We provide individualized patient and family-centered care based on shared decision making involving the entire interdisciplinary care team.

We do this by:

- Application of compassionate, respectful, evidence-based practice
- Fostering continuous improvement in quality and safety-oriented health care delivery.

We embrace our unique professional roles in guiding the care team to achieve these goals through:

- Critical thinking,
- Transformational leadership, and
- Professional development.
Professional Practice Model

S.H.I.N.E.
Salem Hospital is interdisciplinary and nursing excellence

Professional Practice Model

We provide individualized patient/family-centered care based on shared decision-making involving the entire Interdisciplinary Care Team.

Outcomes:
- Quality
- Safety
- Patient Experience
- Engagement
- Finance

Excellence
- Caring
- Integrity
- Accountability
- Teamwork

Empowerment
It’s a privilege and honor to share some of the remarkable achievements our nursing staff accomplished. Just a glimpse of our nursing team’s expertise, passion and dedication are showcased on the following pages. It gives me great pride to share some of our extraordinary highlights, the milestones met and exceeded, and how our daily work has an incredible impact in providing an exceptional experience every time.

Now, more than ever, the future of health care is defined by continual change. As one of the largest health care professional disciplines, nurses are challenged with the expectation to achieve optimal organizational and patient outcomes through their practice. Our nurses -- from bedside caregivers, specialty nurses, and nurse leaders – achieve remarkable empirical outcomes within our Magnet organization.

Nurses are key to providing equitable care, embracing cultural awareness and sensitivity, and managing individual patient interaction(s). Relationship-centered care requires collaboration from the entire multidisciplinary team, patient, and family/visitor(s) for the most effective coordination of care. The deliberate partnerships we’ve established, and nurtured with all members of the health care team is one extraordinary characteristic of our organization. Our Magnet status is owned by our entire organization as our relentless pursuit of clinical excellence and our Magnet redesignation recognition this past year has exemplified.

To achieve this coveted distinction takes steadfast commitment, enormous dedication, visionary leadership, empowered staff, remarkable empirical patient outcomes, tremendous teamwork, interdisciplinary collaboration, and innovation. I am proud of how hard you have worked on maintaining this prestigious credential and wholeheartedly congratulate the team on fulfilling this accomplishment.

It takes the determination of every member of the Salem Hospital team to achieve the goals we reached for over the past year. I want to personally thank each and every one of you for your fortitude, your continuing commitment to clinical excellence, and the remarkable perseverance you have shown. I couldn’t be more grateful to have all of you as colleagues and partners on the quest to transform our professional practice through leadership, empowerment, new knowledge, and the achievement of nursing excellence. As stated by our nursing pioneer Florence Nightingale, “Unless we are making progress in our nursing profession every year, every month, every week, take my word for it we are going back.”

Forging ahead,

Sarah Horn, MBA, BSN, RN, NE-BC, RNC-NIC
Chief Nursing Officer

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What a year we have had! Congratulations to all of you for achieving our second Magnet designation. Your commitment to clinical excellence is both inspirational and extraordinary. I would like to share with you some of the highlights of our excellence that SHINED bright during our redesignation process.

Transformational Leadership

**Clinical nurses have been offered an opportunity to “try on” leadership roles.** In the past two years, 15 clinical nurses from various settings assumed an interim position as an assistant nurse manager (ANM) or nurse manager. In addition to these interim posts, more than 25 clinical nurses received promotions to roles such as professional development specialist, ANM, clinical coordinator, patient safety consultant or house supervisor. Clinical nurses demonstrating an interest in leadership, or possessing skills that demonstrate leadership capacity, were also offered the opportunity to learn the charge nurse role. All of these examples highlight our commitment as an organization to mentoring and succession planning.

Structural Empowerment

**Specialty Practice Teams** are strongly integrated throughout the organization. Our unit-based councils encourage professional growth and serve as a venue for leadership development. Clinical staff involved in our shared decision-making structure get a broader view of their professional practice, serve as champions for unit projects and participate in leadership activities to develop their skill in exercising their voice and owning their practice. Frontline staff are provided with opportunities to lead organization level projects with coaching from organizational and nursing executives and mentors from other departments in the organization.

**Community outreach** was once again recognized as a phenomenal element of our interdisciplinary culture. Our clinical staff have continued to support community organizations like the Boys and Girls Club, and volunteer at the Salem Free Clinic and Liberty House. Nurses and other clinicians also made a debut at the Salem Saturday Market this year. Recruited through the unit SPTs, clinical staff have provided educational information on a variety of health topics, from stroke and diabetes to integrative therapies, not to mention checking blood pressures of more than 5,000 people in the community.
Exemplary Professional Practice

**Diabetes Care Collaborative** - The Salem Hospital Board of Trustees Community Benefit Committee identified Diabetes Prevention and Control as a health priority in Marion and Polk Counties. In November 2014, the Diabetes Care Collaborative of Marion and Polk Counties was formed. Comprised of 13 partnering agencies and more than 20 participants, the collaborative is chaired by Kristen Lorenz, Salem Hospital’s RN Diabetes Navigator. Kellee Borsberry, RN from West Salem Clinic (a federally funded Community Health Center) serves as co-chair. In its formative year the collaborative identified three priority areas: 1) ensure that individuals seeking health services are provided with quality diabetes care; 2) connect community members living with diabetes with self-management resources; and 3) improve the Built Environment to ensure that people in Marion and Polk counties have access to healthy food and a community that supports and encourages active lifestyles. Less than a year old, the collaborative has completed two of the three established goals and will continue to advance this work for our communities.

New Knowledge, Innovations and Improvement

Our commitment to continuous improvement through **Lean and evidence-based practice initiatives** was evident throughout the Magnet site visit. Appraisers commented on the remarkable level of support for staff to attend professional conferences and bring best practice information back to the organization for adoption. All these components demonstrate that a learning organization is alive and well at Salem Hospital.

Our Magnet redesignation is a tribute to you, your hard work, dedication, expertise and commitment to teamwork for the betterment of our patients and families in this community.

CONGRATULATIONS!

