A Nurse Leaders Journey to Improve Geriatric Outcomes
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**INDIVIDUAL LEADERSHIP DEVELOPMENT**

**Model the Way**
- Set boundaries and acknowledge room for improvements
- Use relationships to affirm vision and cast a positive shadow that others desire to follow
- On going self reflection of leadership behaviors that identifies strength and opportunities

**Enable Others to Act**
- Influence others through collaboration
- Developed cooperative goals and roles through partnerships with influential leaders in the organization and the community
- Perceived as a thought leader that developed a track record of making effective day to day and long term decisions

**Outcomes:**
- Enhance self awareness to develop personal effectiveness and integrity to achieve success
- Interprofessional team taught me to be curious and open to new approaches to improve results
- Identify competing priorities and be strategic in setting expectations and clearly communicating appropriately

**INTERPROFESSIONAL TEAM LEADERSHIP PROJECT**

**Purpose**
To implement a continuum of care program to prevent hospital readmissions and reduce unnecessary emergency room (ER) visits of geriatric patients.

**Background**
Nearly 18% of Medicare patients admitted to a hospital are readmitted within 30 days of discharge, accounting for $15 billion in spending, according to the Medicare Payment Advisory Commission. Methodist Lebonhuer Healthcare-South has a hospital readmission rate of 15.53% with a goal of 13.50% and the geriatric population is the primary age group that contributes to hospital readmissions and unnecessary ER visits. With an aging society the care of older adults require attention that extends beyond the hospital. A continuum of care model was introduced and discussed with emphasis placed on hospital readmissions and reducing total costs.

**Outcomes/Desimination Plan**
This high value proposition would allow for early identification of adverse events and help the caregiver avoid preventable poor outcomes among geriatric patients.

- Present ROI to C-suite in which they employ a Geriatric ANP to implement the continuum of care model.
- Disseminate plan to all discharging units and nursing homes
- Implement checklist for discharge and follow-up.
- Develop care tracks and follow-up guidelines for ANP

**EXPANDED SCOPE OF INFLUENCE**

**Goals**
To inspire a shared vision bridging a network of leaders together to use their knowledge and passion to bring older adults to their baseline or better.

**Outcomes:**
- Sought out by CEO to partner with surrounding nursing homes to improve competency of geriatric care
- Pursued by hospital executives to collaborate and devise strategies that will improve the care and outcomes geriatric patients
- Invited to attend community advisory council

**Organization**
- Appointed to corporate pharmacy and therapeutics committee by CNO to focus on impact of medication on geriatric patients

**Community**
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