she is taking any medication prescribed by a doctor. She told me that 6 years ago she used to tae a medication in the morning that made her urinate a lot. She stopped taking it after losing her insurance. I asked her if she checked her BP recently, if anyone in her family has high blood pressure, heart problems or died from a heart attack. She said no to all. Her parents live in Mexico and 2 yrs ago when she visited they were fine. I asked her about LMP and she told me that she doesn't have periods for more than 2 years. I asked how much she weighs and she said that she doesn't know but she is not so heavy. She is a janitor and does a lot of physical work. She mentioned that since the burning got worse she gets short of breath and she needs to stop and rest for few minutes. She did not drink or smoke.

I explained to Mrs. C. that her symptoms may be related to her heart. I told her not to be scared. It will be in her best interest to let me consult with one of my doctors to see what she/he wants us to do. I asked her if her husband can pick her up or she has someone to drive her just in case the doctor wants her to be evaluated immediately.

She didn't know but she will find someone. She agreed to stay on the line and told me to tell the doctor to give her that prescription so she can "get rid of the burning."

By now I knew that her heartburns were more than just that. The urgency in her voice, the last night "bad dream" that gave her cold sweats and shortness of breath, an achy arm since morning, all could be very well signs of cardiac ischemia. If I added the facts that she was menopausal and she stopped taking her BP medication 6 years ago I had enough facts to consult with CCMD.

The job of an advice nurse in a Call Center is similar to a detective job. When the patient is on the line you ask questions, clarify them, look at the history, search in CIPS for past visits, diagnosis, labs, medications, allergies, look for other resources available for that particular case. Then you put relevant pieces together and "solve the mystery." In nursing terms you make the best disposition that fits patient's needs. At the end of the call you may have an ER recommendation, and appointment, advice or other dispositions. Most important is to give a disclaimer. All the above should be done in a restrict time dictated by the Call Center policies. In this case my time was already over twenty five minutes.

The next hurdle was to convince CCMD to send Mrs. C. to ER for evaluation. I gather all my data and in my SBAR presentation I described her symptoms and I emphasized that women at her age and menopausal, can have atypical chest pain. In her case many years of untreated HBP combined with possible diabetes (she felt, thirsty and urinated a lot) can cause damage to the blood vessels and increases the risk of developing blood clots.

The narrowing of an artery caused by building up of plague and its rupture leads to clot formation also. A clot big enough to block the blood flow through a coronary artery can damage or destroy a part of the heath muscle. Chewing an ASA reduces the formation of blood clots thus maintaining the blood flow. It is vital to have patient evaluated as soon as possible.

CCMD agreed and last thing to do was to persuade Mrs. C. to go to ED. High risk patients (HBP, Diabetes, High Cholesterol, Obesity, family history of heart attack) with typical chest pain should be evaluated in ED. I know that I must tell patients that need to go to ED and in many occasions patients get in a state of denial, changing the description of their symptom and asking for an appointment. Sometimes conferencing with CCMD might change their mind or if denial continues a non-compliance disposition is given. In these occasions I am very frustrated because I know that in the end it will be a 911 call and not usually a happy ending.

Mrs. C. also thought that is not that serious she needs to go. I have to explain again in simple words why is so important to get to ED, why she needs to take an ASA immediately and what is going to happened if she does not get there on time. When she heard that she risks death she decided to go. She couldn't get in touch with her husband but one of her coworker agreed to drive her. Finally I felt relieved!

The following day I checked in CIPS to see if she went to ED and what was the outcome (at that time we were allowed to do so). I wasn't surprised to learn that she had an MI and BS of 435. I was delighted for making the right decision and happy for Mrs. C. that she got there just on time.

I am a confident and caring professional dedicated to obtain safe patient outcomes. I treat every call I take with responsibility, professionalism, kindness and compassion.

1. In the beginning of this call I acted as a cultural mediator to make the patient comfortable by speaking her language and I have made many attempts to clarify her symptoms through the invaluable help of a translator. By the middle of the call Mrs. C. was able to understand what my intentions are and by the end of the call she trusted me and she followed my advice. (**The helping role)**
2. I listened to her concerns and using my knowledge and experience I tried to establish a relationship between her acute symptoms and past health problems. I went further and asked other questions and her answers allowed me to anticipate problems. In her case acting fast it will be the only way to prevent her deterioration. **(The diagnostic and monitoring function)**
3. From my past nursing practice I recognized similarities with other atypical presentation of cardiac ischemia and I explained to Mrs. C. in terms she could easily understand the rationale of my interpretation. **(Teaching-coaching function)**
4. Once I identify that her symptoms are life threatening I took action consulting with CCMD and making the recommendation to have patient evaluated in Emergency Room. **(Effective Management of Rapidly Changing Situations)**
5. Before I put patient on hold I told her to chew a tablet of ASA and find someone to take her to ED. Fortunately she arrived there safely. **(Monitoring and Ensuring the Quality of Health Care Practices)**

The Following Benner's Domain will be addressed:

1. **The Helping Role**
2. **The Diagnostic and Monitoring Function**
3. **Monitoring and ensuring the Quality of Health Care Practices**

Exemplar #2

In the dermatology clinic, I have patients who come in regularly for their Narrow Band UVB (ultraviolet B wave) phototherapy treatments. Phototherapy, or light therapy, is exposure to specific wavelengths. Overactive immune cells of the skin are responsible for many skin diseases. UVB therapy decreases the immune cell response. Patients who require this type of therapy must come in for regular treatments two to three times each week in order to obtain improvements in their condition. I, therefore, have become very familiar with my patients, and have good rapport with them. Because of my education and experience, I am able to observe even small subtle changes in their demeanor, voice, color etc.

Mrs. S. had been a patient of mine for about six months. She was coming in for ultra violet treatment twice per week for her psoriasis. Mrs. S. was an elderly frail woman. Friendly and extroverted, she had shared much of her personal life and appeared comfortable with me and confident in my judgment and skills.

On this particular day, Mrs. S. arrived for her treatment looking pale. She appeared agitated and anxious. When I inquired as to her disposition on that day, she advised me that she felt “tired” and “out of sorts.” Upon further questioning, I discovered that she had been experiencing intermittent dizziness since she awoke that morning along with feeling “winded.” Upon further investigation, she advised me that she had been having episodes of dizziness for several weeks, but on that day the symptoms were worse.

I transferred Mrs. S. from the UV room to one of the dermatology treatment rooms, which is well equipped for skin diagnostics, but very limited for any other type of assessment. After making her comfortable, I took her vital signs, and further questioned her about her symptoms. Her pulse was irregular. She was unaware if this was a new symptom. I determined that it was and scheduled an urgent appointment for her with the on-call physician in the Medicine Department. I then called that physician to let her know my assessment and concerns. I explained my thoughts and concerns with Mrs. S. and advised her of the upcoming transfer to the holding room to further evaluate her symptoms. I reassured her that she would be in very capable hands and nothing was going to be done without an explanation and her consent.

I arranged transfer to the holding room for Mrs. S. and for the on call doctor to see the patient in that location. Monitoring, oxygen, and medications are all accessible in that area. I provided an RN to RN report to the holding room personnel and helped them settle Mrs. S., who appeared even more anxious than before. In an effort to calm her fears, I introduced Mrs. S. to the RN who would be taking over her care and also to the on-call physician. I offered to call a family member of a friend for her, and she requested that I call her daughter. After speaking with her daughter I assured Mrs. S. that her daughter was on her way into the clinic. I needed to return to the Dermatology Clinic and to my full schedule of patients, but reassured Mrs. S. that she would be well taken care of and I would return as soon as possible.

I returned to the holding room approximately 45 minutes later. I found that Mrs. S. had been diagnosed with new onset atrial fibrillation and was waiting for ambulance transport to another ED for further evaluation and treatment. She was being monitored, had an IV, and was receiving oxygen. Her daughter was sitting at her bedside. Mrs. S. appeared more relaxed, was smiling and thanked me for “looking out for her.”

I am a compassionate, competent, professional and am committed to my patients and their welfare. I trust my skills and instincts and am an advocate for my patients. Mrs. S. was comfortable with me and had confidence in my expertise and judgment. Because of my experience identifying clinical signs and symptoms, I was able to take the essentials steps to ensure my patient’s well-being.