Margo A. Halm, PhD, RN, ACNS-BC, NEA-BC
Director Nursing Research, Professional Practice & Magnet
### Salem Hospital Leaders in Magnet Nursing and Interdisciplinary Clinical Excellence

#### Transformational Leadership
- Nursing Strategic Plan
- Centers of Excellence
- A3 Strategies
- ANM Academy
- CVCU Mentoring Program
- Succession planning for nurses at all levels

#### Structural Empowerment
- Daisy Awards
- Service Excellence Awards
- SHINE shared leadership structure
- 69 percent BSN+ workforce
- Professional development programs – PDIs, Certification review courses, AHA and trauma courses
- Simulation learning
- New Grad Residency Program
- Geriatric Resource Nurse Program
- Nurses Give Back community outreach
- Saturday Market community health education

#### Exemplary Professional Practice
- SHINE Professional Practice Model
- Patient-Family Centered Care
- Interprofessional teamwork
- Sepsis protocol
- Acuity based staffing
- Peer interviewing for recruitment/retention
- Integrative therapies
- Palliative care team
- Ethics consult team
- Flu campaign
- Safe patient handling
- Exceptional nurse sensitive outcomes (harmful falls, CAUTI, CLABSI, hospital acquired pressure ulcers, patient satisfaction)

#### New Knowledge, Innovations and Improvement
- Evidence-Based Practice Council
- Best practice adoption
- Evidence-based practice champions
- Nursing and interdisciplinary research projects
- Kaizen improvement projects
- Professional practice day presentations
- Presentations at external conferences – Specialty conferences, Oregon Nursing Research & Quality Consortium, Western Institute of Nursing

### Empirical Outcomes

*Our mission is to improve the health and well-being of the people and communities we serve.*
At the end of FY2014, 247 patients at Salem Hospital were harmed by a hospital acquired infection (HAI). To reduce the physical, psychosocial, and emotional impact of HAIs, Salem Hospital identified an opportunity to improve hand hygiene practices across the organization. In October 2014, hand hygiene compliance was at 82.5 percent, well below the organizational expectation. To decrease HAIs and improve hand hygiene across the system, hand hygiene became a strategic focus in 2015. We hypothesized if the organization improved hand hygiene compliance in all patient care areas to 92 percent, then HAIs would decrease by 50 percent.

Throughout 2015, hand hygiene compliance in all inpatient and outpatient areas was an organizational priority. The operating room became a strategic focus as this clinical area was identified as having the greatest opportunity for improvement. Inpatient areas focused on improving hand hygiene compliance for staff entering patient rooms who had been diagnosed with Clostridium difficile (C. diff). Outpatient areas focused on involving patients in the feedback process and continue to ask the patient if their care team performed hand hygiene during their visit. As a result of this focused work, Salem Hospital decreased HAIs by 17 percent and hand hygiene met the 92 percent goal consistently since January 2015.
HAND HYGIENE SCORECARD

<table>
<thead>
<tr>
<th>Organization</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>82.6</td>
<td>84.8</td>
<td>88.5</td>
<td>92.2</td>
<td>93.8</td>
<td>92.8%</td>
<td>94.1%</td>
<td>93.3%</td>
<td>93.4%</td>
<td>92.4%</td>
<td>92.4%</td>
</tr>
</tbody>
</table>
Sepsis Affinity

From Ann Alway, MS, RN, CNS, CNRN

Patients at Salem Hospital with severe sepsis or septic shock have longer length of stay (LOS) and higher readmission rates compared to national benchmarks. At Salem Hospital we set a goal to reduce LOS by one day for both severe sepsis and septic shock. In addition, the team set a goal to reduce readmissions for severe sepsis by 4.7 percent and for septic shock by 7.8 percent.

Countermeasures that were tested and their results include:

1. **Create and implement evidence-based clinical pathways that support the surviving sepsis campaign guidelines for severe sepsis and septic shock.**

   - **January 2015 - N=22 patients**
     In septic shock, the LOS benchmark was met with a reduction of one day.
   - **May 2015 – N=30 patients**
     In severe sepsis, the readmission benchmark was met with a reduction of 4.7 percent.
   - **August 2015 - N=60**
     In both groups, severe sepsis and septic shock, patients met and exceeded the benchmarks set for reduction in LOS and readmissions.

![Graph showing Septic Shock ALOS & Readmission Rate]
2. Develop evidence-based initial screening protocols for severe sepsis and septic shock in the Emergency Department (ED) and a Severe Sepsis Alert to mobilize rapid treatment.
   - Screening protocol is in place after two adjustments. Seventy-six percent of ED patients have been screened for sepsis, severe sepsis and septic shock.

3. Develop standard physician order sets for severe sepsis and septic shock.
   - Utilization is increasing over time.

4. Utilize an electronic modified early warning system (MEWS) for worsening patients
   - Hospitalists support the use of this tool to improve communication among team members. Next step is electronic implementation.
Spotlight on Specialty Practice Teams: Impact on Empirical Outcomes

Emergency/Trauma Services

Over the past two years the emergency department has seen a record high patient census with increased wait times, length of stay, and rate of patients left without being seen.

We hypothesized if we staffed a physician in triage to see lower acuity patients, ambulatory type 3’s, type 4’s, and type 5’s, during the peak hours then we would see improved emergency department throughput with shorter length of stay, shorter door to doctor time, and fewer patients left without being seen.

Our test of change (TOC) for provider at triage involved several one week trials with many variations that led to a 30-day trial during June of 2015. As a result of the 30-day TOC our door to doctor times, length of stay, and left without being seen rates all decreased while the census remained high. Due to the success of provider at triage, there has been approval for continued staffing allowances to keep provider at triage open every day from 1000-2200, staffed with a physician, nurses and techs. Here are the results:

![ED Overall Door-Doc Time (all patient acuities)](image-url)
Adult Health Division

3 West

A physician’s assistant identified that staff was not consistently documenting patient intake and output (I&O). Inaccuracies heighten risk of inappropriate discharges causing patient suffering or readmission.

3 West staff hypothesized if we set expectations for when to place collection devices, clear IV pumps and document oral intake then our outcome will be documented I&O >90 percent. Our test of change set expectations for placement of collection devices; set IV fluids, intake and output documentation timeframes coinciding with assessments; and provided an in-the-moment Epic monitoring screen to see I&O status.
4 South

From June to Nov. 2014, the Medical Telemetry unit experienced 24 patient falls, with 13 related to toileting (54 percent). The team identified there was a lack of adherence to the hourly rounding standard regarding offering the bathroom.

*We hypothesized that if purposeful hourly rounding was completed with a focus on toileting, then the outcome would be that patient falls related to toileting would be < 10 falls in a 6 month period related to toileting (a decrease of 20 percent).*

Our TOC utilized white boards to document that staff either offered to take the patient to the bathroom (O=Offered), the patient went to the bathroom (*=Potty) or the patient was sleeping (S=Sleep). Documentation occurred in accordance to hourly rounding standards. From Dec. 2014 to May 2015, the Medical Telemetry unit had two out of 15 falls (13 percent) related to toileting. Hourly rounding with the emphasis on meeting the patient's bathroom needs - accompanied by using in the moment visual aid - has been effective in reducing the amount of falls related to toileting on the Medical Telemetry unit.
5 South

As of September 2014, the Medical Unit was spending nearly $537 per units of service (UOS) for FY2014. This spending was $83 per UOS more than our allocated budget. We hypothesized that if we changed our staffing grid, we could reach our goal of spending only $454 per UOS for fiscal year 2015.

