6-2006

Patient Care News: June 2006

St. Cloud Hospital

PATIENT CARE NEWS

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St. Cloud Hospital Prepares for Pandemic Influenza

Many experts warn that the world is overdue, and unprepared, for a global influenza outbreak. You may have read or watched media reports about the specter of pandemic flu and the estimated tens of thousands of deaths that could result.

The U.S. Centers for Disease Control and Prevention assumes that:

- More than 1 million people in Minnesota would fall ill;
- 15,000 to 172,000 of these people would be hospitalized;
- 3,600 to 23,900 would die.

Although it is impossible to know when – or whether – a flu pandemic could break out, it is important to prepare.

Readiness planning at SCH

"Surge capacity" is the ability to manage increased patient care volume that otherwise would severely challenge or exceed the existing medical infrastructure. A surge capacity committee at St. Cloud Hospital is working on a plan to determine how we would:

- ensure that we have enough staff, supplies, and equipment available to meet the demand;
- safeguard employees and their families; and
- isolate flu patients to deter spread of the illness.

The surge capacity committee is addressing dozens of related issues as well.

Several hospital leadership staff members also are involved with the regional bioterrorism preparedness group, whose work has provided a basis for flu planning, education and training. This group is participating this month in a pandemic flu teleconference hosted by the Minnesota Department of Health, and is conducting a tabletop drill.

St. Cloud Hospital also is working with area clinics and Stearns County Public Health on community-wide pandemic flu preparedness.

Special rooms for flu patients

St. Cloud Hospital has two dozen negative air pressure rooms (now referred to as Airborne Isolation Rooms) that could be used for isolating patients. These rooms are spread across the house. Additionally,

the two newly remodeled wings on sixth floor feature 18 negative pressure rooms (Airborne Isolation Rooms), giving SCH the ability to create two entire wings of negative pressure.

Personal Protective Equipment (PPE)

Full barrier precautions are recommended for care of inpatients in a pandemic flu situation. N95 masks, gown and gloves will need to be worn. The hospital has a supply of N95 masks, as well as numerous other devices in smaller quantities. Anyone who wears an N 95 respirator will need to be fit tested. More information will be shared on this topic at a later date.

More information to come

As the surge capacity committee's work progresses, they will share information with employees via supervisors, newsletters, e-mail and CentraNet.

How to protect yourself, your family

Health officials encourage you to:

- Wash your hands frequently;
- Cover your nose and mouth when you cough or sneeze, using your sleeve or a tissue (throw the tissue away when you are done);
- Stay at home when you are sick and keep your children home when they are sick;
- Put together a flu care kit and keep it around your home (include things like pain and fever medications, tissues, a thermometer, instant chicken soup, tea and fruit juice);
- Keep a first aid kit and a supply of food, essential personal care items and essential medicines in your home – enough to last for several days – in case you or your family need to stay home for an extended period.
- Keep a battery-powered radio and battery-powered flashlight with extra batteries;
- Keep on hand special items for infants, the elderly and pets;
- Keep in a safe, but handy place: wills, insurance papers, medical records, inventory of possessions, identification;
- Set up a neighborhood or faith community network, so people have a way to care for each other;

Are we at risk from avian flu?

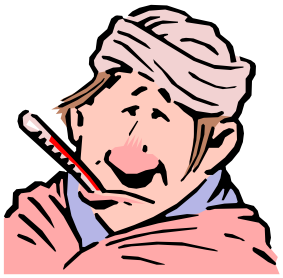
The strain of "bird flu" currently infecting people in Asia is not easily transmitted from person to person. For the most part, people get it from handling or other close contact with birds. In order for the flu to pass easily from person to person, the virus would have to change its genetic makeup. Because health officials are concerned that the avian strain could mutate, they are watching it closely.

It is impossible to predict whether a mutated avian flu would result in a major pandemic, like the one that happened in 1918. It could end up causing a milder pandemic, like those that occurred in 1957 or 1968.

Interested in learning more about pandemic flu?

The following Web sites are good sources of information:

- www.cdc.gov
- www.health.state.mn.us
- www.72hours.org
- www.ready.gov



This article includes information from:
Sally Petrowski, R.N., St. Cloud Hospital Infection Control Specialist;
The Minnesota Department of Health, Stearns County Public Health; and
St. Cloud Hospital's Occupational Health Department

Vaccines

Vaccines are important for everybody: children, adults, people with chronic medical conditions, healthcare workers, and those who travel outside the United States. You all know that there are vaccinations for pets too, and are very important to them as well.

