



# **Podcast Transcript**

### Nurse Innovators: Solving Problems at the Bedside

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#### Guest: Kathleen M. Vollman MSN, RN, CCNS, FCCM, FCNS, FAAN

Ms. Vollman is a Critical Care Clinical Nurse Specialist and Consultant. She has published & lectured nationally and internationally on a variety of pulmonary, critical care, prevention of health care acquired injuries including pressure injury and CAUTI/CLABSI's and other HAI's, work culture and sepsis recognition & management She serves as a subject matter expert on these topics for the American Hospital Association and Michigan Hospital Association. From 1989 to 2003 she functioned in the role of Clinical Nurse Specialist for the Medical ICU's at Henry Ford Hospital in Detroit Michigan. Currently her company, ADVANCING NURSING LLC, is focused on creating empowered work environments for healthcare practitioners through the acquisition of better skills, attainment of greater knowledge, and implementation of process improvement.

#### Host: Candace Pierce: DNP, MSN, RN, CNE

Dr. Candace Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. PIERCE: strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

## **Transcript**

PIERCE: Hello, I'm Dr. Candace Pierce with Elite Learning by Colibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals.

In today's podcast episode, we're going to be talking about innovation. Innovation is more than just a buzzword. It is actually a mindset and a process that helps drive meaningful change in healthcare. As nurses, as those frontline caregivers, we are uniquely positioned to identify challenges and help create solutions that improve not only patient care but also our workflows.

But what does innovation actually mean in the context of nursing, and how do you take an idea and turn it into a practical solution? Hopefully, through this episode, we're going to help you understand what innovation is. We're also going to hear from a nurse who saw a problem and was able to create something, innovate something, to fix that problem.

Kathleen Vollman is here with us for this conversation. Kathleen, thank you for joining me.

VOLLMAN: Hi, everyone. I'm glad you're here. Thanks for having me back.

PIERCE: So glad you're back. This episode is going to go a little differently than how we normally do. I get to talk about innovation and really discuss what that is, and Kathleen's here to join in that conversation. In the last half of our episode, we're going to get down to the details and understand how we can innovate as nurses while Kathleen shares her innovation story about how she solved a problem. Hopefully, we can inspire you through this episode and help you become an innovator. What do you think, Kathleen?

VOLLMAN: I think we're up for the challenge.

PIERCE: Yes, I think it's going to be a fun challenge. I'm so glad you're here with me for this. Kathleen, when you think of the word innovation, do any names come to your mind in healthcare besides yours?

VOLLMAN: For me, names mean you work with technology that has individuals' names attached to it. That tells me that person innovated, created something different, something new, or designed something to fix an issue or a problem. One comes to mind. I can't remember the name of the individual, but it was a pediatric nurse who created the little cup that went over IVs so children couldn't play with them. That came from frustration we experienced in the clinical arena, and she came up with a solution.

PIERCE: Yes, and I'm probably going to be clearing my throat often. I'm struggling with whatever this fall crud is, so please ignore my throat clearing. But I think all the way back to Florence Nightingale. She was a huge innovator, and I don't even know that we fully understand today the innovation that she brought to our profession. From establishing the idea of training for nurses to her work in sanitation and hygiene, much of what we follow in hospitals today began with her. Even evidence-based practice came from her.

VOLLMAN: And her statistics, her measurement and statistics, she is literally on the wall of the math building, I believe, at Oxford as one of the first women statisticians.

PIERCE: Wow, you know, because it was her data. She kept track of so much information in her notebook, and I don't even know if she realized how much of an impact she was going to have with what she was doing at that moment.

VOLLMAN: Well, and it helped her create those innovations.

PIERCE: Yes. Her advocacy and diligence through all of this show us that much of what we have today comes from her, like evidence-based practice, patient-centered environments, and the holistic care that we provide. If you trace all that, it goes back to her. For me, when I think of innovation in healthcare, I go back to Florence Nightingale. She was the innovator for where we are today in our profession. It's amazing to see how much traces back to her.

You also mentioned people who develop things and have their names attached to them. I immediately started thinking of Donna Wong and Connie Baker. Do you know what I'm talking about? The Wong-Baker Faces Pain Scale that we still use today. Yes, they have their names attached to it, but we usually just call it Faces.

We have nurses who have developed color-coded IV lines. The crash cart, I don't remember who developed it, but I know that came from a nurse, and we still use it often in the hospital. I know small changes have been made over time, but the original idea came from a nurse.