Our team performed a 90-day test of change that began January 6, 2015, with the following staffing ratios:

<table>
<thead>
<tr>
<th></th>
<th>DAY SHIFT</th>
<th>NIGHT SHIFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>1 RN to 5 patients</td>
<td>1 RN to 5 patients</td>
</tr>
<tr>
<td>CNA</td>
<td>1 CNA to 5 patients</td>
<td>1 CNA to 8 patients</td>
</tr>
</tbody>
</table>

After 90 days, our total expenses per unit were down to $454. As of August 2015, we were spending an average of $471 per UOS for FY2015 (savings of $66/UOS since January).

Besides financial benefits, we also improved our average activities of daily living completed each day. We went from 60 percent of our patients receiving baths in January to 90 percent in March. In addition, our oral care increased from 50 percent to 90 percent in March. Staff injuries have also decreased substantially over the past nine months. We had 18 workers’ compensation claims in FY2014 and have only had four such claims filed for FY2015. Our certified nursing assistants (CNAs) buddy up more for patient care and there are more staff on the unit to assist with boosts, mobility and responding to bed alarms.

6 South

The RN navigator discharge call team noted a trend in their discharge calls at the end of 2014. Patients were asking many questions related to topics such as bowel care, dressing changes/removal, and medication use. Press Ganey scores revealed a slow downward trend in the scores related to the question, “extent patient felt ready for discharge.” Through a 4SPS team, a multidisciplinary (OT, PT, nursing) discharge tool was made. This tool was placed in all patients rooms and discharge topics where reviewed each day with the patient. This tool had a section for RN teaching, patient teach back and another special section for the patient to sign that “they GOT IT” and they understood the teaching provided.

Another intervention was the updating of the Joint Replacement Center of Excellence (JRCOE) patient guide. A more detailed guide with thorough discharge instruction was made available to patients and the RNs were then teaching patients straight from their patient guide books.
Our RN navigator discharge call team has noticed a decrease in the need to review discharge instructions. Patients report feeling ready for discharge. Our work is never done when it comes to patients fully understanding their discharge instructions. Currently, our orthopedics team is working on group discharge instructions, implemented July 2015, with hopes to have a DVD for JRCOE discharge instruction also available to patients in the future.

### 6 North

Traditionally routine vital signs have been done every six hours at 0600 and 1200. Many patients on the unit receive scheduled cardiac medications at 0900 on one or both shifts every day, resulting in an extra set of vital signs being taken on each shift. To prevent the need for additional vital signs, SPT members discussed the issue and decided to change the time for routine vital signs from 0600 and 1200 to 0900 and 1500. This change in routine vital signs was trialed on the unit for 1 month.

Feedback from the trial was positive for both staff and patients. After the change, vital signs were obtained at the same time the nurse was completing his/her assessment. This change not only prevented extra vital sign checks for cardiac medications, but it also allowed the nurses to group their cares.

### Certified Nursing Assistants

CNA shortage on the nursing units has been an issue. After going through the 4SPS process the root cause was identified as CNAs being pulled from the staffing grid to be 1:1 sitters. The table below shows CNA shortage data.

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Shifts minus at least 1 CNA</th>
<th>Percent of Time Short</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/25/13 - 11/8/13</td>
<td>7/28</td>
<td>25%</td>
</tr>
<tr>
<td>12/20/13 - 1/3/14</td>
<td>21/28</td>
<td>75%</td>
</tr>
</tbody>
</table>

On average 50% of shifts were minus CNAs to provide patient care.
Through further investigation the team found there was no standard for 1:1 sitters. The team hypothesized if we create an algorithm for staff and charge RNs to evaluate the need for sitters and encourage the use of alternatives, 1:1 sitters will be reduced. Another form, the Patient Safety Checklist, was created for staff RNs to measure the effectiveness of alternative options to a sitter. Results of two tests of change are shown below.

<table>
<thead>
<tr>
<th></th>
<th>ICU</th>
<th>NTCU</th>
<th>4S</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOC #1</td>
<td>33%</td>
<td>25%</td>
<td>31%</td>
</tr>
<tr>
<td>TOC #2</td>
<td>44%</td>
<td>17%</td>
<td>22%</td>
</tr>
</tbody>
</table>

**Critical Care Division**

**Intermediate Care Unit (IMCU)**

On any given day, less than 10 percent of heart failure (HF) patients had a standing weight documented. Most heart failure patients were weighed using a bed scale which is not as accurate as a standing scale.

In our new workflow, the Charge RN identifies heart failure patients using charge report papers. The Charge RN communicates to CNAs which patients need to have standing weight, then calls the CNAs at 6 a.m. to verify standing weight has been completed and tracked.

Prior to the intervention, <10 percent of HF patients had a standing weight documented. One month post-intervention, a compliance level of 83 percent was achieved. Within five months of the intervention, 100 percent compliance was achieved. IMCU has sustained >97 percent compliance with standing weight for six months.

Images: Nurse doing standing weight with patient and Charge nurse going through change report papers (Pick best photo for use here.)

**Intensive Care Unit**

Per the American Association of Critical Care Nurses, it is best practice to check the depth of gastric tubes every six hours to confirm the tube has remained at the initial depth of insertion at time of placement as confirmed via X-ray.
As of Feb. 1, 2015, per charting and after initial X-ray, staff verified gastric tube placement by aspiration/auscultation. We proposed adding an option under “Tube Placement Verification Method” to include “Tube depth insertion at ____” to allow staff to document depth in the comment section.

With the May 2015 Epic enhancements, a line for charting/tracking nasogastric and orogastric tube depth was added. This provided an easy way to track the depth of insertion of the enteral lines/drains/airways (LDAs). The new flowsheet row also allows nurses to quickly document the current depth of insertion leading to appropriate action if this value has changed.

![Percentage of Documentation for Initial Insertion Feeding Tube Depth](chart)

**Neurotrauma Care Unit (NTCU)**

Hospital acquired C-difficile (diff) is a preventable infection in the hospital setting. NTCU cared for eight patients with hospital acquired C-diff in 2014. Proper hand hygiene is the most effective way to prevent the spread of C-diff infections in the hospital. NTCU recognized this as a preventable condition and problem solved how to reduce it. The staff participating in problem solving came to the conclusion there was not a specific standard for performing hand hygiene when exiting an affected patient’s room when staffs’ hands are full. The team developed, and now follows, a specific standard that covers what to do with dirty items after exiting an infectious room.