No doubt about it, vaccination is one of the greatest accomplishments of the 20th Century. Vaccination reduces the incidence of serious infectious diseases, reduces the cost of health care, and improves over all wellbeing. Vaccines build defenses against future infections. **Besides helping you, vaccines protect your family, your patients, and anyone around you. Simply put, if you are not vaccinated, you could make others sick.**

There are risks associated will all vaccines. The most common local adverse reactions include pain at injection site, swelling and erythema. The most common systemic reaction includes headache, body ache, tiredness, and fever. **No vaccine awards 100% protection or immunity.**

1. **Influenza Vaccine:** Epidemiological data suggest health care workers can spread the highly contagious influenza virus to patients in their care. While many hospital facilities conduct influenza vaccination programs only 36% of healthcare providers receive the vaccine each year. For SCH, we have slightly higher participation. This influenza season 2006-07, a signed declination will be asked from the HCW. The use of the signed declination is a joint recommendation by the ACIP and the Health Care Infection Control Practices Advisory Committee. It applies to all health care workers in hospitals, nursing homes, physician offices, urgent and outpatient clinics.

2. **Pneumococcal Vaccine:** Pneumococcal disease kills more people in the USA each year than all other vaccines-preventable diseases combined. Although ANYONE can get pneumococcal disease, people over 65, the very young, and those with chronic medical problems are at higher risk. Usually one dose is all that is needed. However, a 2nd dose may be given after age 65.

3. **Acellular Pertussis Vaccine:** In the past 2 decades an increase in pertussis has been reported in the US especially among adults and adolescents. Please note that individuals can become susceptible to pertussis **again** after being infected and/or after vaccination.

   The 2 recently approved vaccines for adolescents & adults have been found to be very effective. This new vaccine (ADACEL) may be used in place of routine tetanus booster shots. Recommended boosters are every 10 years.

4. **Meningococcal vaccine:** Meningococcal disease is a rare but deadly bacterial infection. The disease often begins with flu-like symptoms (fever, headache, stiff neck, vomiting) but can quickly progress (within 48 hours) to serious complications such as meningitis, sepsis, including death. The disease is transmitted through the exchange of respiratory and throat secretions, usually by close and personal contact.

   Meningococci are classified based on their capsular polysaccharides in 13 subgroups, the most common are caused by A, B, C, Y, and W 135.

   a. The predominant subgroup for children under 5 is B. There is currently no vaccine to prevent subgroup B.

   b. In later adulthood (65 & older) Subgroup Y is predominant.

   c. In January 2005, the FDA approved a new vaccine called Menactra. This vaccine like Menomune protects against A,C, Y, and W-135. The target ages for these vaccines are young adults and college students.

5. **Rotavirus vaccine:** Rotavirus is the major cause of severe diarrhea in infants and young children. Did you know that most children are infected with this virus by age 5. The first vaccine approved in 1998 was withdrawn from the market in 1999 because of questions with safety. However, a new vaccine (RotaTeq) already used in other countries has recently gained approval by the FDA. The vaccine is licensed for infants between the ages of 6 and 32 weeks.

6. **Measles, Mumps, Rubella (MMR):** Proof of vaccination/immunity from mumps, measles, and rubella are required for work in a health care facility. Adults born before 1957 are presumed to have been exposed and have developed immunity.

   At SCH, a newly hired employee (regardless of where they work) is required to submit childhood immunization records prior to general orientation.

7. **Varicella vaccination:** Also highly recommended vaccination for all adults especially those who work in health care.

   You have immunity to varicella (chicken pox) if you:

   a. Have evidence of varicella vaccination
   b. Born in US before 1966
   c. Have history of chicken pox disease.
   d. Have history of herpes zoster.
   e. Have laboratory evidence of immunity

Sources/References:

- Immunization Action Coalition, St. Paul, MN
- First Report (Vaccine Consultant), January 2006
- Got your Shots? News, MDH
- Department of Health and Human Services, CDC

Submitted by:
Fay T. Chawla, BSN, MS,COHNS/CM
Adult Nurse Practitioner/Director
Occupational Health Services/Workers' Compensation

MicroMedex: PMIs & IV Compatibility

Micromedex was upgraded on May 31st. It has a new look and functionality to the components that many patient care staff use: Patient Medication Information and IV Compatibility.

Reference guides explaining how to use these upgraded features should be posted on your unit. If not, please contact your unit staff educator for a copy.

