10-2012

Patient Care News: October 2012

St. Cloud Hospital

Patient Care News

October 2012

Standardized Antibacterial Honey (Medihoney) with Standard Therapy in Wound Care: Randomized Therapy

Review by Joyce Simones, RN, EdD, Professor – St. Cloud State University

Robson V; Dodd S; Thomas S; Journal of Advanced Nursing, 2009 Mar; 65 (3): 565-75

There has been an increase of the body of knowledge to support the use of honey in wound healing. Honey has been used to treat wounds for 4000 years. In respect to the emergence of antibiotic resistant strains of bacteria, this is an opportune time for research in this area. This original research article was a comparison of the use of medical grade honey with conventional treatments on wounds healing by secondary intention. Data of 105 patients were collected between September 2004 and May 2007. The median time to healing in the honey group was 100 days compared to 140 days in the control group. The healing rate at 12 weeks was equal to 46.2% in the honey group compared to 34% in the conventional group. Interesting in this review of the research, the researchers stated that the number of patients who were willing and able was less than expected due to the publicity that has been generated about the use of honey as a topical treatment. Because of the lack of blinding, some subjects allocated to the conventional treatment did not adhere to treatment and received honey as a result of patient pressure or external clinical decisions. The implication for practice is that honey is suitable for wounds at all stages of healing.

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IV Catheter Update

Submitted by: Joannie Nei, RN, BSN, Clinical Value Analysis Specialist

Situation: We recently switched from the BD Insyte to the B. Braun Introcan IV catheters. PVAC (Product Value Analysis Committee) requested user feedback in August and September on this conversion. The feedback on the new devices has varied widely. Some users have reported difficulty while others find the new catheter to be superior to the prior one. At the September PVAC meeting, the feedback was reviewed and extensively discussed to determine next steps.

Background: CentraCare obtained access to new IV catheter contracts in early 2011, presenting an opportunity to evaluate new devices. Criteria for evaluation included a preference for a **passive safety device**, quality and cost. Extensive investigation was conducted on five catheters from three manufacturers, including literature research, user testing, consultation with SCH Infection Prevention and Control and Employee Health, and consultation with other health care organizations. This year-long investigation, plus a month-long pilot in several units, resulted in a decision to convert to the Introcan in April, 2012.

Assessment: Reports from other facilities and our own experience with IV catheter conversions, tell us that the learning curve can be lengthy, especially given our large group of users who start IVs with varying frequency.

Literature supports the use of passive safety device and safety was an important criteria. We did have individuals experience needlesticks from the BD IV catheters and no needlesticks since the conversion.

In response to some reports of an increase in IV starts requiring multiple attempts, the data does not show an increase in catheter usage overall or per patient day/visit. While user feedback varied regarding sharpness, threading ease, length, etc., one frequent concern related to blood exposure. Although this wasn't a consistent issue, it was seen frequently enough that the committee recommended a small-group trial of another catheter to assess whether a different device would mitigate this issue.

Recommendation/Decision:

The following are the recommendations that were developed and approved by the PVAC:

1. Continue with the B. Braun IV catheters until they have been in use for at least a year, continuing to gather feedback and observe for trends.
2. Encourage units to purchase IV training models such as the one provided at the inservices for staff to use for practice. This has been beneficial for several areas.
3. Record all attempts in the patient's chart. This is required by policy.
4. The Cancer Center collected data for number of attempts on all patients within a specified timeframe and developed a flowsheet that worked well for them. Units are encouraged to do this as well and contact Joannie Nei for specifics.
5. Trial a new catheter from B. Braun called the Introcan 3 which has a blood control septum to prevent blood coming out the end of the catheter for further protection of staff. The trial will be completed by a team of unit staff members and PVAC members. The team will be comprised of staff willing to be part of the team and work together collaboratively on data collection, feedback and problem-solving. If you would like to be part of this team, please contact your PVAC representative (see list on page 2). 5-10 individuals from select units will then be identified and contacted for the trial. Please contact your PVAC representative by Wednesday, October 24th to indicate your interest in trialing the Introcan 3.