Since implementing the new standard work, NTCU has decreased the hospital-acquired c-diff infections to only two in calendar year 2015.
Women’s and Children’s Division

Mother/Baby Unit (MBU)

The increase in certified unit assistant (CUA) turnover on our unit was a source of dissatisfaction among CUAs. A survey was developed and sent to all CUAs. Survey results showed the following:

- Level of teamwork between staff on MBU before any problem solving was 2.7 on a scale from 1-5 (1 is very poor, 5 is satisfactory).
- Level of support for the CUA role on MBU before any problem solving was 2.4 on a scale from 1-5 (1 is very poor, 5 is satisfactory).

The four-step problem solving resulted in a root cause of a lack of a standard related to a plan for the day that was not consistently created or discussed at beginning of shift huddles. We hypothesized that if we reviewed the plan for the day in huddle for CUAs (tasks for the day, priorities, if we are short-staffed, etc.), the feeling of teamwork/respect for CUAs would increase. We created a test-of-change where the charge nurse visually placed a red or green flag up on the huddle board to indicate if we were staffed appropriately or not (red flag is short staffed, green is staffed per grid). If we were short a CUA on that day, we asked RNs to do their own vitals to help reduce the workload for the CUA on that day. After the test-of-change, we re-surveyed CUAs and found an increase in satisfaction. Level of teamwork was rated 3.5, and level of support for CUAs was rated 3.6 as shown in the graph below.
Surgical Services Division

Operating Room

Hand hygiene has been established as a leading method to decrease health care-associated infections, and remains one of the most important measures in health care personnel safety. The operating room (OR) is a complex environment. Because of the many disciplines and staff required to ensure each surgical case is prepared and equipped for and completed efficiently, improving OR personnel hand hygiene compliance demanded multiple strategies. Our unit’s overall hand hygiene compliance in October 2014 was at 26.9 percent.

The OR SPT chair is a member of the OR Hand Hygiene sub-committee which focused on specific barriers/challenges and engagement issues related to compliance within the OR. OR action plan responsibilities taken to SPT included:

- Participation of SPT members in hand hygiene audits
- Heightened peer accountability
- Encouraged verbalizing “foaming in” and “foaming out” whenever entering or exiting the OR
- Performed self-audits to identify further barriers
- Identified “missed opportunities” and causes

Improving the overall hand hygiene compliance within the OR has been a multidisciplinary endeavor. Because of this effort, our overall hand hygiene compliance has improved to 93.3 percent as of September 2015.
PACU

Surgical Services leadership proposed discontinuing hospital laundered scrubs for PACU staff and moving to wearing personal scrubs, a practice that is aligned with the other nursing areas of the hospital. While there were several concerns voiced related to infection prevention, work flow and the sense of “teamwork” within Surgical Services, the SPT members agreed that their first step should be to seek out the literature and independently evaluate the evidence.

The SPT reviewed the ASPAN standards and practices, as well as examined operational workflow with a particular focus on the day-to-day operational interface with the operating room (OR). SPT members called nine similarly sized hospitals to ask about practices within their organization, and examined the potential impact this change could have on staff morale, teamwork, and feelings of alignment with the rest of OR. Due to concerns related to work flow, the SPT used the Lean mental model as evidenced by collecting data on how frequently staff in the PACU entered the restricted areas of the OR and for what reasons.

As a result of these investigations, the SPT recommended not moving forward with wearing personal scrubs. The SPT requested that if leadership wished to move forward, a test of change be implemented to assess the ability of the OR to appropriately place patients in beds before coming to PACU. Per the team’s recommendation, leadership did not feel it was necessary to move forward with this proposed change.
Float Pool

The Provider Orders policy was being interpreted differently on units throughout Salem Hospital. Some units understood the policy to say that multiple incremental doses of as needed medication were not to be given, even if the maximum dose in the range wasn’t being administered during the ordered amount of time.

Example: Order = 5-10mg oxycodone PO Q4H prn pain

- 5mg oxycodone given at 0800, patient reports inadequate pain relief at 1000, so second 5mg dose administered per MAR at 1000.
- Per policy when can the next 5mg dose be given? 1200 or 1400?
- Some RNs believed 1200, others 1400. The policy was unclear about multiple incremental doses.

It’s key that range orders direct each nurse - regardless of educational level, experience, or workload - to intervene in an identical manner.

A recommendation was made to Joe Schnabel, director of pharmacy, to revise the policy with a clarifying statement developed by the Float Pool SPT regarding multiple incremental doses. The March P&T committee approved the revision and the updated policy was posted to the Intranet in May 2015. The revised section in the Provider Orders policy now states:

- For subsequent dosing, the dosing interval is based on when the final incremental dose was administered, i.e., for q4hr, if the first dose was given at 0800 and the next increment at 1000, the next full dose would be at 1400. If adequate pain relief is not maintained throughout the dosing interval, the nurse should contact the provider for a modified order.

Care Management

Care Management had no standard communication for situation/background/assessment/recommendation (SBAR) handoff between care managers when patients were transferred between units in the hospital. The Joint Commission requires SBAR standard work, as well as SBAR between units to ensure care coordination among care managers.

In response to this need, our team created an audit tool. The tool pulls the MRN/CSN of all patients that transferred units while hospitalized. Standard work was also developed so that when a patient transfers between units, the care manager on the transferring unit emails the SBAR report to the receiving unit. The care manager sending the SBAR is expected to document a progress note in EPIC stating the SBAR has been sent. When the receiving unit reviews the SBAR, the receiving care manager then documents a progress note it has been received.

Our initial audit revealed 23 percent of transferred patients had a progress note indicating SBAR report had been emailed to the new unit care manager/team. The Care Management SPT set a goal of 85 percent compliance and is currently at 73 percent compliance of documenting when a SBAR has been emailed “sent or received.”
We are continuing our audit process and staff education on the importance of SBAR between units when a patient transfers during hospitalization as a Joint Commission requirement and patient safety strategy. Better communication among staff members during inpatient hospital unit transfers facilitates greater care coordination, patient outcomes and patient experience.

Neuromuscular Service Line

Inpatient Rehabilitation

Falls among patients in the inpatient rehabilitation (IP Rehab) unit are an ongoing problem. Fall assessment tools, such as the Morse Fall Scale, Hendrich II Fall Risk Model and the John Hopkins Fall Risk Assessment Tool were all developed and validated for medical/surgical populations and have not proven effective in identifying or stratifying patients at risk for falls in rehabilitation settings. Additionally, many of the interventions recommended for the medical/surgical population may not address the needs of the rehabilitation population.

