11-2004

Nursing News: November 2004

St. Cloud Hospital

NURSING NEWS

Volume 25, Number 11 **St. Cloud Hospital, St. Cloud, MN** **November, 2004**

Insulin Dose Removed from the Medication Administration Record (MAR)

Following a recommendation by the Insulin PI Committee to the Clinical Patient Care Council and the Pharmacy and Therapeutics Committee it was decided to remove the insulin dose from the MAR. The insulin product and time of administration will continue to display on the MAR.

The reason for the change is to focus the caregiver on referring to the Insulin Order Sheet for the current dose. Medication safety events have occurred as a result of a failure to update a dosage change on the MAR in a timely manner. The Insulin Order Sheet is recognized as the most complete profile of insulin therapy and is therefore the best source of information.

The charting of the insulin administration remains on the Blood Glucose Record.

The change will be effective November 11, 2004. Please contact me with any questions.

Arne Tilleson
Clinical Coordinator, Pharmacy

Improving Nursing Practice for the Benefit of Patient Safety

Nursing Practice: When a patient is receiving a medication using the transdermal delivery system (example, Duragesic (Fentanyl), Catapress) it is important to check for the presence and dose of that patch at the time of admission. This should be documented on the MAR.

Rationale: There is a potential for multiple patches to be in place because a previous patch was not removed. This results in the potential delivery of more than the prescribed dose and may lead to adverse effects such as sedation or alteration in vital signs.

Our current documentation does not require documentation of removal. Effective immediately, the MAR will be modified to include a place to document the time of removal for transdermal medication. In the case of Duragesic, a space for the witness to initial wasting will be available. Remember a Duragesic patch should be cut in half and placed in the sharps container after it has been removed. You should wear gloves and the waste must be witnessed because it is a Schedule II Medication.

Kay Greenlee, RN, CNS
Clinical Utilization Coordinator, Pain Resource

"Look Alike/Sound Alike" Medications – Chapter XIV

Medication error reports are caused by drug names sound or look the alike. They may not look alike in print or sound alike when read, but when hand-written or verbally communicated, these names could cause a mix-up.

EFUDEX	EURAX
eldepryl	enalapril
fentanyl	sufentanyl
FLOMAX	VOLMAX
FLUDARA	FUDR
guaifenesin	guanfacine
hydralazine	hydroxyzine
IMDUR	IMURAN
lamivudine	lamotrigine
metronidazole	metformin

Sound Alike Numbers: 18 and 80 (To clarify numbers, say "eighteen: one-eight" or "eighty: eight-zero.")

The above list includes recent and common mix-ups that have occurred and those that have the potential to cause a mix-up, nationally or here at St. Cloud Hospital. (Brand names are capitalized.)

Nancy A. Sibert

Medication Safety Pharmacist

Minnesota Department of Health Adverse Health Events Reporting Law: Minnesota's 27 Reportable Events

One serious medical error is too many, which is why a coalition of Minnesota hospitals, doctors, nurses and patient advocates backed a new law creating a system to reduce medical errors and make care safer.

Minnesota's new Adverse Health Events system is designed to create a culture that promotes reporting, encourages hospitals to share what they have learned and focuses on fixing problems rather than assigning blame.

This fall, the Minnesota Department of Health will release a list of adverse health events that occurred at Minnesota hospitals between July 1, 2003, and June 30, 2004. The report will name the specific hospitals where the events occurred. The Minnesota Hospital Association hopes to coordinate the release of the Adverse Health Events information with the Minnesota Department of Health.

Because St. Cloud Hospital will be on the list, your family and friends may ask you questions about it. We will provide you with more information as the plans for the announcement solidify.

Below is a list of the "27 Never Events" that hospitals are required to report to the Minnesota Department of Health upon full implementation of the law. During the transition period for the new law, these events, findings from root cause analyses and corrective action plans, are to be reported to the Minnesota Hospital Association.

The language is taken directly from Minnesota statutes 144.7065.