Linda Richards, I believe, was the first trained nurse in the United States, and she has been credited with helping to establish the first nursing school in the U.S. Another IV innovation was by Maggie McLaughlin. I apologize if I said that wrong, but she is credited with redesigning the Luer-Lok on the IV delivery system so that we could carefully manage how much medication and fluids go into patients. I believe her focus was on infants and the elderly, but of course, we use it for everyone.

These are just some people within healthcare and within nursing who made big innovative changes. They saw a problem and worked to fix it.

When I started a job in leadership, I had to go in front of the C-suite and meet with all of them. I remember sitting in a chair talking to a CFO, and the only thing he

wanted to talk about was innovation and how I was going to innovate. But his definition of innovation was electronic devices, computers, AI, and IT.

Many of us, when we hear the word innovation, automatically think of electronics, AI, X-ray machines, and those big changes we see in hospitals. Yes, robotics too. That's really big. You see it in surgical suites. So when people talk about innovation, that's often what they mean. But that is not what innovation actually is.

Technical advances with artificial intelligence, telemedicine, and wearable technology do fall under innovation, but innovation is really about looking at a problem and figuring out how to solve it. It can involve electronics, but it can also be a process, paperwork, or even the way we bring patients up to a floor. Innovation is so much more than just computers and robotics.

VOLLMAN: Or a product itself. Oftentimes people think about innovation by connecting it to invention instead of the full scope of what it can be. In my world, innovation is sometimes married to a process improvement component, even though they are, quote, unquote, different. Innovation is often seen as something new and different, whereas process improvement is seen as tweaking for efficiency.

I did an innovation of creating a seamless managed wound care program, a business inside a business. In the 1990s, when I was at Henry Ford as a clinical nurse specialist, it came from the bedside. It came from recognizing that nobody owned this particular problem back then. There weren't as many WOCs, but there were still a lot of pressure injuries. Surgeons didn't want to touch them, they would get consulted, but there was no structure around this. So we built a business inside a business, innovated, saved a lot of money, and created something new and different.

PIERCE: Yes, absolutely. And as we see healthcare change, it's really shifting to value-based care. We're going to have to figure out ways to manage our aging populations. We have so many more chronic disease processes now. When it comes to innovation, it's all about lessons learned. We can take lessons from the global health crisis, like when we were going through COVID-19, which really highlighted the importance of creative, forward-thinking solutions. How can we use what we have to solve this problem and keep everybody safe?

VOLLMAN: There was an example, I believe at the University of Colorado, where they put a WOC in a telehealth box, figured out a camera structure with people's iPhones, and created an app so they could stage from a box. Interestingly enough,

that's catching on because of changes in value-based purchasing. Stage two is going to be incorporated into e-documentation, and they're going to pull it straight from the record. So you need an expert to evaluate that wound. How do you maximize the talent of that human to support the frontline registered nurse and make sure the care is documented appropriately?

PIERCE: I was just thinking about what you said. That nurse could be anywhere and could share their expertise and teaching across the U.S.

VOLLMAN: One could go that far, though there may be some regulatory issues associated.

PIERCE: Yes, I could see where we could get there. Of course, we're not talking about those today. We're just talking about where we could go. Even think about teaching clinicals for students who don't get to see certain types of wounds. Being able to show students how to treat different types of wounds in real time rather than saying, "Here's a textbook, here's a picture." No, here's a real wound, and here's how we're going to take care of it.

VOLLMAN: One of the innovations happening right now is virtual reality in learning. My sister is involved with a colleague who runs an innovation center at Ohio State University and is very engaged in virtual reality. They are now doing virtual reality for sepsis.

PIERCE: Yes, that's big. That's so big right now.

VOLLMAN: And for hemodynamics at national conferences.

PIERCE: Wow, yes, that's really good. I know we've mentioned a lot of electronic-type things like virtual reality and cameras. I think the reason we see the myth that innovation is mainly electronic is because it's easier to recognize and measure. It's more visible, and it gets talked about more. People say, "Look at this big electronic thing we developed," instead of noticing smaller innovations.

Even process changes are innovations. When you think about the term innovation, it can sound like a buzzword. You hear it and wonder what electronic thing they're going to talk about. It's a big term, especially in leadership and larger organizations. But what it should refer to is the creation and implementation of new ideas, new methods, and new technologies that address unmet needs, solve problems, and improve patient outcomes.