While falls had decreased below Magnet Designation benchmark rates during the fall of 2013 and winter of 2014, patient falls continued that we identified as preventable. Our SPT utilized a four-step problem solving approach to address concerns. The goal identified was to decrease falls in the inpatient rehabilitation unit to < 1 fall/month on a rolling 12 month average.
The team solved the problem by developing a unique fall risk assessment tool that assigns a High-Medium-Low risk fall category to a patient based on their FIM (Functional Independence Measure) score. This assessment approach was supported by several recent studies published in the *Association of Rehabilitation Nursing Journal*, as well as presentations at the 2014 ARN annual conference which pointed to some success in fall reduction utilizing FIM scoring to stratify safety approaches.

The fall risk assessment tool was initiated on Oct. 13, 2014. Compliance with hourly rounding and adherence to the suggested interventions at each level was tracked on a daily basis, with the goal of 99 percent compliance with rounding to test the efficacy of our innovative tool. We noted that it took about six to eight weeks for staff to be comfortable and confident with the new assessment tool and utilizing it on a consistent basis. As that consistency improved, we noted that our fall rates were declining as desired. The IP Rehab fall rates goal of < 1 fall/month on a rolling 12 month average was achieved and so far maintained.

![Falls in Inpatient Rehabilitation Chart](image-url)
Nursing Demographics

Overall Number of Registered Nurses: 1574 RNs

Registered Nurses by degree:

- Associate’s degree  – 425
- Bachelor’s degree - 1010
- Diploma - 38
- Master’s degree - 97
- Doctoral degree - 4

Advanced Practice Nurses

- Clinical Nurse Specialists – 6
- Nurse Practitioners – 23
- Certified Nurse Midwives – 6

Age Group

- Age <= 30: 25%
- Age 31-44: 38%
- Age 45-59: 26%
- Age > = 60: 11%

Gender

- Female: 87%
- Male: 13%

Ethnicity

- Caucasian: 90%
- Asian: 3%
- African Am: 0.4%
- Hispanic/Latino: 3%
- Native Am: 1%

Work Status

- Full Time: 68%
- Part Time: 16%
- Benefits: 1%
- Unscheduled: 7%
- Leave: 8%

Tenure

- <=1 YOS: 13%
- 1 to 3 YOS: 25%
- 3 to 5 YOS: 9%
- 5 to 10 YOS: 22%
- 10 to 20 YOS: 18%
- >=20 YOS: 13%

Retirement Age

- Under 55: 80%
- Ready Now (66 & over): 2%
- Ready Early (55 to 65): 18%
Certifications from specialty nursing organizations – 549

- Bariatrics – 5
- Cardiovascular – 3
- Case Manager – 12
- Critical Care – 82
- CNS – 1
- Diabetes – 3
- Emergency – 59
- Gastroenterology – 3
- Gerontology – 2
- Infection Control – 1
- Infusion – 13
- Midwife – 6
- Med/Surg – 71
- Neuroscience – 15
- Nurse Executive – 27
- Nurse Practitioner – 14
- Nurse Leader – 2
- OB – 77
- Oncology – 26
- Orthopedics – 15
- Palliative Care – 3
- Pediatrics – 7
- Perioperative – 55
- Psych – 12
- Radiology – 4
- Rehab – 4
- Stepdown – 17
- Wound – 10

College Scholarships Supported by the Salem Hospital Foundation

- 6 ADN - $9,050
- 17 RN to BSN - $34,150
- 9 MSN, DNP, FNP - $19,600
- 5 MHA, MPA - $11,250
- 1 MD - $3,000
- 2 Pharmacy - $4,250
- 5 Other - $9,550
Celebrations

Awards

National Awards

• Diane Branson, RN, CEN (ED) – BCEN Distinguished CEN Award winner, Board of Certification for Emergency Nursing
• Kelly Owen, RN, CEN (ED) – Media Award, Emergency Nurses Association
• Michael Polacek, MSN, RN(Clinical Education) – National Award for Excellence in Psychiatric Practice, American Psychiatric Nurses Association

Daisy Award Recipients

• Heidi Classen, RN – Pediatrics
• Brooke Kamm, RN – IMCU
• Catherine King, RN – Infusion & Wound
• Taylor Lovell, RN – IMCU
• Kim Mullins – NTCU
• Melissa Ngaida, RN – L&D
• Zoe Rain, RN – IMCU

Service Excellence Award Recipients

• Kelly Anderson, RN, CCRN – ICU
• Anja Brahmer, RN, BSN – IMCU
• Diane Branson, RN – ED
• JoAnn Bucher, RN – Med/Surg Oncology
• Brenda Burnett, RN – General Surgery
• Thatcher Ferris, RN – CVCU
• Janice Harless, RN, BSN – IMCU
• Nathan Holan, RN -- ED
• Kristin Jordan, RN, BSN, MPH -- CHEC
• Danyelle Landry, RN – ICU
• Andrea Limont, RN – General Surgery
• Leila Lopes, RN, BSN – Radiation Oncology
• Stephen Morris, RN – ED
• Veronica Nunez, RN, BSN – General Surgery
• Sandra Robinson, RN – ED
• Beverly Schmidgall, RN – Infusion & Wound Care
• Denice Scotland, RN, BSN – ED
Schlifka Smith, RN – Med/Surg Oncology
Katie Traeger, RN – Med/Surg Oncology
Heather Yancey, RN – IMCU

Trillium Award Recipients

• Bryce Combs, CNA —5 North
• Matt Salinas-Hernandez, CNA —5 North
• Ryan Kessler, CNA —5 South
• Martha Ramirez, CNA —5 South

Hospital-wide Awards

• 100 Great Community Hospitals, Becker’s Hospital Review
• Magnet Re-designation, American Nurses Credentialing Center

• Medical Excellence Award for overall medical care, CareChex Hospital Quality Ratings
• HealthStrong Top 100 Hospitals, iVantage
• Leading Participant Award, Oregon Patient Safety Commission
• Best Hospitals, #5 in Oregon, US News & World Report
• Consumer’s Choice-Best Hospital in Salem, National Research Corporation
• Top Oregon Hospitals 2013 (awarded Nov 2014), Portland Business Journal

Critical Care Awards

• Beacon Award Silver level for CVCU
• Beacon Award Silver level for IMCU
• Beacon Award Silver level for ICU
• LifeSaver Award, Pacific Northwest Transplant Bank – ICU
Cardiovascular Awards
• 50 Top Cardiovascular Hospitals 2015, Truven Health Analytics

Gastrointestinal Awards
• High performing in Gastroenterology, Surgery, and Pulmonology, US News & World Report

Psychiatry Awards
• National model for psychiatric care for reducing the use of seclusion and restraints in psychiatric care, Substance Abuse and Mental Health Services Administration