Product Value Analysis Committee Membership

Name		Facility/Department/Unit Representing	Role
Long Prairie Hospital and Clinic			
Ron Anderson		Long Prairie Hospital and Clinic	SCM
Darla Finke		Long Prairie Hospital and Clinic	SCM
Jodi Hillmer		Long Prairie Hospital and Clinic	Clinical
Long Prairie PV Team			
Melrose Hospital and Clinic			
Vern Dingman		Melrose Hospital and Clinic	SCM
Keri Wimmer		Melrose Hospital and Clinic	Clinical
Saint Benedict's Senior Community			
Shelly Jacobs		Saint Benedict's Senior Community	SCM
Wanda Leuty		Saint Benedict's Senior Community	SCM
Tom Wachlarowicz		Saint Benedict's Senior Community	
Clinics			
Patti Bruggeman		Heartland	
Donna Slettom		CentraCare Clinic River Campus	Clinical
Joyce Dingmann		CentraCare Clinic River Campus	Clinical
		CentraCare Women's and Children's	Clinical
		Other Clinics	
Saint Cloud Hospital			
Debbie Sadergaski		Contracting and Procurement	SCM
Marvin Kiffmeyer		Contracting and Procurement	SCM
Kris Peterson		Supply Chain Management and Support Services	SCM
Joannie Nei		Contracting and Procurement	SCM & Clinical
Jennifer Heidecker		Med 1, Med 2 and Oncology	Clinical
Peggy Lange		Respiratory	Clinical
Diane Gabrielson		North PACU/POH/CSC South PACU, Surgery & Central Processing Department, Surgery	Clinical
Bonnie Curtis		Intensive Care Unit and Surgical Care Unit	Clinical
Amy Junes		FBC/Women's Health	Clinical
Bridgette Worlie		Children's Center (NICU/PEDS/PICU) Child & Adol Specialty Care at Plaza Short Stay/Specialty Clinic	Clinical
Paul Schoenberg		ETC/Trauma Service	Clinical
Sam Stone		Endoscopy, OPS, Endo Plaza, Endo/Outreach	Clinical
Jenelle Brekken		Neuroscience, Spine, Sleep Center, Neurodiagnostics	Clinical
Kelen Sohre		Bone and Joint Center/Rehabilitation Center	Clinical
Mary Arnold		Cardiac Cath Lab (Electro-physiologists, etc.) Central MN Heart Center, ECG, EECP, Pacemaker, Echo, Cardiac Rehab, Stress Lab/Nuclear Cardiology,	Clinical
Laurie Annett		Telemetry, CPRU, CCU	Clinical
Brenda Swendra-Henry		Imaging	Clinical
Jeremy Angell		Lab	Clinical
Ellen Simonson		Infection Control	Resource
Karen Witzman/Karen Dinndorf		Employee Health Service	Resource
Kristi Patterson		Clinical Utilization	Resource
Greg Klugherz		SCH Administration	Resource
Ad Hoc Members (receive minutes and agendas to determine when to attend)			
Donna Braun		Dialysis	Clinical
Jane Vortherms		Coborn Cancer Center (Medical and Radiation Oncology),	Clinical
Cheryl Pflipsen		Home Care/Hospice	Clinical
Karen Kinsley		Surgery Center at Plaza	Clinical
Shar Wallack		Family Practice Clinic – Mid-Minnesota Residency	Clinical
Diane Buschena-Brenna		CentraCare Plaza – Surgery Center and Mid-MN	Clinical
Sue Omann/Amy Gorecki		WOCN	Clinical
Jennifer Kime		Administrative Nursing Supervisors; Patient Care Support	Clinical

Family Members' Informal Roles in End-of-Life Decision Making in Adult Intensive Care Units

Sponsored by the Nursing Research Committee
Submitted by Roberta Basol MA, RN, NE-BC

To support the process of effective family decision making, it is important to recognize and understand informal roles that various family members may play in the end-of-life decision-making process. This research ethnographic, prospective study was conducted in 4 intensive care units in one hospital. Participants included health care clinicians, patients, and patients' family members. 157 interviews were conducted with 130 participants. A six member research team used observation, field notes, and semi-structured interviews to examine different perspectives of the end-of-life decision making process. All interviews were taped and transcribed verbatim. Ethnographic research is the study of people in their own environment. The purpose was to identify key roles that family members played in end-of-life decision-making.