The following Benner's Domains will be addressed:

1. **The Healing Role**
2. **The Teaching-Coaching Function**
3. **The Diagnostic and Monitoring Function**
4. **Administering and Monitoring Therapeutic Interventions and Regimes**
5. **Monitoring and Ensuring the Quality of Health Care Practices**

Exemplar #3

It was a typical day in the Emergency Department (ED). Everyone gathers in the break room for shift brief. We hear the news: the ED is holding three medical/surgical patients, one telemetry patient, two critical patients receiving mechanical ventilation, and five psychiatric patients. There were no admission beds in the hospital, at least until discharged have occurred. I knew it was going to be a busy day.

I received report, in room 7, Mr. F..-GI Bleed, will need blood. Room 5- Mr. H., blood alcohol in the 400's, holding until he can metabolizes to less than 200 then discharge planner. Room 6-Mrs. Jones. Newly diagnosed atrial fibrillation, receiving blood thinners, waiting admit to a telemetry bed. The last patient was Mr. Y.. This was Mr. Y.'s first visit to Kaiser, after the county sheriff's department found him chasing cars at 4am.

The more detailed report that I received on Mr. Y. included. He is a nonmember, and has never been to Kaiser. Not sure where he has been receiving his medical or psychiatric care. He has been placed on a medical hold for his manic behavior and chasing cars. His speech is rapid and unable to give us much of a medical history. The night shift nurse was unable to ascertain if Mr. Y. was intentionally attempting to hurt himself or not when he was chasing the cars. He was given one dose of PO Ativan that he took without incident. He has been sitting on the edge of the gurney since then. He is medically cleared and waiting for Psychiatric services to see him in the morning.

After receiving report I was able to visual see Mr. Y. from the nurse's station. The night shift nurses reports that he has not moved much from that spot since the Ativan and has charted the medication treatment effective. I made my rounds with my other patients, and noticed Mr. Y. has not moved since that last time I observed him.

I stopped at the doorway before entering Mr. Y.'s room for two reasons. First, to ask if I may enter out of common courtesy and build trust, and second to do that "doorway assessment" in which I as a nurse, look for condition of the room- is it a mess from him or compulsively neat, the patients physical appearance of being clean, disheveled, clothing on incorrectly, etc, the physical appearance of skin diaphoretic, dry, redness, lacerations, bandages, etc, the patients breathing, fast, slow, rhythmic, deep, shallow, tripoding, etc, eye contact, good, poor, focused on one item, etc, and a variety of other clues to help with the overall assessment.

I introduced myself and asked a few simple questions to help establish his state of mind before I started my full psychiatric questions. I noticed that Mr. Y. had poor eye contact and keep looking toward the corners either on the floor or towards the ceiling. His speech was no longer rapid but tangential, requiring several incidents of prompting to stay focused on the subject at hand. Mr. Y. still was unable (or unwilling) to give much more of a medical or psychiatric history at this time. He did deny thoughts of want to hurt himself or others. His overall appearance was clean, including his hair appeared washed and combed, and his nails short and clean. His morning vital signs were stable with heart rate in the low 60's. Thinking back about the report I had received about Mr. Y., what

precipitated his arrival to the ED, and my interaction with him during the morning assessment, I did not feel that Mr. Y. was bipolar (on a manic upswing) or had intended on deliberately hurting himself.

Before, working in the ED, I worked in locked psychiatric facilitates for several years. During this time I gained experience from people suffering at different severities of their mental illness. And Mr. Y. did not fit the typical manic presentation. I suspected that Mr. Y. was suffering from a thought disorder such as schizophrenia or schizoaffective disorder rather than a mood disorder such as bipolar.

During my assessment I observed the patient unable to stay focused and consistently looking at the corners leading me to speculate he was having hallucinations. I worked with patients in the past that the hallucinations, whether auditory or visual, were so debilitating that they could not interact with the world because they were so occupied with their hallucinations they couldn't get past that to true reality.

Though all of these diagnoses are an Axis I in the Diagnostic and Statistical Manuel of Mental Disorders, they are not treated the same. If you give a benzodiazepine such as Ativan, to a schizophrenic, you slowed the body, but not the mind. In a way, trapping the schizophrenic and preventing the patient from using their coping mechanisms in dealing with their symptoms.

I took my assessment and experience and make a case to the physician to discontinue the Ativan and allow me to give a psychotropic such as Haldol. The physician was reluctant in my suggestion but allowed the change in medication. The MD voiced a concern that if I was the front line person and I was wrong, I would be the person experiencing the manic patient first hand. Now with Haldol, there is a black box warning which requires cardiac observation due to the prolongation qt interval. This creates more work for the nurse (me), more observation from the team, and more of an inconvenience for the patient. I felt this was the best course of treatment for Mr. Y. and the right thing to do.

I did the right things and gave Mr. Y. the Haldol. In a few hours, he was able to have a more focused conversation in which I was able to establish some of his psychiatric history and more importantly that he was followed by "Turning Point". With Mr. Y.'s permission I contacted Turning Point and was able to get a more extensive history. He had missed a few appointments with his psychiatrist and the case worker feared Mr. Y. had not been taking his Risperidone (a psychotropic medication). I was able to pass this data on to ED physician and the Psychiatric services' LCSW who came to assess Mr. Y..

I could have done my morning assessment, made sure he was safe and fed, and left his treatment to that. No one would have questioned my care and maybe even said good job in keeping Mr. Y. comfortable by dosing him with Ativan. This may have been acceptable, but not the right thing to do. The right thing to do was to help Mr. Y. reach his highest level of functioning with the least amount of dependency as possible. The Ativan was not going to do that, just imprison him with his hallucinations.

Now Mr. Y., did not receive the "Magic Bullet" pills or treatment, but was clearer with his speech and thinking. This allowed him to be able to participate more in his care.

The following Benner's Domains will be addressed:

1. **The Helping Role**
2. **The Teaching-Coaching Function**
3. **The Diagnostic and Monitoring Function**

4. **Effective Management of Rapidly Changing Situations**
5. **Monitoring and Ensuring the Quality of Health Care Practices**

Exemplar #4

I received a call last May via the GYN line from a 27 yr women named J.. She was requesting advice or a message be sent to her doctor. She explained to me that she had just delivered a baby girl 3 days ago, and she had awakened in the middle of the night last night with a moderate to severe HA. She took 600mg of ibuprofen, fed her baby and tried to go back to sleep. She slept for an hour or so, the HA got better, but it did not go away completely. She states that she had some complications after delivery. She developed a severe HA and elevated BP and was put on IV Mag sulfate which alleviated her HA and brought down her BP. She was then switched over to PO Mag sulfate, observed for a day and then discharged the next day. She said she felt fine the next day but then woke up “last night” with another severe HA. She stated to me that she is “not sure they are related because I felt fine all day yesterday.” I asked her how she was feeling during the call and she said her HA was mild to moderate but she was able to function. She attributed it to lack of sleep and new mother anxiety, but wanted reassurance. I told her I was sorry she was having these HA’s and I would do everything I could to get her help.

I quickly looked through her history and CIPS and began to triage her through the Postpartum protocol. J. denied any chest pain, swelling, fever, dizziness or heavy bleeding. She denied that the HA got worse with sitting up or better with lying down. She denied having a severe HA now. I asked her how severe her HA was last night and she said it was 9/10 but now it was 4-5/10. I asked her if she had been drinking fluids and eating, she said she was drinking a lot and urinating normally and she just had eaten a sandwich prior to calling. J. had no other symptoms. I explained to her that being sleep deprived and overwhelmed are normal postpartum situations especially for a new mother, but being woken up with a severe HA is not. As I was continuing to assess and talk with J., her daughter started crying. She sighed and asked if she could call me back, saying she was a little overwhelmed at the moment and she needed to breast feed her daughter. I assured her these feelings are normal and valid, but she said I was concerned about her HA so I would wait for her to go get her daughter, and told her to take her time. She thanked me and put the phone down.

When she came back she thanked me again and expressed to me again how tired and overwhelmed she was. I reassured her that it was common for new moms to feel this way. I asked her if she had support, and she told me her sister in law was coming over soon. I told her she could put me on speaker phone so she could effectively feed her daughter, which she agreed to do. I asked her how her daughter was doing and if she was having any trouble breast feeding. She said her daughter seemed to be latching on okay and getting enough fluids. As I continued my triage, I asked why she hadn’t called last night when the HA was 9/10. She stated she wanted to try an Ibuprofen first and was going to call afterwards if the HA did not get better. She waited 30 mins and ended up falling back to sleep. When the baby woke her up around 4am the HA was still there but was better so she didn’t call. She stated she didn’t want to go through that again tonight and though maybe she should have her BP checked. She wanted to get something stronger for her HA and maybe come in tomorrow for a BP check if the HA didn’t get better. She asked if I could send a message to her provider or if I thought she needed an appointment. I told her I was concerned about her HA especially because of her complications after delivery. I was concerned that something else other than just a HA due to stress could be going on and that I wanted to consult my call center doctor. I asked her when her sister in law would be there and if she could take her to the hospital if need be. She said she really didn’t want to come in today but if we thought it was really necessary her sister-in law would be there in about 20 mins. She could take her in but she didn’t want to bring her daughter with her. I agreed with her that it was probably not a good idea. She told me she lives 10 minutes from the hospital. I asked her if she could please give me 3-5 minutes and I would be back after talking with the CCMD. She agreed. I talked to the CCMD and my SBART. I explained that these

were not emergent symptoms per protocol or even an appointment today, but with her complications after delivery and severe HA last night, I thought she could possibly be having a brain hemorrhage and she needed to be evaluated in the ER. The CCMD agreed with my evaluation and ED with a driver was the best outcome.