Orthopedic Awards
• #1 in state for medical excellence in orthopedic surgery and joint replacement, CareChex Hospital Quality Ratings
• 125 Hospitals with Great Orthopedic Programs, Becker’s Hospital Review

Breast Center Awards
• Women’s Choice Award-American’s Best Breast Centers, Women Certified

Women and Children Services Awards
• Best Place to Have a Baby, Statesman Journal online reader poll
• Best practice for lowest percentage of cesarean sections and highest percentage of vaginal births, American College of Nurse-Midwives
• Women’s Choice Award-America’s Best Hospitals for Obstetrics
Educational Advancement

• Sarah Acosta, BSN, RN (ED) – BSN, Western Governors University
• Skyler Anderson, BSN, RN (ED) – BSN, Linfield College
• Ellie Barnhart, MSN, RN, PCCN (IMCU) – MSN, Eastern Mennonite University
• Jennifer Broadus, BSN, RN, CNOR (WVH Administration) – BSN, Western Governors University
• Iuri Cernev, MSN/FNP, RN (WHP) – MSN/FNP, University of South Alabama
• Tori Child, BSN, RN, CCRN (Care Management) – BSN
• Tricia Cole, BSN, RN, CMCM (Medical Staff) – CMCM, Grand Canyon University
• Luanna Dishon, BSN, RN (NTCU) – BSN, USM, University of Saint Mary
• Leann Drake, MSN, RN, (WVH Medical Services) – MSN, Gonzaga University
• Curtis Gill, MSN, FNP, RN (Convenient Care) – FNP, Cox Health
• Shallon Gould, BSN, RN (ED – BSN, Western Governors University
• Tammie Gregor, BSN, RN (NTCU) – BSN, George Fox University
• Carol Hannibal, BSN, RN (Float Pool) – BSN, Western Governors University
• Kerrie Hayman, DNP, RN (Medical) – DNP, University of Portland
• Joel Helms, BSN, RN (Medical Telemetry) – BSN, Grand Canyon University
• Chantel Hilbert, BSN, RN (L&D) – BSN, Linfield College
• Jessica Hoff, BSN, RN (Endoscopy) – BSN, Grand Canyon University
• Melissa Huber, BSN, RN (WVH Infusion/Wound) – BSN, Western Governors University
• Debra Jasmer, BSN, RN, VA-BC (Vascular Access) – BSN, University of Texas at Arlington
• Jules Johnson, BSN, RN (5 North Medical Surgical Oncology) – BSN, Linfield College
• Marci Jordan, BSN, RN, CNOR (OR) – BSN, University of Saint Mary
• Brooke Kamm, BSN, RN (IMCU) – BSN, Linfield College
• Tiffany Karnaghan-Wirt, BSN, RN (IMCU) – BSN, Western Governors University
• Joseph Kelley, BSN, RN CNOR (OR) – BSN, Linfield College
• Nicole Klaus BSN, RN, (NTCU) – BSN, Western Governors University
• Chris Lentz, BSN, RN, CNRN (NTCU) – BSN, Grand Canyon University
• Elizabeth Lowery, BSN, RN (Float Pool) – BSN, Linfield College
• Ryan Mackey, BSN, RN, CNRN (Clinical Decision Support) – BSN, Western Governors University
• Kathryn Mahosky, BSN, RN, (IP Rehab) – BSN, Grand Canyon University
• Georgianne Mayer, BSN, RN CNOR (OR) – BSN, American Sentinel University
• Barbara Merrifield, MSN, RN, (Medical Surgical) – MSN, Western Governors University
• Rayanna Mitchell, MNE, RN (NTCU) – MNE, Oregon Health & Science University
• Virginia O’Reilly, BSN, RN CMSRN (Care Management) – BSN, American Sentinel University
• Sandra Pickle, BSN, RN, CNOR (OR) – BSN, University of Texas at Arlington
• Michelle Polander, BSN, RN (WWH ED) – BSN, Jacksonville University of Florida
• Jeneanne Saggs, BSN, RN (General Surgery) – BSN, Walden University
• Allison Sandall, BSN, RN, (Care Management) – BSN, Western Governors University
• Tabor Scrabeck, BSN, RN, CNOR (OR) – BSN, American Sentinel University
• Misti Shilhanek, MSN, RN (Patient Advocate) – MSN, Benedictine University
• Sandra Shore, MSN, RN, NE-BC (General Surgery) – MSN, Western Governors University
• Rebecca Sparks, MSN, RN CEN (ED) – MSN, Western Governors University
• Heidi Spear, BSN, RN (PACU) – BSN
• Joanne Spink, BSN, RN (IS Clinical) – BSN, Grand Canyon University
• Randi Stephens, BSN, RN (Orthopedics) – BSN, Linfield College
• Candace Tiley, BSN, RN, CNOR, CRNFA (OR) – BSN
• Jeremy Togstad, BSN, RN (Medical Surgical Oncology) – BSN, Linfield College
• Nicole Webber, MSN, FNP, RN, FNP-C (Medical) – NP
Certifications