Surgical Events

1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
2. Surgery performed on the wrong patient;
3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and
5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

1. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;
2. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Device includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and
3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

1. An infant discharged to the wrong person;
2. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and
3. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Care Management Events

1. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
2. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
3. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
4. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;
5. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;
6. Stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission; and
7. Patient death or serious disability due to spinal manipulative therapy.

Environmental Events

1. Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;
2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
3. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;
4. Patient death associated with a fall while being cared for in a facility; and
5. Patient death or serious disability associated with the use of or lack of restraints or bedrails while being cared for in a facility.

Criminal Events

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;
2. Abduction of a patient of any age;
3. Sexual assault on a patient within or on the grounds of a facility; and
4. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

Smoke Free Communities Coalition Conducts Survey

In February, the Minnesota Department of Health awarded $222,358 to the Central Minnesota Heart Center at St. Cloud Hospital as part of the 2004 Tobacco-Free Communities grants.

The Heart Center leads an advisory coalition made up of community partners seeking to create a region-wide smoke-free indoor public policy to increase the number of smoke-free work sites, including bars and restaurants. Jodi Rohe, whose office is in the Heart Center, was hired to coordinate this effort for the six-city area, which includes the municipalities of St. Augusta, St. Cloud, St. Joseph, Sartell, Sauk Rapids and Waite Park.

Currently, the Smoke Free Communities coalition is working with the University of Minnesota to conduct a community opinion survey on secondhand smoke. Once complete, the coalition will share the results with local decision-makers to inform them of how their constituents feel about clean indoor air and smoke-free environments.

This two-year grant runs through December 31, 2005.

Communications Dept.
St. Cloud Hospital

"What can you do to help ensure that a complete (with regulator) oxygen tank is available when you need one?"

Starting November 30th, we need you to help implement and continue to do the following:

- Each unit (other than Critical Care and ETC) will have a pad of Oxygen Tank Request Forms available.
- Charge nurse on the night shift on each of the units will be responsible that this form is completed by delegating it to the appropriate person on the unit

  - Suggestions to help remember to do this
    - Attach form to your clipboard
    - Include on any checklist of duties that you have on your unit
    - Include on your assignment sheet as a reminder

- Form needs to be completed and tubed to Distribution (in place of the current phone call) by 3 a.m. on every night shift.

"How is the form completed? Just 5 easy steps."

- **First**, turn on each oxygen tank and read regulator to check psi on **every** tank.
- **Second**, indicate number of empty complete oxygen tanks on the form.

  - **What is meant by empty complete tank?**
    - **An empty complete oxygen tank has a psi of 500 or less and includes the tank, regulator and key (all three must be present).**

- **Third**, place **all empty** oxygen tanks in soiled receiving room by 3 a.m. **These will be picked up by Distribution and replaced as needed to reach your PAR level. DO NOT REMOVE THE REGULATORS.**
- **Fourth**, indicate number of complete oxygen tanks with psi greater than 500 on the form. **This is needed so that Distribution knows how many new tanks you need.**
- **Fifth**, place all these tanks in the clean receiving room.

We need your help for us to help you. Please contact Peggy Lange (ext. 54304), Keith Gerding (ext. 54643), or Joannie Nei (ext. 55753) if you have any questions.

Thank you for all your help in making sure tanks will be available when needed.

Central Minnesota Heart Center at St. Cloud Hospital Ranks in Nation's Top 100 for Sixth Consecutive Year

The Central Minnesota Heart Center at St. Cloud Hospital was named one of the 100 Top Cardiovascular Hospitals in the United States for the sixth consecutive year – one of only seven hospitals in the nation to accomplish this feat.

Solucient, an Illinois health care data repository, chooses Top 100 hospitals nationwide that treat a broad spectrum of cardiology patients and meet patient volume criteria established for the ranking. Solucient developed the *100 Top Hospitals: Cardiovascular Benchmarks for Success* study to identify the nation's outstanding cardiovascular hospitals and to set performance standards for care.

