COACHING GUIDE for the Lantern Award Application

Coaching Guide by Application Section

Each section of the Lantern Award application is presented with background information and supporting evidence described. This information is provided to assist your team in a successful journey to the Lantern Award. Note: Successful applications demonstrate a ***variety*** of initiatives, projects, and/or process improvements throughout the application with **quantifiable outcomes**, sustained improvements, and innovative processes.

Leadership – Operations (Sections E - H)

Questions in this section focus on operational improvement activities and development of systems and processes.

Throughput – Patient Flow: Section E

Optimum care can only be delivered when the patient is in the right place at the right time. Patient flow is a challenge that is faced by emergency departments and their facilities on a daily basis. Developing the ability to manage unpredictability and assure that the correct resources are being deployed is fundamental to the issue of throughput. Timely and effective care supports optimum outcomes and delays in care may increase patient discomfort but also add risk for the patient. Clinical variability is a factor of the health care environment and the delivery of patient care. This variability cannot always be factored into solutions and programs. Variables such as volume, census, wait times, staff availability, and location of organization are indicators that can be studied to develop a program that supports patient flow.

The Evidence

Both metrics and narratives are the sources of evidence that are needed for a presentation of patient flow strategies, tactics, and timing appropriateness in identified clinical situations. Provide information regarding system-wide processes that support the emergency department's patient flow, which must explain the metrics that are reported in this section. Explain the measures of success that demonstrate the improvement or challenges in the setting.

Patient Satisfaction: Section F

Patients and their families generally view the emergency department or facility experience in its entirety. The commitment to creating an environment that nurtures and continually strives to meet the needs of the patient and their family is a key component of a setting where excellence is the expectation. Optimizing the patient's experience may have correlated gains in resource utilization, expenses, and strong clinical outcomes.

The Evidence

A narrative is required that outlines the efforts in place to assure an exceptional patient/family experience. Details from your surveys must be utilized to highlight areas of concern and the action plan developed to improve your scores. Be specific and use supporting data.

Patient Safety: Section G

The safety climate of a department defines the atmosphere where care is delivered and the values, attitudes, competencies and patterns of behavior of the care givers who practice there. The safety climate of a department also reflects the structure and processes of the organization as a whole and the priorities and actions of leaders. There are many key strategies that have been recommended for the cultivation of a culture of safety and assuring its sustainability over time. The identification of risk, the recognition of error, the analysis and investigation of error, the development of non-punitive action plans, as well as participation and the education of the care givers are all elements in a strategic approach to patient safety. While all errors are serious and have potential for severe adverse reactions, there are some extremely serious events that have significant or fatal consequences for patients – these are "Never Events." Nurses play a key role in the development of a strong safety culture within a department and are vital in all collaborative efforts to utilize effective interventions to assure safe patient care.

The Evidence

Descriptive narratives are required on the culture of safety in the emergency department with emphasis on specific identified events. The tools, techniques, communication processes, prevention tactics, and outcome analyses relative to various events are expected. Any changes in work flow or other elements of care in the department should be identified if they were generated from the analysis of a breach in safety. Avoid generalities as well as patient/staff identifiers. Describe failure mode analyses conducted in response to errors. If your department has not experienced one of the events identified in this section, then share the proactive risk assessment strategy, prevention program, and best practices in place that promote patient safety.

Emergency Management and Preparedness Planning: Section H

While there are many types of disasters, mass casualties and hazard scenarios, all incidents and events share common response actions and organizational principles. The emergency department is a primary entry point into the hospital system and often times the initial facility-based patient care area for victims of any hazard. Therefore, emergency nurses should be equipped with the skills, knowledge, and resources (integrated within a community-wide plan) necessary to provide victims the best care possible during an all-hazards incident. The development of meaningful and productive relationships outside the organization is intrinsic to

the concept of preparedness. Innovative solutions are often tested in real events and go on to become practice implementations.

The Evidence

Narratives are needed to describe emergency management and preparedness. Provide descriptions that include the integration of the team, joint training, educational concepts, and innovative initiatives that provide a comprehensive picture of your readiness and preparedness. For example, describe lessons learned from a recent drill or actual event and how these lessons learned resulted in changes to policies, procedures, and education/training. Identify any innovative strategies that were utilized. Identify key positions responsible for management and coordination utilizing the incident command system.

If you have questions, please contact LanternAward@ena.org.