- Sarah Acosta, BSN, RN, CEN (ED) – CEN certification
- Jenenne Aguilar, MSN, RN, NE-BC (Trauma) – NE-BC certification
- Erica Alvarez, BSN, RN, CMSRN (General Surgery) – CMSRN certification
- James Ball, RN, CCRN (CVCU) – CCRN certification
- Emily Barker, BSN, RN, CCM (Care Management) – CCM certification
- Anne Barr, BSN, RN, CMSRN (Ambulatory Anti Coagulation) – CMSRN certification
- Cheeri Barnhart, MSN, RN, NE-BC (ICU/CVCU) – NE-BC certification
- Elizabeth Batory, BSN, RN, ONC (Orthopedics) – ONC certification
- Katie Bearden, BSN, RN, CMSRN (Medical Surgical Oncology) – CMSRN certification
- Andrea Bell, MBA, RNC, NE-BC (Pediatrics/NICU) – NE-BC certification
- Angie Bishop, RN, RN-BC (Psychiatric Patient Services) – RN-BC certification
- Carlee Bizon, BSN, RN, CMSRN (Medical) – CMSRN certification
- Brenda Bublitz, RN, MSN, NEA-BC (Surgical Services) – NEA-BC certification
- Tara Budreau, BSN, RN, CEN (ED) – CEN certification
- Benjamin Burlison, BSN, RN, CCRN (ICU) – CCRN certification
- Kate Bush, CerATT (OR) – CerATT certification
- Wendy Cabrera, RN, CMSRN (Medical Telemetry) – CMSRN certification
- Rashed Eduard Ceniza, BSN, RN, CMSRN (Medical Surgical) – CMSRN certification
- Gordon Todd Chandler, RN, CBN (General Surgery) – CBN certification
- Cassie Cooper, BSN, RN, CWON (Infusion & Wound Care) – CWON certification
- Gina DiGiusto, MBA, BSN, RN, NE-BC (IP Rehab) – NE-BC certification
- Terah Farrester, MSN, RN, PCCN (CVCU) – PCCN certification
- Shiree French, RN, ONC (Medical Surgical Oncology) – OCN certification
- Kendra Fresh, BSN, RN, CEN (ED) – CEN certification
- Gabriel Gaertner, BSN, RN, CCRN (CVCU) – CCRN certification
- Michelle Galos, BSN, RN, CCRN (CVCU) – CCRN certification
- Lacey Geigle, BSN, RN, CCRN (ICU) – CCRN certification
- Jennifer Graham, MNN-RNC (MBU) – MNN-RNC certification
- Barbara Haines, RN, ONC (Orthopedics) – ONC certification
- Margo Halm, PhD, RN, ACNS-BC, NEA-BC – NEA-BC certification
- Jay Harris, MSN, RN, RN-BC (Psychiatric Patient Services) – RN-BC certification
- Jessie Hawkins, BSN, RN, OR-SANE (Prep/Recovery) – OR-SANE certification
- Karl Henich, RN, CEN, ATCN (ED) – ATCN certification
- Cheryl Holub, BSN, RN, CCRN (CVCU) – CCRN certification
- Sarah Horn, BSN, MBA, RN-C, NE-BC – NE-BC certification
- Matthew Hunt, CerATT (OR) – CerATT certification
- Kathy Johnson, RN, RN-BC (Psychiatric Patient Services) – RN-BC certification
- Katharine Joslin, RN, CMSRN (Medical Surgical) – CMSRN certification
- Lani Kelley, BSN, RN, CNOR (OR) – CNOR certification
- Lori Kessler, MSN, RN, NE-BC (PMC) – NE-BC certification
- Catherine King, BSN, RN, CWCN (Infusion & Wound Care) – CWCN certification
- Cheryl LaBronte, RN, OCN (Research) – OCN certification
- C Langbecker, BSN, RN, CCRN (ICU) – CCRN certification
- Kristie Lawrence, BSN, RN, NE-BC (Prep/Recovery) – NE-BC certification
- Leah Lindsey, BSN, RN, CMSRN (Medical Telemetry) – CMSRN certification
- Sheila Loomas, BSN, RN, NE-BC (IMCU) – NE-BC certification
- Laura McDonald, BSN, RN, RN-BC (Medical) – RN-BC certification
- Jaime McKnight, RN, CEN (WVH ED) – CEN certification
- Sarah McMillen, BSN, RN, CEN (ED) – CEN certification
- Victoria Merrell, BSN, RN (ICU) – CCRN certification
• Emily Middleton, BSN, RN, CCRN (CVCU) – CCRN certification
• Tina Morris, BSN, RN, NE-BC (Care Management) – NE-BC certification
• Brittany Olson, BSN, RN, RNC-MNN (MBU) – RNC-MNN certification
• Emma O’Neal, ADN, RN, CPEN (WVH ED) – CPEN certification
• Katherine Orr, BSN, RN, CCRN (ICU) – CCRN certification
• Jessie Pick, BSN, RN, CEN (ED) – CEN certification
• Molly Pizano, BSN, RN, RNC-OB (L&D) – RNC-OB certification
• Michael Polacek, MSN, RN-BC (Clinical Education) – Psychiatric/Mental Health Nurse RN-BC certification
• Zoe Rain, BSN, RN, CWON (IMCU) – CWON certification
• Katelyn Ridders, RN (ED) – CCRN certification
• Michael Rierson, BSN, RN, CEN (ED) – CEN certification
• Michelle Riley, BSN, RN, ONC, NE-BC (Orthopedics) – NE-BC certification
• Renee Rogers, BSN, RN, SANE-P (ED) – SANE-P certification
• Allison Romolino, BSN, RN, OCN (Medical Surgical Oncology) – OCN certification
• Emily Rousse, BSN, RN, CEN (ED) – CEN certification
• Daniel Ruby, CerATT (OR) – CerATT certification
• Jovita Sandoval-Morgan, BSN, RN, CMSRN (Radiation Oncology) – CMSRN certification
• Nancy Schimmel, BAN, RN, CNOR, NE-BC (OR) – NE-BC certification
• John Schwarte, BSN, RN, OCN (Research) – OCN certification
• Susan Schrank, RN, CMSRN (General Surgery) – CMSRN certification
• Jeanine Scott, MSN, RN, NE-BC, CRNFA, CNOR (Clinical Education) – NE-BC certification
• Sandra Shore, MSN, RN, NE-BC (General Surgery) – NE-BC certification
• Daniel Smith, BSN, RN, CCRN-CSC, CCRN (CVCU) – CCRN certification
• Cheri Sorenson, BSN, RN, CCRN (ICU) – CCRN certification
• Audra Stauffer, BSN, RN, RNC-LRN (Pediatrics/WCS FP) – RNC-LRN certification
• Mary Stevens, BSN, RN, CEN (ED) – CEN certification
• Dennis Struth, RN (Medical Surgical Oncology) – Bio/Chemo Therapy certification
• Shannon Thompson, BSN, RN, CEN (ED) – CEN certification
• Brenda Umulap, BSN, MBA, NE-BC, RNC-OB (Medical) – NE-BC certification
• Amy Ursprung, BSN, RN, NE-BC (NTCU) – NE-BC certification
• Kelly Veasman, BSN, RN, CCM (Care Management) – CCM certification
• Sara Wargnier, RN, ONC (Orthopedics) – ONC certification
• Nicole Webber, MSN, FNP, RN, FNP-C (Medical) – FNP-C certification
• Janelle Williams, BSN, RN, CPN (Pediatrics) – CPN certification
• Kelly Wolfe, BSN, RN, CEN (ED) – CEN certification
• Sarah Wolfe, MSN, RN, RN-BC (Clinical Education) – RN-BC certification, Nursing Professional Development certification
• David Wood, RN, CCRN (IMCU) – CCRN certification
• Elizabeth York, RN, CRNI (Infusion/Wound) – CRNI certification
• Kimberley Yorke, RN, RD, CDE (Diabetes Education) – CDE certification
Professional Appointments