Eight informal roles were identified; primary caregiver, primary decision maker, family spokesperson, out-of-towner, patient's wishes expert, protector, vulnerable member, and health care expert. The primary caregiver was described as the person who had spent the most time caring for the patient prior to hospitalization. With admission to the ICU, the primary caregiver was confronted with the reality that it was no longer possible for him or her to care for the ill family member. The role of primary decision maker emerged when there was a need for surrogate end-of-life decision making. Sometimes this role was formally designated by other family members, other times a person was sought out by the nurse. At times there were multiple decision makers identified. The family spokesperson role was encouraged by clinicians because of the need to address families' needs for information efficiently and to facilitate the decision-making process. Many clinicians preferred to deal with one person. Three of the 4 ICUs had this role formally identified in their ICU brochure.

The out-of-towner, described as a family member who had not been involved in the daily care giving and may not have been engaged early in the ICU stay. This person often brought a different perspective to the in-town family's decision-making discussions. When the patient's wishes expert role was enacted, if the family members knew the patient's wishes, collectively the family felt more confident in their decisions. When a person was in the protector and the vulnerable family member roles, they were viewed as vulnerable for some reason, and another family took on the role of protector of the vulnerable person. Commonly these paired roles emerged when adult children believed they needed to protect an older parent. The health care expert was a family member who could influence decision making through a claim of clinical expertise, e.g. nurse, physician. Family members viewed this role as one that had the potential to facilitate the decision-making process.

The study discussion outlined how these roles may contribute to a potentially complicated family dynamic for end-of-life decisions. They also noted not all roles emerge in every family. Situations were other family members came together to support a single member as decision-maker or family spokesperson revealed consensus decision making was more easily achieved. The investigators suggest a closer examination of family meetings and the role of palliative care services, as a way to foster effective end-of-life decision making.

After you have read the summary of this article, please email Debbie Weber at weberd@centracare.com to have your name entered in a drawing for a meal ticket.

Quinn, J. R., Schmitt, M., Baggs, J., Norton, S. A., Dombeck, M. T., & Sellers, C. R. (2012). Family members' informal roles in end-of-life decision making in adult intensive care units. *American Journal Of Critical Care*, *21*(1), 43-51. doi:10.4037/ajcc2012520

Back to the Basics of Mobility

Written by: Eric Schloe, MPT, CWS

Medications. IV fluids. X-ray. MRI. Surgical procedures. All are possible interventions we provide to our patients when they are admitted to the hospital. We provide these interventions because they are medically indicated and have been proven effective for a given condition.

Much like the interventions mentioned above, mobilization is a critical component of a patient returning to health. As humans we are designed to be mobile. The effects of immobility can be severe, including blood clots, pneumonia, pressure ulcers, increased weakness and loss of independence. Improving mobility can lead to improvements in overall care such as removing Foley catheters sooner which reduces the risk of catheter associated urinary tract infections.

For patients with specific diagnoses, such as pneumonia and congestive heart failure, there are studies that show early mobilization to be effective at reducing the length of stay in the hospital and improving the patients' overall outcome. In reality, most of our patients can benefit from early and frequent mobilization after being admitted to the hospital. This is one area in which we have a big opportunity to make a difference.