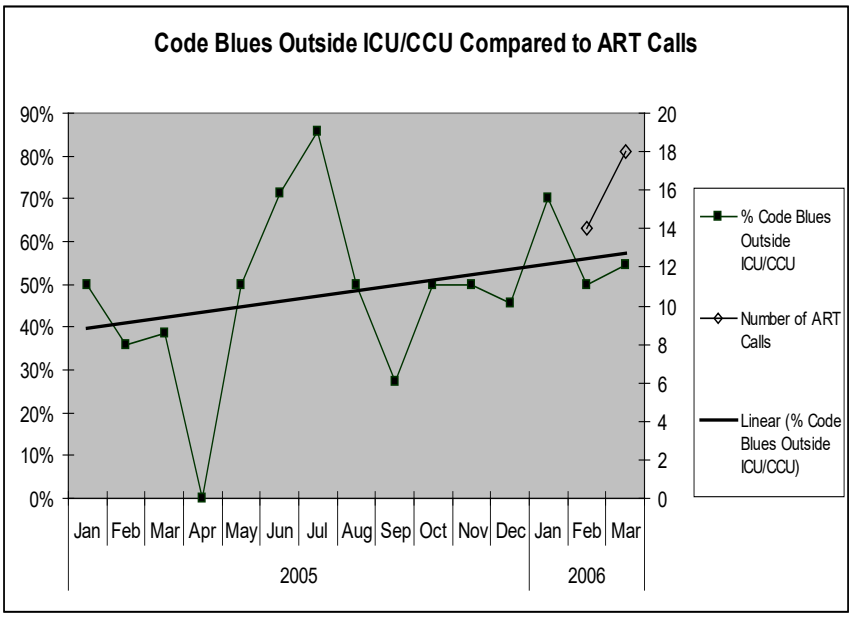
Thank you!
Michelle Parson, RN
Information System, CCHS

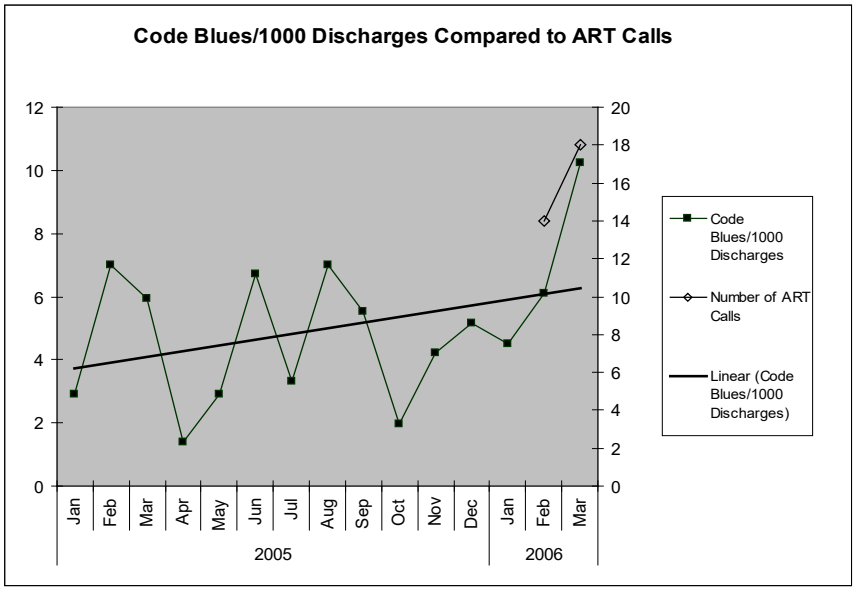
Acute Response Team

Below are the outcomes of the first two months of the ART calls. There were no CART calls during this time. Feedback from the evaluations is overwhelming positive in relation to the support of patient care. Thank you for helping our patients by placing an ART call. Over time we hope to see fewer code blues outside of ICU/CCU as well as overall reduction in the number of code blues. The ART team will soon be coming to calls with a cardiac monitor, oximeter and NIBP to assist in the assessment. Keep up the great work everyone!