I came back to her and thanked her for the patience. I explained to her that we were concerned by her symptoms and we would like her sister in law to driver her to the ER. She became a little frightened and asked “What could be wrong?” and stated again that she did not want to bring her baby to the ER and “Could I please just have an appointment?” I told her that this could possibly be complications from her delivery. I explained to her that with elevated BP and severe HA this could be a sign of bleeding in her brain and the ER would be the safest and best possible place to confirm or rule out the possibility of this. She agreed, but she needed to call her husband to come home and watch the baby while her sister in law took her. I asked her how long that would be and she wasn’t sure if he could. I didn’t want to hang up with her without knowing if her husband was able to come home in case she just decided not to come in. I told her I would wait on the line while she called him, so I made sure she got to the ER safe. She thanked me for my concern and called him on her cell phone. He was able to come home right away and told me she would be at the ER within 1 hour. She thanked me for my patients and kindness. I gave her the appropriate disclaimer in case things worsened.

I felt that I made a difference in the outcome of the call for this patient. After assessing the patient and not really coming to a clear outcome I felt uncomfortable with giving her an appointment or a message. Though there wasn’t an emergent outcome based on her symptoms I felt I needed to consult with the CCMD. She just wanted a message and something stronger for her pain but I intuitively knew something more was going on her and I felt she needed more urgent care. I took the time to really listen to her history and her feelings. I took the time to wait for her while she breastfed her daughter and called her husband for child care. A less experienced nurse would have just sent a message since her symptoms did not warrant an emergent outcome or even an appointment. A less experienced nurse would have let her call back when she went to breastfeed. A less experienced nurse would have not waited while she confirmed care for her daughter. All of these or even one of these would have delayed her care which would have resulted in a very bad outcome.

Normally we do not see the outcomes of ER visits, but a few weeks after this call I received a letter from QA. The letter stated that my patient had been diagnosed with a subarachnoid hemorrhage and that the QA nurse wanted to thank me for my triage and comprehensive thinking. (see letter attached)

a) **The Helping Role:** I am a confident and caring professional who is dedicated to achieving positive patient outcomes. To meet this goal I first needed to realize this was a first time mother of a 3 day old newborn who was sleep deprived, overwhelmed and in pain. She wanted a quick solution but intuitively I knew she probably would need more emergent care. By integrating my experience, my computer skills and ability to provide a calming environment, I successfully gained her confidence and trust. I used calm, clear communication, while at the same time expertly navigating through CIPS, triaging her and listening to her history. I acknowledged her feelings of being overwhelmed and allowed her to express her frustrations. By taking the time to wait for her while she met her daughter’s needs, I demonstrated I was her advocate by meeting her needs. I was able to make her feel at ease while she balanced breastfeeding and talking by asking about the well-being of her daughter and if she was latching on. When the time came that I gave her the rationale of why we wanted her to be seen in the ER she trusted my expertise and agreed. I drew upon the patient’s husband as a resource to watch his daughter while her sister-in-law drover her to the ER. I was also able to

be a confident and caring advocate for her 3 day old daughter as well, as the best care for the baby would be a healthy mother.

b) **The Teaching-Coaching Function:** I was able to recognize that J. may have a more serious problem than she thought. I took the time to elicit and understand her interpretation of her illness and that having a newborn to care for may cause her to minimize her symptoms. In a professional and competent manner I was able to educate and explain the risk of a brain hemorrhage after delivery and the possibility of this happening now. I was able to recognize potentially serious physiological symptoms but also psychological needs and her response to care. J. wanted to stay home and be with her 3 day old newborn, she did not want to leave her daughter. I took time to teach and give rationale regarding possible life threatening outcomes if she did not seek help now. By also drawing on the help of her sister-in law and husband I was able to formulate a plan of care that she was comfortable with. She was able to trust me and agree to go to the ER.

c) **The Diagnostic and Monitoring Function:** I successfully triaged and assessed J. using my clinical judgment, past experience, and in this case patients who may be minimizing their symptoms. My inquisitiveness and intuition using the nursing process brought me to an emergent outcome that was not in the protocol. I anticipated that she would not want to leave her daughter. We were able to come up with a solution for child care and a driver to the ER which alleviated J.'s anxiety, ensuring her to seek treatment now. The CCMD agreed with my assessment and outcome of ER. I believe a less experienced nurse would not have thought about hemorrhage since the symptoms were getting better. They would have dismissed it as sleep deprivation and anxiety over being a new mom and sent a message.

d) **Effective Management of Rapidly Changing Situation:** I was able to rely on past experience with stroke/hemorrhage to identify clinical signs and symptoms that predict a possible life threatening situation. Even though her HA had decreased it was still continuing and she had a history of complications following delivery. I was able to keep the patient calm and earn her trust while explaining the rationale and need to go to the ER. I was able to initiate a plan for her husband to come home from work and stay with the newborn while her sister-in-law drove her in. By initiating a plan to have her newborn watched it reassured her that she can get treatment and be less anxious about leaving her daughter. I told her to tell her sister-in-law if the situation became unsafe to pull over and call 911.

e) **Monitoring and Ensuring the Quality of Health Care Practices:** OB-GYN is not my specialty, but I have taken approximately 7,000 calls over the last 8 years in this queue. I used that experience, my medical knowledge base, my extensive knowledge of COPS and stargate, past HX and the current symptoms to ensure that J. received the safest and timely care possible. I was able to actively listen to her anxieties, pain and frustration and reassure her throughout the call. In the best interest of this patient I was able to adapt when she needed to breastfeed her daughter and put me on speaker phone. I continued to use active listening skills throughout the rest of the call. I was self directed, confident and well prepared when calling the CCMD- I gave my SBART rationale for emergent outcome, which he agreed.

See attached letter from QA

Brenner's domain of nursing practices:

1. **The diagnostic and monitoring function**
2. **Administering and monitoring therapeutic interventions and regimes**

3. Monitoring and ensuring the quality of health care practices

Exemplar #5

It was six hours into my shift on a very busy Sunday. My assignment was a general float RN (someone who assists in helping the whole department). While working I heard someone yell for help and it sounded as if it were coming from A side. I rushed to A-side trauma room 1. There was a lot of activity noted in the room. I asked the clerk what was going on after hearing a cry for help. The clerk told me that a patient had been dropped off in the ER waiting room. The patient had been attacked with a hammer and shot in the face. I went into the trauma room to see if I could help in any way. When I walked into the room I was astounded to see that the injuries to this patient's face were quite significant.

The patient, Mr. L., was awake, alert, oriented yet slow to respond to questions that were being asked by the ED MD at bedside. I immediately noted multiple head depressions related to being hit by a hammer numerous times. In looking at Mr. L.'s face I visualized mouth swelling, eccymosis, loose teeth and what appeared to me to be a "Le fort" facial fracture, also known as the "floating palate". The upper and lower jaw was loose and appeared to be "floating". It also appeared to me that here were bilateral orbital fractures with depressed cheek bones. This is why I was amazed he was awake and attempting to speak.

Although I was initially impressed at Mr. L.'s ability to speak and remain awake. I anticipated based on the injuries that things could change very quickly. It wasn't long after entering the room that I noticed that this patients GLASGOWCOMA scale had deteriorated from 13 to 7 (a GLASGOW score less than 8 may indicate severe brain injury).

The ER MD prepared to intubate. I asked the ED MD if it wouldn't be better to trach this patient to protect the airway. The MD disagreed at this point and stated her plan was to use a fiber optic scope as she placed the ET tube. She said this might help stabilize the lower jaw. Accordingly, I began to assist in the intubation process and manual stabilization of the jaw. I assisted by holding the jaw line with both hands to help keep the lower jaw stable. The intubation began was successful without compromising the airway.