Examples of mobility range from having a patient walk in the halls to sitting up in a chair to sitting at the edge of the bed with a variety in between. For patients who are not able to get to a chair, sitting at the edge of the bed offers a change of position and challenges the cardiovascular system while making patients activate core muscles that are important for sitting and standing balance. For patients who are able to stand at the side of the bed but not walk, standing forces them to use leg muscles that will be important for walking, allows muscles to stretch to prevent tightness, and further challenges the cardiovascular system.

Now that we've decided our patient needs to mobilize, we have to determine how that is going to happen. How we mobilize our patients is dependent on a few things. First, how did the patient mobilize prior to being admitted? If the patient wasn't walking prior to admission, chances are he or she will not be able to walk (at least initially) when admitted. Patients who have been transferring using a mechanical lift prior to admission would be expected to continue using a mechanical lift during admission. Second, what is the patient admitted for and has this made the patient weaker or unable to mobilize? For example, if a person is admitted with pneumonia, he or she may be weaker than normal but the pneumonia might not prevent the person from mobilizing. On the other hand, a person admitted with a hip fracture would be expected to have a harder time mobilizing than his or her baseline because of the pain associated with the fracture. Finally, does the patient's medical status allow for mobility out of bed? A person on mechanical ventilation may be able to sit at the edge of the bed or get to a chair, but walking down the hall isn't very likely.

Whatever the mobility is, start with the basics. Work on getting the patient sitting at the edge of the bed first. Then progress mobility as you are able. Remember to keep in mind to stay under the OSHA-mandated 35-pound lifting restriction. Stand next to the bed, move to a chair, walk short distances and gradually increase the distance. If at any point the patient is not able to perform the mobility without assistance, provide the appropriate level of assistance. If the amount of assistance exceeds 35 pounds, don't be afraid to use mechanical assistance such as an EZ Lift, EZ Stand, or ceiling lift. Having to use mechanical assistance is not an excuse to avoid mobilization.

Often times, if a patient is having a hard time mobilizing, physical therapy is involved to work on strengthening, transfer training, gait training and balance with the patient. But that should not be the only time the patient is mobilized for that day. In addition to the mobility performed in therapy, the patient can benefit from more time out of bed to the chair, walking to the bathroom instead of using a urinal or bedside commode, and taking walks in the halls. In addition, nursing does not need to wait until therapy has seen the patient to mobilize that patient. Do the best you can, whether that means having the patient sit at the side of the bed, getting them to the chair, or having them walk. We all need to be responsible for the patient's mobility, whether we provide the encouragement, the setup, the education, or the physical assistance.

Please keep the preceding tips in mind for your patients. Encourage them if they are able to mobilize by themselves and assist them if they can't. Mobilization, as with other interventions we provide, is critical to regaining overall health.

Critical Event Notice

Written by: Joy Plamann, MBA, RN, Kris Nelson, RN and Jennifer Burris, CNS

There was a situation recently in the hospital where a patient made very specific and significant threats to staff. Unfortunately, violence against health care workers is a growing problem at our hospital and across the nation. One of SCH's responses to this has been the requirement for patient care staff to attend training on violence prevention and aggression management. All verbal or physical threats should be taken seriously.

Please note the following information:

- When a patient threatens to harm a staff member, security should be notified immediately. They will come up and assess the situation which may involve interviewing the staff member, interviewing the patient, and notifying the police department.
- Documentation should occur as an event note. For example:

  Event note: Threatening behavior:

  D: After explanation of need to draw blood, patient became extremely upset. Yelling, using foul language, and making specific threats to staff. (In these cases, it would be good to cite the exact words the patient uses in the threat).
  A: Attempts to calm and provide explanations failed. Code Green called. Security notified of threats made. Patient interviewed by security. MD notified.
  R: Patient appeared calm after security visited with patient.

  Progress Note: No further outbursts of threatening behavior. Plan of care updated to address safety measures for staff.

- An FYI flag should be added to alert staff during this and subsequent hospitalizations of the patient's behavior. You should add a "special health care needs" flag and indicate, for example: "Patient has exhibited behavior outbursts and made threats to harm staff".
- Update the care team communication that an event has occurred to promote thorough shift to shift report.
- The plan of care should be updated to promote consistent actions with the goal to decrease these behaviors and keep staff safe. Consult a Case Manager and/or a CNS to assist with the development of this care plan.
- Below is an example of a care plan that was added after a threatening event occurred.