The Solucient study found that:

- If all acute care heart hospitals performed at the same level as the nation's top heart hospitals, survival rates for cardiovascular patients could increase by 4,200 patients each year and an additional 1,600 patients could be complication-free.
- The survival rate for congestive heart failure at benchmark hospitals is nearly 23 percent higher than at non-winning hospitals.
- The survival rate for acute myocardial infarction, or heart attack, at benchmark hospitals is nearly nine percent higher than at peer hospitals.
- Cardiovascular patients at benchmark hospitals stayed fewer hospital days – 4.92 days versus 5.45 days – than at peer hospitals.
- Average cardiovascular-related costs for benchmark hospitals were $10,588 versus $12,192 at peer hospitals.

"Every employee, physician and supporter of the Heart Center's work is to be credited with this great achievement," said Bob Johnson, Executive Director of Central Minnesota Heart Center. "Together, we are creating a program of vast significance for those we serve and are all doing our part in the prevention, discovery and management of heart disease in our region."

Cheri Tollefson Lehse
Communications Specialist, St. Cloud Hospital

Educational and Professional Development Programs

January, 2005

21st	BLS Instructor Renewal Course, SCH Conference Center

February, 2005

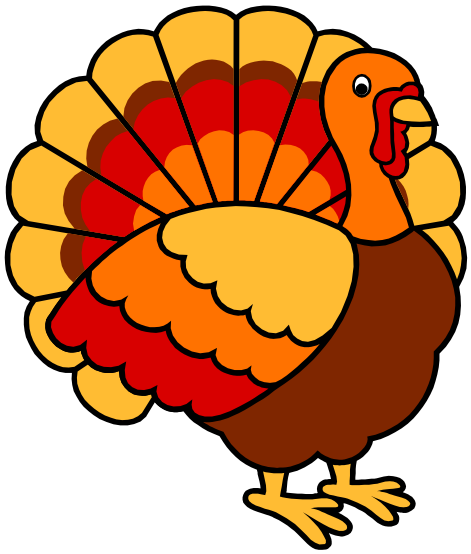
1st	TNCC Renewal, Conference Center
7th	Cardiology Seminar, Windfeldt Room
11th	BLS Instructor Renewal Course, SCH Conference Center
18th/25th	BLS Instructor New Course, SCH Conference Center

March, 2005

21st/22nd	ENPC Initial, SCH Conference Center
23rd	Social Worker's Event, Hoppe Auditorium
29th/30th	TNCC Initial, SCH Conference Center

Call Ext. 55642 for more details.

Happy Thanksgiving!



Please send items that you would like included in the *Nursing News* to Deb Kaufman in the Patient Care Support office via interoffice mail, e-mail, or by calling ext. 54230. The deadline for items is the 22nd of each month.

Congratulations to the Following For Achieving and/or Maintaining Their Level IV & III Clinical Ladder Status!

Level IIIs

Janet Kociemba, RN FBC

- Perinatal Loss CCP
- Student Preceptor
- Prenatal Classes
- RTS Posters
- MPO Planning Committee
- Member MPO-GPO
- RTS Support Group, Antepartum Council, RN/LPN Pairing Task Force
- Somalian Movie for Patients

Colleen Layne, RNC CSC

- Tours for Perioperative Open House
- Unit Hostess for Magnet Visit
- Preceptor
- Good Catch Reporting Poster
- Sigma Theta Tau Member
- Medical/Surgical Certification

Doreen Schultz, BSN FBC

- Unit Hostess for Magnet Visit
- Magnet Poster Story Boards
- PI Committee
- Taught C-Section Portion of Labor and Delivery Class
- Perinatal Committee
- EMR Committee

Michelle Scepaniak, BSN Peds/FBC Float Pool

- Craniofacial Advisory Board Member
- Child Passenger Safety Inservices and Clinics
- Magnet Flash Cards, Scavenger Hunt and Magnet Forces Posters
- Poster for Cleft Lip and Palette
- Sigma Theta Tau Member

Carol Steil, RN, CCRN CCNS

- Nursing Process Core Group Leader
- Certified Donor Requester
- Preceptor, Nursing Students/Paramedics
- Cardiovascular Surgery Inservice
- Preceptor
- CNPC
- CMAC-AACN
- CCRN