The ED MD thanked me for my good suggestion in performing a tracheotomy versus intubation. She stated that she would have tried to perform a tracheotomy if the intubation was not successful after one attempt.

In addition to the facial injuries, there was a large hole to Mr. L.'s right middle check area. There was a bullet entry, yet no exit wound. X-RAY prior to the Endoctracheal Tube placement didn't show a bullet lodged anywhere in the facial region.

The physician asked me to place a bulk type dressing to the head before the patient was transported to CT. The physician also asked another nurse in the room to place a Nasogastric Tube to decompress the stomach. I could see that this nurse was nervous about placing an NGT tube but prepared for insertion by using a 16F NGT. I was almost finished with the dressing when the nurse began to place the NGT in the right nare. I place my hands over the patient's nares. This nurse stood back and said "What's wrong?" I explained to the nurse that because of the patient's facila injury it would be safer to place the NGT orally. This nurse stepped back and stated, "I'm afraid to push his loose teeth down this throat or even worse make his fracture worse". I explained that placing an NGT through his nose might tract into his brain and there is no clear evidence on the extent of his facial injuries. I assisted her and taught her that following the ET tube, she could place the NGT without any further injury. The NGT was placed successfully after the first attempt. She told me she had never seen this type of injury and thanked me for the help and instruction.

Later the patient went to CT, returned and was transferred to a trauma center. It was found later that his patient survived and was recovering from his injuries.

I have over 20 years experience nurse including trauma nursing. My experience led me to become a Certified Emergency Nurse. I have continued to keep my trauma nursing core courses (TNCC). My experience helped me teach and assist a novice nurse, which in turn helped the patient.

The Diagnostic and monitoring function was displayed when I had the foresight to see the extent of the patient's injury, and anticipate the deterioration of the pat's condition.

I assisted in maintaining the pt's airway during and after the intubation. This helped to ensure the therapeutic required to help this patient.

Most importantly, I prevented a novice nurse from making a potential lethal injury to this patient, thus ensuring the quality of health care practices. I also gave a suggestion to the physician on alternatives methods of care displaying signs of confidence and experience while remaining a patient advocate throughout the process

The following Benner Domains will be addressed:

1. **Helping Role**
2. **Diagnostic and monitoring function**
3. **Administration and monitoring therapeutic interventions and regimes**
4. **Monitoring and ensuring quality of health care practices**

Exemplar #6

Time to leave for lunch had already passed and I was just getting ready to clock out when I hear a knock on the entrance floor from the waiting room. All of the ancillary staff had already left for lunch.

I went to check and see who could be there. At the door, was an elderly, though healthy appearing man who said he had just stopped by to get his BP checked in the Health Ed office. They had checked his BP which he was slightly elevated and per protocol, he was sent to the station. I noted that the BP obtained in Health Ed was slightly elevated, but not in the dangerous range. Once again, the thought crossed my mind to have him come back after lunch, but I had this vague uneasiness that t here was something deeper going on with his health. I escorted him to our injection room and had him take a seat. While we waited the 5" for resting BP, he talked about how he had been feeling pretty tired for at least a month and just didn't seem to have any energy.

The BP machine gave a 'malfunction error message' with the first attempt. In all my years of being a nurse, the usual reason for his malfunction error message is that the pulse is sometimes below 50; I attempted to get another reading. This time, I got a BP that was indeed elevated but the pulse was 30. I rechecked the pulse manually - it truly was 30—40 and the pt was slightly clammy.

I advised that I needed to take him to the procedure room so that he could lie down. I hooked him up to the cardiac monitor which showed an apparent 2nd or 3rd degree heart block. I alerted the only physician left on the station; who was eating his lunch he also happened to be a brand new MD as well as new to Kaiser. On my way back to the procedure room, I grabbed the EKG machine. The EKG verified that the patient was in complete heart block. I directed the physician to call the ED for the physician to physician report prior to transport by ambulance.

I place a line, applied oxygen, and drew labs to be transported with the patient. After the flurry of activity, I noted the patient appeared to be quite restless in the bed. He had gone from just stopping by Heath Ed for a 'routine blood pressure check' after getting his meds in pharmacy to laying in a procedure room awaiting transfer to the ED for a life threatening arrhythmia. Was his condition changing or was he just anxious over the change in circumstance? I rechecked his vital signs and all appeared to be stable.

I sat at his bedside, holding his hand. I made a simple explanation about the physiology of the heart and that most likely he would need to have a pacemaker inserted, knowing that knowledge is a powerful tool in allaying apprehension. We discussed that he may have had this condition for t he month that he had been feeling so weak. He did seem more relaxed, but I was becoming uneasy as he still was clammy.

By this time, the doctor who had been thrust into this situation, (because he hadn't left the clinic for lunch), returned to tell me that the ED physician had requested that he call the cardiologist on call who in turn requested that he make an appointment for the patient in a few days. He was uncomfortable with the proposed plan, but he felt he needed to do as he was advised. I found this plan of action totally unacceptable.

At this point, I felt that this patient needed an advocate. On one hand was a patient who was elderly pulse of 30-40, slightly clammy who had been officially seen by any in the clinic or worked up for this condition and on the other hand is a new physician whose being told that this patient can wait several days before getting definitive treatment by physicians who hadn't even seen the patient. I then aged the Team Lead physician. He had been at a meeting in the building. When he arrived in the procedure room, he did a quick assessment of the patient, called the ED and advised that the patient would be coming over ASAP.

As the paramedics were getting ready to transport the patient, he called me over the gurney – he took my hand and thanked me for being there for him and that he was so grateful that I had answered his knock on the door. I was glad that I didn't get off on time for lunch that day.

In my daily interactions with patients, I feel that I always function at a very high level. In this particular situation:

1. **Helping role:** I felt that I guided and gave emotional support to this patient through this much unexpected even in his life. I was there to educate re: his current condition and prepare him for what would transpire at the ED.

2. **Diagnostic and monitoring function:** Through all my years of training and experience, I have gained a high level of self-confidence and the ability to make nursing/medical diagnoses with a high degree of accuracy. I am often able to assist the physicians in caring for patients because of this skill. Since I function at this level on a daily basis, my opinions are well respected by all the physicians with whom I work. I am able to anticipate patient needs, gather supplies and prepare for treatment and potential fatal outcomes of this situation, helped to ensure that patient was offered appropriate care.

3. **Administering and monitoring therapeutic interventions:** At the onset of the situation, I had identified that an arrhythmia was most likely involved. Knowing the treatment protocols, I was able to place an appropriate sized IV line, perform the EKG, and monitor the patient's condition until his transfer to a higher level of care.

4. **Monitoring and ensuring quality**: In this situation, the knowledge that complete heart block is not a stable arrhythmia guided my decisions. I had been aware that prior to this incident,

the 'new' physicians had not been having positive interactions with the ED. In turn, this physician was reluctant to countermand what he was being advised by the ED staff. I took the steps to ensure that this patient would receive appropriate triage and treatment and in a timely fashion. As a later outcome, I also discussed with the assistance Chief of medicine the prior negative experiences that had been incurred by out new physicians. Corrective measures were taken.

The following Benner's Domains will be addressed:

1. **The Helping Role**
2. **Monitoring and Ensuring the Quality of Health Care Practices**
3. **Organization and Work-Play Competencies**

Exemplar #7

My patient was discharged from the hospital at 7 pm, forty minutes before I got the call from her family. Her history included Parkinson's disease, CKD, COPD, and HTN and elevated K.

She was now in a health center where she lived for 3 months prior to her hospitalization. The family was calling to ask that the patient be readmitted to the hospital immediately. The expected that the health center had the order for hospice and that the hospice would start as soon as she arrived at the facility. I talked to the supervisor of the facility and was told that there was a mention of hospice but no "order" for hospice. She also told me that the facility did not have the Morphine prn as ordered and that they would not be able to obtain any narcotic from the pharmacy until tomorrow

The patient had been hospitalized for confusion and the discharge diagnosis was Urinary Tract Infection. I opened the protocol Urinary Tract/Flank Pain – Female. The patient was awake, alert, oriented with warm and dry skin. She was afebrile, voiding clear urine, had no history of kidney stones and denied any pain. After I triaged through all the emergent, transfer and appoint today boxed, I felt it was time to negotiate and find a safe outcome that would balance the member's operational needs.

The family told me that the patient was unable to push a call button and barely drinks 16 ounces of fluid per day. They were upset and afraid that their mother would not get the pain medicine she may need and asked if one of the family members could spend the night in the patient's room to observe and assist her. They were told that it was against the facility's policy for family members to stay overnight.