  Problem: Risk for Injury to self and others
  Description: Has expressed threats and threatening behaviors to hospital staff, particularly females
  Goal: Decrease Behaviors
  Description: Goal is no verbal or physical threats to staff. Ensure staff safety.

  - Initiate measures to protect staff and other patients
  - If verbal or physical threats made, notify security immediately.
  - Assign male caregivers as possible.
  - Case Management to follow – recommend Behavioral Case Manager.
  - Security to accompany patient at discharge.
  - Place sign outside door instructing staff to contact nurse prior to entering room. (This was written for purposes of alerting lab, housekeeping and other hospital staff who may enter room).
  - Cluster cares and minimize unnecessary interruptions.
  - Keep door open. Maintain visibility of staff from hallway when in room.
  - If privacy necessary or unable to maintain intervention above, 2 staff should be in room.
  - Implement personal safety measures.
  - Do not allow patient between staff and exit.
  - Keep door open and lights on for intervention
  - Personal alarms recommended
  - Identify triggering behaviors or events that escalate the patient

- Everyone has varying levels of tolerance for patient behaviors – and, **in all cases**, threats need to be reported and staff supported.

Questions may be directed to Joy Plamann, Medicine Care Center Director and Chairperson of the Aggression Management Task Force: Plamannj@Centracare.com.

October 5th is Founders' Day

Submitted by: Mallory Mondloch, RN, BS, PHN

The Honor Society of Nursing, Sigma Theta Tau International (STTI): In 1922, six nurses founded STTI at the Indiana University Training School for Nurses (now the Indiana University School of Nursing in Indianapolis, IN). The founders chose the name *Sigma Theta Tau* from the Greek words Storgé, Tharsos and Timé meaning "love," "courage" and "honor." Every October 5th, known as *Founders' Day*, we celebrate those six founding nurses who established the honor society of nursing

Now, 90 years after it was first established, STTI has over 125,000 active members residing in more than 85 different countries. There are currently 486 chapters at institutions of higher education throughout the world, including those in the US, England, Kenya, Hong Kong, and Australia, just to name a few. *Founders' Day* is the time we recognize the founders' for their contribution to professional nursing, the value of scholarship, and appreciate the impact that STTI has on nursing worldwide.

Our local chapter of STTI, *Kappa Phi-at-Large*, invites you to come and learn more about what STTI has to offer in honor of *Founders' Day*. Active members from *Kappa Phi-at-Large* will be hosting an informational table in Riverfront Dining at the St. Cloud Hospital on October 4th from 11:00 am to 1:00 pm. These members will be speaking about the membership benefits, raising awareness about STTI's mission, and be available to answer any of your questions. Treats will be provided for participants that attend this informational table. We hope to see you there!

If you are unable to attend the informational table but would like more information, please visit www.nursingsociety.org.

Funeral Directors to Use "C" Level Garage for Removal of Deceased

Submitted by: Barb Scheiber, RN, BSN, NEC, Director of Patient Care Support

Effective 7:00 am on Tuesday, October 9, 2012, Funeral Directors will no longer use the ETC entrance for removal of bodies. They will be given a temporary badge and elevator key to access the K5 (staff elevator) in the East addition. The Urology Tech (Orderly) will no longer accompany them for every removal on the units. If the body is in the Morgue, the Urology Tech will still need to be called.

Since the east addition is new to them, please assist with navigating to the correct room when needed. Funeral Directors will use the K5 elevator, which is the only one that goes to the "C" level. It is the elevator farthest to the left. If Funeral Directors need assistance accessing the elevator, your help is most appreciated. However, staff are not allowed to accompany them to the "C" level. Only a Urology Tech, Security Officer, or Administrative Nursing Supervisor are authorized for "C" level access.