That's what innovation is in healthcare. I want to say that again because I want to make sure everybody understands. Big things and small things all fall under this definition: innovation is the creation and implementation of new ideas, new methods, and new technologies that address unmet needs, solve problems, and improve patient outcomes.

VOLLMAN: To me, that's why the nurse is in a phenomenal position. Day to day, they're looking at challenges in the processes and the routine ways they've been required to do things. You could literally sit a group of nurses down and identify what is not working. Then you start to ask, "What if this?" Sometimes they already have the ideas, or they've done what we frequently call in nursing a workaround. By the way, a workaround is an opportunity.

PIERCE: Exactly.

VOLLMAN: It is the opportunity to innovate. Whenever you run into challenges or frustrations repeatedly, you should stop and think, "Okay, this is happening all the time. It's happening to my peers. What can we do?"

PIERCE: Yes. So what we're saying is that innovation goes beyond simply refining existing processes. We are introducing transformative changes that redefine how we deliver care. While process improvement focuses on optimizing current workflows or systems, innovation gives you the chance to think outside the box to develop entirely new approaches or tools that can truly disrupt traditional practice.

Disrupting traditional practice leads to significant advancements in care. A lot of times we don't like to disrupt traditional practices, and that's why we end up with workarounds. But the whole point of innovation is to disrupt those practices so we can find better, more efficient, and more effective ways of doing things.

VOLLMAN: Yes, and sometimes you have to blow it up. Sometimes you have to move it out.

An example is my colleague at Roddy Medical. She created a company and a product based on a need in the environment for effectively managing lines without attaching them to the bed but instead to the patient, using a better force pull. You could tug on it without any movement at all. She saw how it related to central line infections and dressing changes because the lines were getting yanked. So she decided to take it up and innovate.

PIERCE: Yes, and that's why I really want to point out that innovation is so much more than technological advances. Nurse-led innovation can reduce medication errors, improve communication, and create tools to streamline documentation so that the entire team understands what's going on with the patient.

We really need to broaden our definition of innovation because that allows us to see opportunities in areas beyond gadgets and software. Nurses are on the front lines of patient care. We're the ones encountering challenges and inefficiencies firsthand. That puts us in a dynamic position to look for innovative solutions that improve care delivery, enhance patient safety, and optimize workflows across the profession.

VOLLMAN: Besides that, a person grows a lot in their journey.

PIERCE: Yes, it is definitely a journey because we don't like to disrupt things. You're probably going to get a lot of pushback. But when you can take a page out of Florence Nightingale's book and have the evidence-based data to show this is a problem and here's how we can fix it, that's powerful.

VOLLMAN: The best example I can give, even though it's an outside product, happened at my organization. I was on a committee to review and redo the enteral nutrition guidelines. In there was a line item that said, "Don't give immunocompromised patients tap water." I thought, okay, but this was in the 1990s. I was bathing my MICU patients in tap water, so I asked infection control what was going on. They said, "We have pseudomonas in the pipes." By the way, more hospitals have it than people think. But that's when I first saw a nurse invention. I don't know if you remember, it was called Bath-in-a-Bag.

VOLLMAN: The problem was it required tap water to activate it. It had the right solution and all the right components. Then a product walked into my office, connected to a human, but it was a packaged bath. I thought, my heavens, there it was. But then I faced the innovation part of changing a routinized practice of bathing that we had been doing since Florence Nightingale and the Crimean War. The innovation that it took to do that was significant.

PIERCE: Yes, I love that. Some ways that we see innovation today include implementing teams, because some innovation is simple, like developing teambased care, creating standardized protocols, or writing new policies or guidelines to address emerging challenges or improve equity in care. Those are forms of innovation.

There is also innovation in design, such as improving the physical environment of our setting or creating tools that enhance the patient or provider experience. You talked earlier about simulation-based learning, so even introducing that into a setting can be a form of innovation. Interprofessional education, bringing other disciplines together to help with teaching, also represents innovation.

Continuing education that focuses on real-world problem-solving and even leadership innovation, like redesigning organizational structures or leadership models to improve efficiency and decision-making, all fall under innovation. It is a big part of what we do.

I also want to talk about mindset. I had a lot of trouble with this myself. I went through training at a college for educators where we focused on innovation, and I learned that I had a hard time thinking outside the box. To be successful with innovation, we have to start thinking outside the box.