1. The Helping Role

I am a Kaiser Hospice Volunteer who attended several weekly staff rounds and knew that if there had been an administrative error with the order not getting transcribed correctly before discharge, it could and would be fixed immediately the next day. I am aware that when a family member is dying there are complex family dynamics that require staff to pay close attention. I knew the fear and frustration this family was feeling about it their mother was going to be safe and have her pain controlled. To the family, this was a crisis and their most 'desperate' coping mechanisms were emphasized.

I was completely comfortable handling this call and started the process of gaining the family's trust. I understood the family's sense of urgency but also realized that most if not all of the problems could be fixed within fifteen hours. I have extensive knowledge from years of doing front line clinical

work and a sincere passion for my profession. I knew that before I could do anything, I needed to provide emotional and informational support to the family and then to include them in decision.

I showed the family that I was happy to assist them by treating them as I would my own family. They soon realized I understood their concerns and was there to help.

2. Monitoring and Ensuring the Quality of Health Care Practices

First I asked the operator to page the on-call hospice nurse to see if he/she had any awareness of this patient. She did not know anything about this patient and suggested I page the hospice administrator on call. The administrator did not know anything about this patient. I then consulted the CCMD and after discussing the case with him, we decided I should try speaking to the hospital based doctor, Dr. S. was consulted and when I told him about the case, H recognized the patient and told me that he had talked to the family a few days ago. He ordered Ativan 1 mg oral or sublingual every 4 hours as needed for shortness of breath. The facility did have Ativan available.

3. Organization and Work-Role Competencies

I built a therapeutic relationship with the facility charge nurse and advocated for the family. I gave her the order for the Ativan and again verified that t he patient was currently pain free. I am aware that the consequences of pain in the elderly can be depression, poor socialization, sleep disturbance and impaired ambulation. Analgesics including opiods, can be used safely and effectively in the elderly.

I then worked to integrate the family's beliefs and practices by understanding their desire to stay with the patient that night. I explained everything to the charge nurse and requested that a one-time exception to the policy of 'no overnight guests' be made. I asked that one family member be allowed to stay tonight and she agreed. I met the needs of the patient, the family, the charge nurse and Kaiser.

My actions were important because I was patient and persistent. I believed that moving the patient back to the hospital was not the safe and appropriate action. My actions differ from a less experienced nurse because I value the time and needs of the patient, family and doctor. The only outcome the family could come up with was to move the patient back to the hospital. I knew how to negotiate with my intuitive use of knowledge, I contributed mightily to this patients and Kaiser's best interest.

The following Benner's Domains will be addressed:

1. **The helping role**
2. **The teaching- Coaching function**
3. **The diagnostic and monitoring function**
4. **Effective management of rapidly changing situations**

Exemplar #8

T. was a seventy-five year old gentleman with metastatic sarcoma in his left chest wall, elected hospice in March of 2004. He was added to my caseload in June when his nurse retired. This was a gentleman with a very progressive cancer and had lost much of his independence over the past six months and was struggling with accepting the new limitations and the impending decline. My first visit was spent establishing trust and identifying his goals for care which were pain control,

decrease in shortness of breath and decreased anxiety. The next few week required much patience and flexibility on my part as his goals changed with each visit. It also became evident that the psychological impacts of these changes were adding to his feeling of anxiety, thus increasing his shortness of breath. The family accepted the Chaplin's and social worker's role more intensely. In the first week with this patient, it was apparent that his pain was growing at a rate the oral Methadone and Dilaudid could not control and his ability to swallow had begun to be compromised. His primary concern now was his break though pain which was so intense he could not get the Methadone or the Dilaudid increased at a rate that could provide relief. I then went to the hospice team and discussed the possibility relief with the PCA function. T. and his family agreed this was a logical step in providing relief and increasing the quality of his remaining days.

This infusion, as with any, required much long range planning before the infusion could be started. Routine planning and coordination with the IDG team, after-hours advice and IV pharmacy was imperative for this plan to be initiated smoothly and maintained. I also needed to teach the family how to operate this pump at a pace which would provide them with the knowledge they needed to become independent, without causing anxiety in a situation growing in intensity. My calm, reassuring approach and this family's readiness to learn, was an intricate part of being able to increase the complexity of his care and allow T. to remain at home.

T.'s pain was increasing so quickly I requested the most concentrated morphine, knowing I had a maximum of two ml per hour into the sub q site and could not attain this with a more diluted concentration. Ted was started on thirty mg/hr and was receiving tremendous relief. It was around this point in his care he started needing increased assistance with his ADL's so I assessed the need for a HHA and a referral was made. The team also encouraged his daughter to take a more active role in his care which she was willing to do. Around June 30th his morphine rate had increased to sixty mg/hr. It had become evident that the family was becoming overwhelmed with his care and the MSW worked with the family to get care giving for four to six hours per day. By the first week of July T.'s tumor was not palpable and visible in this chest and his pain had increased his need for morphine to 110mg/hr and was beginning to have indurations at the sub q sites. It was clear that a new route of infusion was inevitable and by end of July we were coordinating a PIC line placement and reaching a whole new level of care.

The simple task of scheduling a PIC line placement now became a serious nursing challenge. At this time, radiology had two doctors out on jury duty, the self care learning nurses were maxed out and T. was on a waiting list. After a week of hearing there was no way to get this patient scheduled, I took this case to the managers of the radiology and self care learning departments. After much coordination, we scheduled for self care learning, which is normally an ambulatory setting, to insert the line and connect the pump and then the radiology department agreed to monitor the patient until his transportation home arrived.

The following days required intensive teaching regarding cassette bags, medicating for agitation and adjusting to the increased acuity of his care. During the week T. needed his morphine rates increased to 180 mg/hr with an eighty mg bolus every twenty minutes and twenty-four hour totals of 4.350 mg morphine IV was needed for good pain control. By August, 6th T. required 230mg.hr to maintain comfort. On August 6th T. climbed out of his bed during the night and pulled out his line. His daughter found him, called hospice and was instructed to take the PIC line with her to the ER by ambulance transfer. Because the family brought the medication to the ED, the doctors could see the amount of pain made he was on from the pump settings and a peripheral IV was started. The daughter notified hospice at eight o'clock AM that T. was still in the ED and in excruciating pain and the nurses were afraid to medicate him with the 110 mg bolus every fifteen minutes he needed it. I immediately intervened by speaking with his nurse and educating her regarding the needs in this case. The nurse informed me the IV push was every thirty minutes and did not feel comfortable requesting more. I then called the hospice medical director on that day and

requested she call the ED doctor and coordinate the needed doses to get this patient comfortable. Knowing T. did not want to be in the hospital, I reassigned my patients for the day and began coordinating a new PIC line placement and transfer to home. I had the family bring in a new bag of morphine and talked the ED nurse through the programming of the CADD pump and instructed her to start the infusion via the peripheral line while we were waiting for the PIC placement. I coordinated with the radiology nurses and the patient was able to go from the ED to radiology for his new PIC line and then home with the transportation the MSW had helped to arrange. With much team effort and the cooperation of many departments Ted was home that evening.

By August 11th T. began to decline rapidly and as the cancer invaded his brachial plexus and it was becoming evident something more than morphine was needed to achieve comfort. The concept of palliative sedation was discussed with the core IDG. Using the second lumen the daughter volunteered to learn how to give IVP Phenobarbital in effort to respect her father's wishes to remain at home. The next two weeks of T.'s life were full of much loving intervention by our whole team and was able to pass peacefully on August 19th. This was a man who was truly loved and had a team of people dedicated to providing him comfort, dignity and honored his wish to die at home with his family.