Thank you in advance for any help you can offer Funeral Directors as we begin this new process.

Daisy Award Honoree

Margaret (Peg) Laraway, RN, Family Birthing Center. Comments from her nominations included: Peg is a post-partum nurse on FBC. Peg gives caring, compassionate nursing care to every one of her patients. Quality, Patient and Family Centered care is evident in Peg's work. She includes the patient and her family in the plan for the day, updates other care providers as needed and respects all people. The quality of nursing care is of utmost importance to Peg. Peg is a great teacher for staff, students and her patients.

A SCH DAISY nurse demonstrates compassion and clinical excellence for his/her patients and families using patient and family centered principles and is an outstanding example of the core values of SCH through their daily work. Throughout the year, St. Cloud Hospital (SCH) employees, Medical Staff, patients and their families can nominate a nurse for the DAISY Award. SCH LPNs, RNs, and APRNs working in designated care centers or employed by SCH are eligible for the award. To nominate a nurse or learn more about the DAISY award, go to CentraNet/ Recognition/DAISY Award, download a form, fill it out and send to Brenda Ackerman in Administration.

Clinical Ladder

Congratulations to the following RNs for achieving and/or maintaining their Level III Clinical Ladder Status:

Josie Asplund — Oncology
Oncology Certified Nurse
Creator: Oncology Nursing Resource: Leukemic Patient
Medication Safety Committee

Jennifer Couzens — Surgery
Certified Perioperative Nurse
Presenter: Day in Surgery & Anesthesia Overview
Perioperative Conference Planning Committee

Robert Davidson — Post Anesthesia Care
Critical Care Certified Nurse
PI Committee
EBP: Family Visitation in the PACU

Julie Dockendorf — Medical 2
Medical Surgical Certified Nurse
Facility Planning Move Committee
PI: Code Blue & Volumes Audit

Melany Jungles — Surgical Care 1
Medical Surgical Certified Nurse
Presenter: Cultural Considerations
ROE Committee

Carol Thelen — Coborn Cancer Center
PI: 7 Audit
EBP Lead: Family Presence During Radiation
ROE Committee

Kristi Tomporowski — Surgical Care 1
PI: JCAHO Tracer Audit
SCRUBS
Preceptor

Lynn Wellner — Medical 2
EPIC Super User Committee
EBP: Skin Ulcers on Admission
Staff Governance

Upcoming Education & Professional Development

October 2012

1/2	Pediatric Cert Review Course, 7:30am- 4:00pm, Windfeldt Room, Plaza
5	NCI Initial Course, 2:00pm-10:30pm, Spruce Room
9	5th Annual Lessons for Professionals: Optimizing Care for the Seriously Ill and Dying Patient, 7:30am-4:30pm, Windfeldt Room, Plaza
11	NCI Initial Course, 7:30am-4:00pm, Windfeldt Room, Plaza
16	NCI Refresher Course, 8:00am-12:00pm, Hughes Mathews Room, Plaza
16	NCI Refresher Course, 12:00pm-4:00pm, Hughes Mathews Room, Plaza
19	PEARS Course, 8:30am-3:30pm, Skyview Conference Room
22	ACLS Refresher Course, 9:00am-5:30pm, Aspen Room
25	Harvest the Fruits of Orthopedic Nursing 2012, 7:30am-4:30pm, Windfeldt Room, Plaza
25/26	Basic ECG Course, 8:00am-4:00pm, Skyview Conference Room
29	NRP Course, 8:00am-12:00pm, Oak Room
29	NRP Course, 1:00pm-5:00pm, Oak Room
31	NCI Initial Course, 8:00am-4:30pm, Aspen Room
30/31	TNCC Initial Course 7:30am-5:30pm, St. Cloud Hospital Conference Center

Please call the Education & Professional Development Department at ext. 54268 if you have any questions.

Linda Donabauer passes the Clinical "Ladder" to new Facilitator, Jeanne Friebe effective October 1st.