What I mean by that is that somewhere in childhood, we leave that creative thinking behind. Our imagination just kind of fades. I see this with my children, and I don't know why it happens or where it goes. We just tend to leave it behind.

VOLLMAN: The pressure to conform in school. It starts when they move into structured learning, not so much in kindergarten because there is still a lot of free form there, but once they reach first grade. At least that is my observation from my thirty nieces and nephews.

On prone positioning in the back conference room, I read that and convinced a couple of my nurse colleagues on the midnight shift to turn some patients prone. It was mobility, so we did not ask for an order because mobility belonged to nursing.

PIERCE: Yes, he was setting you up for success, of course.

VOLLMAN: We turned the patient and saw a huge improvement in oxygenation. Then I started investigating devices. The CircOlectric bed, which you have probably only seen in movies, or the Stryker frame were the only options other than manual turning. But those did not allow the belly to hang free.

So on night shift, I started cutting up egg crates, stuffing bath blankets between them, and swirling Kerlix around it. We started using that setup to prone patients. I knew I wanted to go to grad school and thought this would be a really good study.

My sister's brothers were both engineers. One drew the original design while we were hanging out. Several months later, the other brother asked, "What are you doing with that drawing?" The first one did not remember. The other, a mechanical engineer, said, "I can build that."

Then I went to my physician colleague, the medical director, and talked to him about doing research on this. I said, "I want to go to grad school in California. Will you be on my committee?" I knew the literature on prone positioning was not strong, and I could not convince people out there who had never seen it. This doctor had seen it and recognized the benefit.

So I went to grad school, and he created a wooden device in his garage. By the way, if you have that kind of idea, engineering programs at universities are always looking for projects. You can collaborate with them easily.

Nobody in my school wanted to be my chair because they thought I would never finish grad school. I was building a device, testing it in a lab, and studying it with critically ill patients.

That was a comfort zone fear moment. I spent about three hundred dollars calling home to my mom and sister, asking, "Is this something I really want to do? Do I have the skill?" I was writing my first chapters on pulmonary physiology and thought, I do not know if I can do this. But that single decision to say, I am moving forward, changed my life. It also changed how I view the world. When you create something new and different, you never see the world the same way again.

That experience allowed me to keep innovating while I was in hospitals. It also allowed me to take agency work while working nights during grad school. I started examining all of our processes. My curiosity was huge, it was wide open.

We tested the device in a lab, made adjustments, and got it ready for the study. I went back to Detroit and did the research at the Detroit Medical Center. The first year my research was complete, I presented it as a poster at NTI, the National Teaching Institute for Critical Care. A company approached me, and we started discussions. I thought, wow, okay.

I also wrote the policy and procedure piece that went along with it as part of my thesis because you needed a safe process for turning critically ill patients prone. That same tool was the one used during COVID everywhere in the world. The sequence of steps from my thesis was included, just slightly modified.

PIERCE: Amazing. You were ahead of your time. Since you were ahead of your time, how did you gain support from leadership and stakeholders?

VOLLMAN: So literally, I tend to call it a soft sell. I published a big article on ARDS and included a piece of that. I submitted presentations on positioning critically ill patients and ARDS to the National Teaching Institute in 1991. It did not get accepted. They said it was too pathophysiologic.

However, I went to my local chapter, presented, and said, "Can I do this for free? The evaluations came back, "makes complex things easy to understand." I submitted those evaluations with my next abstract submission, and it got accepted. I introduced proning that way, not as proning by itself, but as positioning critically ill patients.

Then another company approached me, and I ended up creating an agreement with Hill-Rom, and it got launched in 1997.

PIERCE: Wow. And it is still being used today.

VOLLMAN: Yes, and people still have it in the storage areas of their hospitals. It went off the market in 2011 before the seminal research happened in 2013. Again, I was ahead of my time. But there are other tools now, such as turn-and-position systems and lift systems that make it easier to turn patients, as well as foam wedges and other equipment. So I did not really need to bring the device back on the market because other strategies had been developed.

But knowing that the safety of how you turn was what was used everywhere around the world in their protocols helped me understand the significance.

PIERCE: Yes, for sure. You are the foundation for where these turn systems and devices came from. You went out there, saw the studies, did the research, created something, and wrote the policies and guidelines that are still used today for safe proning. That is amazing. I hope you can see and know how amazing your work is.