This was a case requiring more time than most and yet proved to be one of the most rewarding. Example:

a) Helping Role
- Provide emotional and information support to patients families.
- Guiding a patient through emotional and developmental change: providing new options

There was much support and information given to facilitate and identify the goals of care for this family. My knowledge and expertise in the area of IV's and family dynamics, paved the way for a trusting relationship in the difficult situations encountered in the course of T.'s care. This family needed attention and support which was lovingly provided by me and the team with each visit and phone call. The sensitivity and counseling given aided this family to maintain a positive perspective and make informed decisions in this difficult time in their lives. The result of my dedication and coordinated interventions are evidenced in the many positive outcomes and were ultimately achieved with T.'s peaceful passing.

b) Teaching Coaching Function
- Assisting patient to integrate the implications of illness into their life style

The teaching needed for a family to manage this acuity at home is tremendous. It was a daily challenge to balance each visit. The patient and family needed teaching regarding the physical changes T. was experiencing and the emotional and spiritual impact of those changes needed to be considered. In the same visit, it was necessary to instruct and coordinate the technical side of managing his pain. The additional caregivers and team members that were brought in to assist with T.'s care were there to provide the family with the respite they needed to be wife and daughter rather than primary caregiver in the end.

c) The Diagnostic and Monitoring Function
- Anticipating problems: Future think

A great deal of my time in this case was spent anticipating problems and putting back up plans in place. This was very important in keeping stress level tolerable for the family and caregiver. I made sure I coordinated with pharmacy to ensure there was never a short supply of medication, arranged dressing changes during a routine weekly visit, communicated changes with after hours and weekend staff so crisis were managed and changes in condition were coordinated smoothly thus minimizing stress for the family.

d) Effective Management of Rapidly Changing Situations
- Contingency management: Rapid matching of demands and resources in emergency situations

T.'s admission to the ER was clear example of my ability to use resources and coordinate with the patient's goals as my guide

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The following Benner Domains will be addressed:

1. **The helping role**
2. **The teaching-coaching function**
3. **The diagnostic & ensuring the quality of health care practices**
4. **Monitoring & ensuring the quality of health care practices**
5. **Administering & Monitoring therapeutic interventions & regimens**

EXEMPLAR #9

Mr. R. is in his 70's and was admitted with diabetes and peripheral neuropath. He has a long history of PAD with severe lower extremity necrosis. His hospital stay will require diabetic control, restoring blood flow to bilateral lower extremities, wound care to necrotic diabetic ulcers and restoring proper nutrition.

The moment I met Mr. R. I had no idea of the impact I would have on his life and he mine.

As a Would Care Champion, my assessment of the dressings on his feet was a priority. Report did not prepare me for what I would see when I unwrapped his feet. I had to catch my breath and make sure that my face didn't reveal what my mind was thinking. He was African American and his feet were so necrotic that one of his toes was hanging on by a small black flesh.

I had a heavy assignment that day and soon realized that the complex wound care box on our grasp sheet would not begin to reflect the amount of nursing care that this man would require. I immediately instituted a plan of care for him.

And so our relationship began …. He was a quiet, giant of a man, months later I would realize that he when he stood up was 6'4" or taller. His gentleness did not go unnoticed. Lying on his back in our hospital bed he remained soft spoken and only spoke when he had something to say, there was no idle chatter with this patient.

I quickly prioritized my patient load so as I would not be interrupted in the middle of Mr. R.'s would care. I explained to him that I would gather some supplies and would return to begin his wound care and asked him at that time did he want me to pre-medicate him for the pain he might ensure during the procedure. He looked worried and replied, "I have no feeling in my feet". I touched his arm and said "Don't you worry, that is what I get paid to do". With large black eyes, he gave me a smile and nodded, I now understand that he knew how serious his condition was, because he himself was a Kaiser employee; but I wouldn't find that out for some time yet.

Mr. R.'s wife entered his room while I was proceeding with his wound care; she had a worried look on her face and asked me "How come that wound isn't bleeding?" I gave her emotional support and reassured her that our Vascular Surgeons were going to see him, while I mentally began implementing future care plans.

I notified HBS of there being no sign of bleeding and suggesting a vascular consult, made a referral to the Would Care RN for proper wound care orders and maybe some agents for debridement, and notified dietary of his need for proper nutritional supplements to aid in would healing.

Mrs. R. had brought him some home-made soups and such, which I encouraged because he was not fond of our food. Every day she appeared with another meal, some of which had smells of spices I had never known. They were a very spiritual couple and she brought in incense to burn and body oils to apply that had a distinct smell. She assured me that these meals and the oils increased his healing power. It was not for me to question their rituals. Recognizing their need for spiritual support, I made arrangements and facilitated the movement of several patients so he could have his privacy and experience his cultural/spiritual rituals without offending other patients.

Mr. R. ended up having his left foot amputated after he received a diagnosis of MRSA. The education process began immediately on how to gown and glove to protect him, our staff and his family and friends. I gathered all the information I could and verbally reinforced the importance of the isolation and the need for compliance. The questions and concerns were many and the information I reiterated time and time again, explaining the antibiotics, the troughs that would need to be drawn and what each of those meant. Caring for Mr. R. became tricky at times because he had six children from a previous marriage. Family dynamics became uncomfortable at times but taking care of my patient included his whole family.

My IV skills are excellent, but over the course of his admissions multiple IV sticks became more difficult. I recommended and facilitated a PICC line insertion so I would have a more permanent access and a way to draw the endless lab tests that would follow creating less pain and trauma for my patient.

Mr. R. had many surgeries on his bilateral extremities on many different admissions to facilitate blood flow and healing. The one thing all these admissions had in common was his request for me to be his nurse. Doing what I thought was the impossible he had opened up to me about many things. He confided in me that he had lost two of his children and how no parent should outlive their children …….. We both cried. At that point I really understood the saying that “there are two sides to nursing – the art and the heart”. We had developed a very special relationship, one built on mutual respect and trust during the course of these treatments. I became the point of care for this man’s treatments. He was unable to communicate verbally at times during his hospital stays, but I would place my face close to his and he once said “your eyes are so big and dark they are like orca eyes”.

Mr. R.’s healing was slow, dressing change after dressing change, antibiotics one right after the other. Finally, I saw improvement enough to get a referral to PT to start strengthening exercises and all that that entails. Then, I encouraged a referral to Psychiatry and notified them of Mr. R.’s altered body image, something he had confided in me but had also agreed that he needed help with. Social Services and Discharge Planners were no on my list to summon to start preparing for his departure to a rehab facility. I emphasized the need to find a rehab center close by so his wife could continue her daily visits and rituals, something he had grown to look forward to.

Mr. R. was eventually sent to a rehab facility to learn to use his prosthetic leg. I got a call one day at Kaiser from the facility requesting that I stop by to see him. It was the first time I ever saw Mr. R. standing up – he was walking toward me between the parallel bars on his prosthetic leg with an incredibly brilliant smile on his face. That man stood so tall in person and in spirit. Once again teas flowed, we both cried.

Mr. R. ended up with bilateral below the knee amputations. I came to see him one last time, the day he died. It was my day off and I got a call informing me of his eminent demise. Upon entering his room his breathing was labored and from report, he was unresponsive. Pressing real close to his face and whispering his name, he opened his eyes slowly, as I had seen him do so many times before. Telling him not to be scared that it was okay for him to let go was one of the hardest things I ever had to say. I explained to him that soon his pain would be over and he would once again have the ability to walk on both legs again. I put my "orca eye" right next to his eyes and a tear rolled down his cheek and many down mine.

Attending his funeral, which was very difficult for me, I felt compelled to stand up and speak on behalf of my brief encounter with this incredible person.

There isn't a day that I walk past room 417 that he doesn't come to my mind.

The following Benner Domains will be addressed:

1. **The helping role**
2. **The teaching-coaching function**
3. **The diagnostic & ensuring the quality of health care practices**
4. **Monitoring & ensuring the quality of health care practices**
5. **Administering & monitoring therapeutic interventions & regimens**

Exemplar #10

I can still remember the first time I set eyes on Mrs. B.'s chart……. I had to look twice at the age of this patient. How could a 62 year old woman have this complex medical history? Bilateral knee replacements, diabetes, sepsis, pancreatitis and so many surgeries that it was hard to count them all. I quickly had to focus on the current dilemma that she was experiencing.

Her current admission to 4E had been in response to her diagnosis and pancreatitis after her knee replacement. She had been discharged from 4W and after returning home for a brief period of time, returned with major abdominal pain. I got her post-operatively after surgery for the pancreatic abscess. That diagnosis did not prepare me for what would soon follow. Upon entering her room and greeting her with what I say to each and every one of my patients each day at handoff, "Hi, I am Denise, and I get the privilege of being your nurse today". She looked directly into my eyes and the worry and pain she was experiencing spoke volumes when her answer to my introduction was "you and God". It only took that statement and a short conversation that followed to realize that she was a very spiritual person and I would definitely need to include her beliefs in my plan of care. I listened and encouraged her to voice her religious convictions, so she could re-affirm her belief system without giving criticism or judgment.