- Nancy Alt, BSN, RN, RNC-OB – Co Chair, Oregon AWHONN Conference
- Jamie Baxter, RN, CEN – Deputy Team Leader, Oregon Disaster Medical Team
- Steve Buck, MSN, RN – National Education Committee, Association of Nursing Professional Development
- Sandra Bunn, MSN, RN, CNS-OO, ACNS-BC, CDE – Advisory Board Member-Professional Practice and Prescriptive Practice, OSBN
- Robert Dow, BSN, RN, CEN – Treasurer, Mid-Willamette Valley & Coastal Chapter of Emergency Nurses Association
- Margo Halm, PhD, RN, ACNS-BC, NEA-BC - Research Committee, Oregon Center for Nursing; Research Committee, American Holistic Nurses Association
- Phil Haworth, PT - Board Member, State of Oregon Physical Therapist Licensing Board
- Michael Polacek, MSN, RN, RN-BC (Clinical Education) – American Psychiatric Nurses Association (APNA) Member at Large; APNA Suicide Competencies Workgroup; Journal of the APNA Editor-in-Chief Search Committee
- Beverly Smith, MSN, RN – Program Administrator, Commission on Cancer: Cancer Committee
- Katherine Spann, MS, RDN, LD, CDE – AADE/Oregon Willamette Local Network Group Coordinator and Grant Committee
- Rhonda Wood, BSN, RN – President Elect, Oregon ENA; Secretary, Area Trauma Advisory Board; TNCC/ENPC Chair, Oregon ENA
- Heather Cofer, BSN, RN – Medical Detachment Commander, Medical Command, Oregon Army National Guard

Presentations

- Jamie Baxter, RN, CEN (ED) – Emergency Management in Nursing, Clackamas Community College Nursing
- Amy Brase, MSN, RN, CNE (Clinical Education) – When to Call the Doctor, Linfield College; Developmentally Appropriate Communication, Teen Parent Program, Salem Keizer School District
- Margo Halm, PhD, RN, ACNS-BC, NEA-BC - Healing from Coronary Artery Bypass Surgery: Navigating Mind, Body and Spirit Caregiver Challenges, 1st International Integrative Nursing Conference, Reykjavik, Iceland
- Evelyn Jones, BSN, RN (WCS) – When to Call the Doctor, Winema Place
- Michael Polacek, MSN, RN-BC (Clinical Education) – Marking, Unmarking & Remarking: Plastic Nursing to Reduce Violence in Health Care, Mental Health America, Roanoke Valley, Roanoke, VA
- Rhonda Wood, BSN, RN (ED) – ENPC, TNCC, Samaritan Health, Capella Health
- Ann Alway, MS, RN, CNS, CNRN (Advanced Practice Nursing) – Neuroscience Patient Challenges in Critical Care, Greater Portland Chapter of Critical Care Nurses, Critical Care Consortium
- Sandra Bunn, MSN, RN, CNS-PP, ACNS-BC, CDE (Advanced Practice Nursing) – Diabetes Basics and Considerations for Geriatric Patients, Type 1 and Type 2, OHSU Nursing Program
- Kacy Bradshaw, MSN, RN, NNP-BC (Nurse Practitioner WCS) – Family Integrated Care, VON NICQ Webinar, hosted out of Vermont
- Angela Jane Ray, MSN, RN, NE-BC (Spine Center) – Development of an Integrated Approach to Quality in a Spine Center Care System, 2015 ANA Quality Conference, Florida
Extramural Grants

- Andrea Bell, MBA, RN – March of Dimes, “Reducing Neonatal Abstinence Syndrome (NAS) through Provider Education” – March of Dimes $5,000.
- Margo Halm, PhD, RN, ACNS-BC, NEA-BC – “Evaluation of the Impact of EBP Education: Development of a Modified Fresno Test for Acute Care”. American Nurses Foundation Nursing Research Scholars Program; Funded by the American Nurses Credentialing Corporation, $5000.
- Sharon Heuer, MS, MEd, RD, LD– “Non-Emergency Medical Transportation Coordinator Position” (identified as a high priority in the community needs assessment) – Salem-Keizer Transit Special Transportation Funds, $50,000.

Publications


Community Involvement

- Erica Alvarez, RN– Headstart of Yamhill County
- Ann Alway, MS, RN, CNS, CNRN – Lung Love/Run Walk
- Denise Arnold, BSN, RN, BS, CMSRN, STII – Outdoor School Nurse
- Christine Baker, RN – Marion County Search and Rescue
- Ellie Barna, PT – Health Professions Workshop, Pacific University
- Melissa Berry, PT – Saturday of Service Program
- Sandra Bunn, MSN, RN, CNS-PP, ACNS-BC, CDE – Boy Scouts of America
- Brad Busey, BSN, RN – Without Strings Dental Clinic
- Gordon Todd Chandler, RN, CBN – Habitat for Humanity
- Schlifka Smith Collier, BSN, RN – Lung Love/Run Walk
- Cassie Cooper, BSN, RN, CWON – Salem Area Trail Alliance, No Strings
- Georgea Dovich, RN – Homeless Dental Clinic
• Robert Dow, BSN, RN, CEN – Dallas Lions Club
• Jennifer Graham, RN – Family Building Blocks
• Margo Halm, PhD, RN, ACNS-BC, NEA-BC – Lung Love/Run Walk
• Carol Hannibal, BSN, RN, TNCC – Union Gospel Mission, Marion County Medical Relief Corps
• Phil Haworth, PT – Sports physicals, North Salem High School
• Aja Jensen, RN – Habitat for Humanity
• Catherine King, BSN, RN, CWCN – Salem Saturday Market
• Marlaine Magee, BSN, RN, CCRN – Without Strings-Hands Bridging-Board Member
• Dawn Melvin, BS, LPTA, CSCS – Salem Saturday Market, Earth 411, Restore Habitat for Humanity
• Lindy Mongenel, BSN, RN, CMSRN – Turner Community Emergency Response Team
• Kate Morris, PhD – Professional training in somatic experiencing therapy
• Sara Nash, BSN, RN – Lung Love/Run Walk
• Veronica Nunez, BSN, RN, CBN – Marion-Polk County Food Bank
• Lily-Claire Orme, BSN, RN – Oregon Food Bank
• Christine Powell, BSN, RN – JLPN
• Hannah Pratt, RN – Relay for Life
• Angela Jane Ray, MSN, RN, NE-BC – Salem Free Clinic
• Sandra Shore, MSN, RN, NE-BC – Habitat for Humanity
• Beverly Smith, MSN, RN – ACS Relay for Life, Race for the Cure, Breast and Cervical Free Clinic Screening
• Katherine Spann, MS, RDN, LD, CDE – American Diabetes Association
• Lindsey Spencer, RN, BSN, CEN – Volunteer Medic
• Karisa Thede, BSN, RN, CEN, CPEN – Salem Free Clinic, Celebrate Recovery