VOLLMAN: I am very blessed, and I work hard to take that in when I get complimented. One of my favorite stories about this, and something important in your journey, is that you have to take those moments in because they feed your soul. That is what keeps your passion, patience, and persistence alive.

This happened, I think, around 1998. One of my clinical nurse specialist colleagues had never used the proning device at her hospital. She paged me and said, "Can you walk me through this process? I have a forty-year-old patient whose wife is pregnant with their first child. They have done everything, and the only thing we have not tried is proning."

I walked them through it. That gentleman survived. He became really good friends with my CNS colleague, who hosted a party every year. One year I was sitting on the porch, and this gentleman walked up with his wife and two kids. He introduced himself. I recognized his name because he had sent me an email thanking me after everything. He put his daughter on my lap and said, "She would not be in this world without you."

PIERCE: Wow, yes. Without you. That is amazing. That is an amazing story.

VOLLMAN: The reason I tell that story is because as nurses, we tend to say, "That is just my job," and we downplay the impact. When a patient thanks you for teaching them about their medications, we often say, "No big deal." But we need to take those moments in because they feed our souls. That helps keep our curiosity, creativity, and critical thinking going so we can innovate and make things better for ourselves and our patients.

PIERCE: Absolutely. If we have a leader who is listening, how can healthcare organizations support and create an environment that really encourages innovation among their staff?

VOLLMAN: Shared governance structures and strong unit councils. Strong, unit-based councils that have designated time. Not just an hour, because that turns into another staff meeting or FYI session. They need enough time to truly problem solve and think through ideas. Ours met for four hours so we had enough time.

That is where our individual projects started. That is where our bereavement program came from. That is where the bowel management program came from. That is where innovation came from, because staff discussed challenges they were hearing from their colleagues and thought through solutions. That is where innovation happened.

Providing time to think is key. Also, creating innovation centers and supporting multidisciplinary innovation centers for all disciplines, not just physicians, allows everyone to collaborate and innovate together.

PIERCE: Yes. Now, what advice would you give to other nurses who have ideas that they think could solve problems but do not know where to start?

VOLLMAN: I would start by identifying the problem. Then ask your peers, "Are you experiencing this as well?" You are beginning to gather data that shows it is not just you, and that there is an opportunity. Then start discussing your ideas casually. Say, "Hey, what do you all think about this?"

Next, take it to the unit governance council. If that council connects correctly, it feeds into larger areas. We were in critical care, and we fed into other critical care units. Then you can ask broader questions or conduct a survey to gather more data.

PIERCE: That is the curiosity.

VOLLMAN: Exactly. Then you pilot your solution in your own environment and gather your data. After that, you spread the solution to others, again collecting before and after data. Then you work with people in your organization.

One of the blessings we had in our professional development department was having PhD-prepared nurses, scholarly nurses who helped the frontline with projects.

PIERCE: That is always good to hear. Yes, because they are very invested.

VOLLMAN: Those projects would then get presented and published. They would be shared beyond our hospital. A lot of innovation stays at the local level because there is not enough time for dissemination.

What I started doing, because I did not always have the time myself, was collaborating with local schools. If they had master's students who needed projects, or internally, staff nurses could ask the education department, "Do you have links with universities? Can you find out if someone is interested in working on this project with me?"

It requires stepping out of your comfort zone because our comfort zone is caring for patients, but that collaboration can elevate your work.

PIERCE: Many hospitals already have affiliations with universities or smaller colleges that send students for clinicals. There is usually an existing connection that you can use to bring in help for your research or innovation projects.

VOLLMAN: Exactly, and you do not even need to call it research.

PIERCE: No, that is just a fancy word.

VOLLMAN: That is a fancy word that scares me. It scared my staff. But what would happen is the staff would have the issue, the question, the challenge, and the ideas. I would connect them with the master's student I was mentoring, and that student was connected to a PhD faculty member at the university.

PIERCE: They were gathering information.

VOLLMAN: Yes. This whole chain helped develop everyone involved, and no one felt like they were alone in the process. My sister once listened to someone present on positioning critically ill patients and oxygenation. She went up to the speaker and said, "My sister is at Cal State Long Beach working on her thesis on prone positioning. Would you be interested in connecting with her?" That speaker ended up joining my thesis committee. Those connections are important.

PIERCE: Nice, yes. Important. And we have to get out of our comfort zone to make those connections, especially if you are an introvert.