As a recently post-op patient, I normally would have waited for surgery to remove the original dressing but I noticed her abdominal binder was saturated with serous fluid. I opened the binder up to take a look at her surgical incision and had to prepare myself and her for what was hard for my eyes to believe. She had six, yes six, drains coming out of her abdomen. There were drain sponges around the insertion sites and 4 x 4's wrapped around the actual drains for absorption. Removing all of the sterile gauze revealing her peri-skin already red and angry, just short of excoriation, I assessed immediately that the plan of care for her dressings would require more than simple sterile gauze. These drains were draining fluid and lots of it. I immediately paged the surgeon on call, notified HBS, who recommended I do what I could to protect the surrounding skin, made a referral for the Would Care RN and then got the would care/ostomy cart. While waiting for the Surgery to round, I

proceeded to design different ostomy bags to cover and protect the surrounding tissues and catch the toxic draining before it interfered with her skin integrity As a Would Care Champion, I used my training and expertise to design and implement would drainage collection devices. Some of them were bags that normally are used for urostomies that would allow me to turn the valve at the end of the bag to remove the drainage without actually having to change the whole device. I made a template of each of the six devices opening and drew a diagram of their respective locations so anyone needing to replace any of these devices would not have to start from scratch.

I looked into Mrs. B.'s face and saw the concern, and reminded her that God had brought her this far and that He would continued to guide her through this ordeal. I asked her I she wanted to say a prayer out loud and she at once started to verbalize her convictions to God. Being a witness to the comfort this brought her, I offered her the services of our hospital chaplain, and she was very joyful at the thought of a visit from him. Who knew how their relationship would unfold.

Surgery rounded on her the next day and was very impressed and verbalized to me what a great idea and how inventive it was that I had taken the time to "think outside the box". Mrs. B. mustered up some humor and replied "you mean outside the bag". It was wonderful to see her personality start to immerse. Her skin improved almost immediately but these drains were in place and would remain there for some time to come.

Mrs. B. had so many antibiotics and each day when her husband and family would arrive, I would take the time and patiently go over each category of medication and what each one did. I notified HBS that maybe we should start some probiotics before c-diff came a knocking on her door. She had plenty to deal with already she sure didn't need diarrhea.

Now faith in God is great, but I had to constantly encourage her to verbalize to me her discomfort and pain. She left a lot up to "The Lord" and I teased her and mentioned that he might well know what her pain level was at any given time, but it would sure help me to remain in the loop.

Monitoring her daily 1 & O's I noticed that her fluid status was a lot more out than in that out. Checking labs confirmed where my thought process was going, her albumin was very low and that would really delay her wound healing. Mrs. B. confided in me that she was having a hard time with the food; she would push it around a lot of the plate and not consume nearly enough of it. Nutrition being so important in her wound healing; I recognized that she needed tube feedings. I got a verbal order to place an NG tube and begin the feedings. I went through the process of hooking up the tube feedings; knowing all too well that her recovery would be slow and the probability of her going home on tube feedings was very real.

I was correct; Mrs. B. was discharged with the tube feedings. Although I had gone over and over the procedure many times with them, I wanted to make sure that they would feel secure at home with the process. I typed up the whole procedure in layman's terms with bullet points that were easy for them to follow, they were so appreciative.

Mrs. B would not remain home for long. Fevers began and she was readmitted, requesting 4E. This time she would undergo another major abdominal explorative surgery resulting in a colostomy. Her faith got her through the news, after her anesthesia wore off. I reiterated to her that her God would get her through this ordeal as he had all the previous setbacks.

I entered her room one day to see her in rigors; her abdomen was distended and very tender to the touch. I called for a Nursing Assistant to come in and help me with her vitals. Her vitals were 7-/32, Heart rate 142, Temperature 103.8 and her respiratory rate was so fast they were hard to count. Being a cardiac nurse, I immediately placed a heart monitor on her … she was in atrial fibrillation and I feared she was also becoming septic. I paged HBS, I gave a brief history of her past admissions

and how almost everyone of them had ended in some kind of exploratory abdominal surgery. Once again, she returned to surgery, resulting in a colostomy. A surgeon once put her medical condition and her risk for surgical complications into perspective in a phrase I will never forget. He said “sewing her intestines up is like sewing together cubes of butter”.

I at once began colostomy teaching. How to check the stoma, prepare the peri-skin and how to change the appliance. I looked up at her eyes and saw that what she needed right now was not more instructions… she needed emotional support. I gave her a big hug. I realized that sometimes the best thing you can say is nothing ….. just listen. Mrs. B. poured her heart and soul out to me that day and I listened to each and every worry and concern she shared.

Her wounds healed, her drains were removed, her colostomy was taken down and she sated daily that her prayers had been answered.

Mrs. B. finally was discharged to go home with her family. She returned two months later to invite me to her Church to witness what she called “Her Affirmation to God”. Little did I know that during this affirmation she would call me up to the altar and introduce me to her congregation as “The Angel that God had sent to her”.

Now … each Thursday, you can find Mrs. B. working side by side with our Chaplain, giving back the love and faith she states she received from our Kaiser.

The following Benner Domains will be addressed:

1. **The Helping Role**
2. **Monitoring and Ensuring the Quality of Health Care Practices**
3. **Organization and Work-Role Competencies**

Exemplar #11

Over the course of my nursing career, I have had the honor of caring for many patients, a few of whom become very specialize in their care needs. This was one such patient. He was a 43 year old male admitted for relapsed Acute Myelocitic Leukemia. He came to my unit for reinduction chemotherapy. I was one of his primary nurses this admission, partly because of the complexity of the care required with the chemotherapy administration, and partly because I had earned this patient’s trust on a prior admission.

After his second round of high dose chemotherapy, a bone marrow biopsy showed poor prognosis, the leukemia was not responding to the aggressive treatment we had started. The patient then decided that he wanted no more chemotherapy treatments/infusions, and we began many discussions of what was to come. I was able to discuss with him the process of dying, answering questions as he would process the information. I used my presence with this patient to guide him through some emotional changes.

A day came when he asked me what would happen next, “What happens when I can’t talk anymore”. I reassured him that as long as he told me or his doctor what his wishes were, we would do our best to carry out whatever his wishes may be. Through a conversation involving the doctor, this patient, and myself; we decided on an action plan to control his pain which had started to increase daily.

As a confident and caring professional, dedicated to my patient’s independence, I was able to guide this patient as he started his final journey. I was able to preserve this man’s sense of dignity

and personhood through my expertise and presence. A newer nurse would have been less effective in this role simply from discomfort with death, and the inexperience would leave this patient with a sense of loneliness and isolation.

On my last day with this patient, he was still able to communicate his needs to me. He told me, “I feel like I can’t catch my breath, and I’m hurting more than yesterday”. I suspected that the end was nearing, and sat with this patient to talk to him about his plan for the day. Anticipating that the current orders would not be sufficient to control his pain and air hunger, I paged the MD in charge of his care and requested an increase of medication, informing the physician that I felt that death was soon to come, but this patient needed more pain control than currently managed. Returning to the patient’s bedside, I noticed his anxiety level increasing along with his respiratory rate. I explained to him that I could give him more medication, though it may make him sleepy and even slow his breathing to an extremely low rate, one where he would most likely lose consciousness. He stated, “Please take away my pain, I’m ready to rest and stop fighting”. His family arrived at that time. Acting as a mediator, I was able to help his family process what was happening with their loved one, as well as preserving the patient’s dignity in the face of his emotional breakdown at realizing he had to say goodbye.

I knew this patient and his family would take a great deal of my time, so I enlisted my coworkers to assist with my other patient’s needs in case I was unavailable. I was able to re-adjust my priorities so that all of my patients knew I was still caring for them despite this period of work (and emotional) overload.

My teammates became an invaluable source of support for me as I processed my patient’s death and proceeded to care for the next patient. As a nurse, I think that our professional boundaries are important to preserve our sense of self, but sometimes patients touch our hearts, and their passing is felt more acutely. My newer, more inexperienced colleagues could not quite understand my reaction, as they were still trying to establish their boundaries. I was able to guide them to the conclusion that although every patient is special, I must still continue with my job because there are always patients that need my care.

I feel my patient’s care was positively impacted because I was able to give this man a “good death”, something a newer nurse would not have been able to do. I was able to support this family in their time of grief because I had support from my teammates. I intuitively knew when to be with this patient and his family and when to leave them alone. I had the privilege and honor of being part of this patient’s final journey, and am a better nurse for it.

The following Benner’s Domain will be addressed:

1. **The Helping Role**
2. **The Teaching – Coaching function**
3. **Effective Management of Rapidly Changing Situation**
4. **Organizational and Work Role competencies**

Exemplar #12

It promised to be a relatively straightforward day in OR Room 3. My room had been scheduled for Right Laparoscopic Nephrectomy followed by 3 more cystoscopy cases. I knew that it was going to be a long day but I love doing urology cases after all. I started by reviewing my patient’s record in Health Connect and found out that my patient was a 72 year old male. The medical record was not

unusual for the scheduled procedure. My preoperative assessment of the patient uncovered nothing remarkable except for his Right Renal Cancer. Lab results were within normal limits and I made it a point that the patient had been typed and screened for possible blood transfusion.