VOLLMAN: Yes, and if somebody says no, there is always somebody else. That is where resilience and passion come in. If this is something in your gut that you want to fix, that you want to innovate and improve, that passion will allow you to take the no and find someone who will turn it into a yes.

PIERCE: Right, and that is where the resilience comes in. Keep going. You have to be committed. What lessons did you learn from your experience that you want to make sure you share with others?

VOLLMAN: We have talked about it throughout this conversation, curiosity. For me, it has always been about asking, how do I make it easy for the frontline nurse to do the right thing? That question alone drives innovation because the barriers that nurses face often spark solutions.

When I speak on this, I emphasize passion, persistence, and reaching out. If you do not know something, do not be frightened by that. I had no clue about business. That was not my area. I can read a contract now because lawyers and other people taught me what to look for. Did I ever go to school for business? No. But I have a

fairly decent business education because I kept pushing outside my comfort zone to make the right things happen.

PIERCE: What you have learned along the way, absolutely. One of the things I want to emphasize is how nurses can recognize opportunities to innovate in their daily practice. We have talked about this, and I want to bring it all together.

First, you need to maintain curiosity. Let your imagination come back. I also want to point out the importance of a problem-solving mindset. Instead of saying, "This is so frustrating," try thinking, "How can I solve this problem?"

VOLLMAN: By the way, that is the cue. If you are repeatedly frustrated by something or challenged by something, that should be a bell ringing in your head to flip the switch to innovate.

PIERCE: Turn on the problem-solving mindset. Flip that switch and turn it on. When you do that, you will start to see areas where you can innovate and have a meaningful impact. Maybe it is just for your staff or your unit, but it could grow to a nationwide or even worldwide level. You never know where it will go.

To recognize opportunities, observe the recurring challenges and inefficiencies in your workflow. Listen to patient feedback. Often, they identify unmet needs and frustrations, and you will start to hear themes. Reflect on your processes. Can they be simplified, improved, or made safer and more effective?

Collaborating with your colleagues, especially across disciplines, will help you discuss shared challenges and brainstorm solutions. I could not get "brainstorm" out for a second, but I finally did. Staying informed about your field is another part of it.

Kathleen, you mentioned reading newly released articles that your mentor shared with you. Staying informed about emerging trends, technologies, and best practices can help you identify new opportunities to innovate. Conferences are another great place to find ideas and see what others are doing.

You can also ask critical questions like, "Why do we do it this way?" and "Is there a better way to achieve this goal?"

VOLLMAN: Going to conferences too. You hear a lot, yes.

PIERCE: Those are the "why" questions. "Yes, and" is another really popular phrase in innovation. We do not say no. We say "yes", and how do we figure out how to get to the "yes, and" and away from the no?

So those are some important innovation questions. Is there anything else that you want to emphasize?

VOLLMAN: Very true. Just keep your mind open. There is so much that every nurse can do to create a better work environment for themselves and their patients through innovation.

PIERCE: Yes, and you can go online and read about so many nurses, even this year, last year, or twenty years ago, who have innovated and created solutions to problems. To me, that is inspiring to see how many people have contributed to healthcare. I wish there was more acknowledgment of how much nurses have brought to the profession and to healthcare overall, the positive changes they have made, and the evidence-based practices they have influenced. It is truly awe-inspiring when you look at it. It is very exciting. What do you think the future holds for nurse-led innovation?

VOLLMAN: For me, if we are willing to get out of our comfort zones, we could lead it all. We just have to take the necessary steps.

PIERCE: Yes, absolutely. Innovation starts with recognizing a problem and having the courage to think differently. It can be small adjustments or large-scale solutions. You never know where that idea might take you, but that idea has the potential to have a meaningful impact. As leaders, it is our role to foster a culture of creativity and collaboration because that is the key to driving change and improving patient outcomes.

VOLLMAN: I agree.

PIERCE: Yes. Thank you, Kathleen, for being here, for sharing your story, and for your support and excitement for innovation.

VOLLMAN: My pleasure.

PIERCE: Yes, such a joy to chat with you today. Thank you. To our listeners, in the theme of our discussion today, I want to close by encouraging you to stay curious, stay innovative, and continue to make a difference in your practice.

Thank you for joining us, and I encourage you to explore many of the courses available on EliteLearning.com to help you continue to grow in your career and earn CEs.