I started the preparation in my room. I checked all the instrumentations and surgical supplies with my surgical technologist. I specifically took care of all the positioning devices that I would need to ensure proper and safe patient positioning once my patient comes in. I was aware that lateral positioning opted the most possible injury to the patient if not properly taken care of. After all the trays had been opened, I started counting all the instruments with my surgical technologist. Knowing that my room was ready I went straight to the preoperative department to meet my patient and to receive a handoff.

I met Mr. Kinney, a real gentleman. He had such a positive attitude and I could say that he was indeed very pleasing. By his side stood his wife, a very sweet lady. After introducing myself to them, I began checking Mr. Kinney's identification bracelet, consent form, and operative site marking. I also asked questions pertaining to preoperative assessment. I had a nice conversation with Mr. Kinney and his wife, and I found out that they would be celebrating their 50th wedding anniversary 2 weeks after the surgery date. All of a sudden Mrs. Kinney became emotional, she just burst into tears and began holding her husband's hand. I acknowledged her fears of her husband's surgery and assured her that the whole surgical team would be doing their best to render a safe and successful surgery. Mrs. Kinney told me she was entrusting her husband to me. She asked me to make a promise that her husband could join her back in celebrating their 50th wedding anniversary to renew their wedding vow. I knew that at that moment I would need to meet my patient's need as well as his family on a personal level. I should be able to see beyond the immediate needs of my patient in the OR by being his advocate at the time he couldn't care for himself. My patient and his wife were both counting on me.

I asked my patient about any concerns that he might want to clarify with me. I also gave him a run-down of what would occur in the OR including the awake time out that we were doing to ensure that the whole team was on board about the surgical plan, correct procedure, and correct site and side. I gave him an idea of how he would be positioned during his surgery. I also told his wife that our surgeon would be looking for her right after the procedure and most likely she would be informed of the progress of surgery in case any delay occurred.

As I pushed the gurney towards the OR, I felt the anxiety that my patient and his wife shared. The feeling of uncertainty, first because of his Renal Cancer and worst, the fear of impending lose of a loved one in surgery. Again, I told Mr. Kinney that I would be with him in the operating room and that I would do my best to ensure that he would be kept safe all throughout the procedure.

The induction went smoothly. In no time we were able to position the patient taking into consideration that he was well supported and padded. The first few minutes of the surgery went smooth as the case was stable. As I was watching the monitor, I saw a squirt of blood. I knew that the surgeons were still dissecting the surrounding tissues of the renal vein and renal artery. I noticed that the mood of the surgeons changed; suddenly they were trying to establish homeostasis. Knowing that rapid blood loss could occur during kidney procedures, I prepared all my homeostasis agents. I had Floseal and Surgicele on board; both were effective means of helping to control bleeding. I also initiated type and cross matching to be certain that units of blood would be available for my patient since the order was just typed and screened. I immediately called the Central Processing Unit to ensure that I had the instrument trays that we would need in case we did the case open instead of laparoscopic.

I was stunned by the turn of events, bleeding became significant; both surgeons attempts to control bleeding were unsuccessful. As I checked the blood loss in the suction canister and observed

the vital signs monitor in the anesthesia screen, I knew that the anesthesiologist would need to monitor hemoglobin and hematocrit level at some point. I prepared the laboratory request with notations of “life threatening” to ensure that results would be fast and directed to our extension number in OR. Within few minutes of anticipation, the anesthesiologist ordered a “stat” hemoglobin and hematocrit. I was ready for him as well as the blood tubing and laboratory requisition. I also reminded the surgeon and anesthesiologist that units of blood were ready for our patient. Our anesthesiologist ordered two units of blood immediately as I anticipated. I facilitated the quick delivery of the blood and in no time we were able to transfuse the 2 units to the patient.

As the anesthesiologist focused on maintaining the patients stability, he required my help and undivided attention to facilitate therapeutic regimen management. With the kind of scenario I was facing I was fully aware that as the RN in the room, my nursing skills and critical judgment should prove exceptional to be able to attend to all the needs of my OR team. Multitasking is a quality that I possessed as an OR nurse. Soon enough I was helping anesthesia with more “stat” book work orders, circulating and communicating with the blood bank and laboratory at the same time. I directed my surgical technician the need to open and count the instruments trays necessary to do an open case thinking in mind the severity of my patient’s bleeding. As I heard the alarm in anesthesia cart. I knew that the patient’s vital signs were deteriorating. Impending shock was inevitable. Blood loss brings about disturbance in fluid and electrolyte imbalance that could rapidly alter cardiovascular, neurologic and neuromuscular functions. All my laboratory requisitions were ready in case anesthesia personnel needed it.

With all the efforts exerted by the whole team to stop bleeding, a decision to do the case open was made. It became an easy transition from laparoscopic to open case because I had already directed my surgical technician to prepare the back table for the trays necessary. Doing the case open made it easier for the surgeon to control bleeding which lead to stabilizing the patient’s condition. Finally there was a big relief felt by everybody in the room. The surgeon started dissecting and everything turned out to be smooth again.

It took at least 3 more hours to do the procedure. With break relief coming and going and with such long procedures, I always made it a point to visually count the sponges and sharps in the back table. I always felt at ease knowing that everything was accounted for. After coming back from my lunch break, the relief nurse and surgical assistant were in the process of counting the sponges and sharps. They announced that the counts were correct including the instrument counts. At that point the surgeon would be ready to begin closing the cavity. The count board showed 30 laparotomy sponges but the sponge counter showed 28 sponges. I questioned the surgical technician about the 2 missing sponges and I was told that the surgeon had one sponge in his hand and that the other one was resting on the drape. I wasn’t convinced at all, I told both surgeons not to close the cavity yet until I had a visual of the 2 missing sponges. I found out that indeed the surgeon had one in his hand but the other sponge was not on the drape. I started searching the floor and all areas of the drapes. I instructed both surgeons to look for it as well as the surgical tech.

I told them that unless I see it physically it was always a possibility that it was still inside the patient. I asked a second RN to look in the trash bag and she was unable to find it as well. Finally I urged the surgeons to go back and search for the sponge in the patient. To everyone’s astonishment the missing sponge was still inside the patient. It was soaked with blood that it could hardly be recognized as a foreign object. I was so thankful that I stood up firm to find the missing sponge. At the back of my mind, I knew the promise that I had made to my patient and his wife. Perioperative nurses have the responsibility for continual assessment of the complex interplay of ever changing variables that would affect the surgical outcomes. I know that all my patients deserve the best care that I can give them. I respect the promises that I make with each of them. With that promise I agree to make their experiences unique and safe. I continue doing the correct count and finally the skin count, but this time I was confident that I had done the correct count. By being sure that a patient

does not experience retained foreign object in the body, we were ensuring that the success of the surgery that would lead to fast recovery.

As I was changing my patient's gown to keep him warm and dry. The surgeon thanked me for being firm and confident. He expressed his appreciation for being on top of things. He even said that it could have been a wrong count if I didn't insist on finding the sponge. I told him that I was just speaking and acting on behalf of my patient. It was my job to ensure my patient's safety at all times.

I accompanied the patient to recovery room. I gave a detailed report to the recovery room nurse. Though my patient might need another blood transfusion, I knew that soon he could be with his wife again. After all I had kept my promise of being his advocate at the time that he couldn't take care of himself.

1. **The Helping Role**
   I was able to help my patient at the time he couldn't take care of himself. My critical thinking and years of experience being an OR nurse has made it possible for me to protect my patient from a sentinel event that would endanger his life because of retained foreign object in his body.

2. **Teaching/Coaching Function**
   I was very consistent in providing my patient and his wife the details of surgery to alleviate their doubts and worries. I was able to acknowledge the needs of my patient and his wife a personal level. Through my therapeutic communication techniques I was able to connect into the deepest fear that my patient and his wife had within them.

3. **Effective management of rapidly changing situation**
   I was able to anticipate every need that was required to run the operating room when the case experienced instability. The rapid change in the patient's condition under anesthesia was crucial. It took presence of mind and effective skills on my part to have a clear plan in promoting calmness amidst difficulties

4. **Organizational and Work Competencies**
   Being the experienced RN in the room, I was able to direct the entire team in doing their part to ensure that our patient was safe and all needs attended. I was able to promote calmness in spite of deteriorating patient condition. I was always a step ahead helping everyone in the team. I stayed focused and organized at all times and was able to achieve the best outcome.