Outcome Measures/Findings * = IHI measures	**3rd Quarter Feb-Mar 2006**	
	Mar	**Feb**
Number of ART Calls *	18	14
Code Blues outside ICU/CCU * **(excl Surgery, PACU, NICU, ETC out of hospital arrests)**	n=12 55%	n=6 50%
Number of codes/1000 inpatient discharges * **(excl NB & NICU)**	10.24	6.10
Patient Outcome:		
Stabilized with ART intervention	56%	50%
Transferred to higher level of care	39%	50%
Code Blue called	0%	0%
Expired	0%	5%
Location of ART Calls		
AMHU	1	1
CSC	1	0
Family Birthing Center	1	1
Med 1	2	2
Med 2	2	2
MPCU	1	1
Onc	1	1
OPS	0	1
Ortho/Neuro (records report “Ortho/Neuro”)	4	0
Rehab	0	0
Surgical Care Unit	1	1
SPCU	1	2
Telemetry	3	2
Attending Physician Specialty		
Hospitalist	11% (2)	29% (4)
General Surgeon	11% (2)	7% (1)
Orthopedic	6% (1)	0%
Family Practice	17% (3)	14% (2)
Internal Medicine	39% (7)	36% (5)
Cardiology	11% (2)	0%
Other	6% (1)	14% (2)
Average length of time of ART call	30 mins (8-72 mins)	28 mins (8-65 mins)
Team arrived within 5 minutes of call	100%	93%
Team was responsive and helpful	100%	100%
SBAR Communication clear among the team	100%	100%
Actions improved condition of patient	89%	79%
All supplies and equipment available and working	94%	93%
If physician involved, did physician do what was requested?	100%	93%
Overall evaluation of team effort:	1 critique not completed	
Good	94%	100%
Fair	6%	0%
Poor	0%	0%

Acute Response Team Data
Feb-Mar 06





COMMENTS OR SUGGESTIONS FOR IMPROVEMENT:

Feb:

- Very reassuring.
- My only patient in ICU was being prepared for a S/G insertion. Felt somewhat difficult to leave unfinished business in unit.
- Could we ask the charge nurse to document?
- Overall very positive.
- Who is to fill out the ART record?
- When the ART arrived there were already two physicians present. Pt's BP had returned to normal and the MDs had regretted calling the ART.

- Staff had all necessary monitoring equipment available, very helpful. Also able to give a lot of helpful information about the patient.
- RT suggested that unit involved also call their assigned therapist (not just charge RT).
- While bed not immediately available for transfer, we requested Levophed to be sent to floor to get started. Would this be permissible while ART nurse present? If so, pharmacy needs to know this is permissible.
- Front bottom of ART record should state "progress notes".
- Patient condition stable on transfer to CCU.
- Both primary RN and ART RN should be present when calling MD if primary RN will be the one speaking with MD.
- Was very helpful, RN on floor as 1:1 with patient for 90 minutes prior to call.
- ___ RN and RT did an excellent job along with patient.
- Strong assessment skills. Helpful suggestions.
- Non-rebreather applied 10 minutes before arrival of ART team with improved saturations.

Mar:

- (One blank critique)
- Good response by hospital personnel. Patient did not respond to interventions.
- Everyone worked well together. It was very beneficial to have the members of the ART team together to discuss the case and the multiple issues and get everything done so efficiently.
- Team responded perfectly. Good patient outcome. Team did excellent job.
- ___ was extremely helpful. Made appropriate suggestions and was able to facilitate the transfer to ICU much quicker.
- Excellent help and response.
- Maybe for team to come back and assess in 2 hrs or so…. I did call them to update them though as actions did not improve patient's status much. Improved O2 sats but HR and BP remained elevated.
- Patient's respiratory status rapidly improved after arrival of ART team. Prevented transfer to ICU.
- Great job. Thank you for the help and reassurance.
- This particular patient was DNR/DNI. Family does not want certain meds given to pt so ART team was helpful to get pt stabilized. Good job.
- Good response and outcome.

SYSTEM ISSUES:

Feb:

- Team arrived within 5 minutes of call: One event of RCP arriving 10 minutes after ART call made due to not hearing pager.
- Unable to contact attending physician. Paged attending and partner physicians (two) stat for 2 hours, 55 minutes before call returned. Oximeter reading inconsistent.
- ART called overhead, paging operator informed of error (not on pager). Should have paged "Adult Response Team" instead of ART team.
- ART called overhead on intercom instead of pager.
- The ART team was called and CRNA to intubate patient. Everything went well and we got the patient to ICU within about 30 minutes from when ART was called and patient intubated on floor after transfer. No ICU room was available when team first called.
- ART team called for near respiratory arrest which became respiratory arrest. ART RN felt lack of support to address all patient issues and needs.

Mar:

- ART call cancelled by physician moments after called.
- Did not have equipment available to improve patient's respiratory status, pt. transferred to ICU. (Requested ambu, non-rebreather, suction, suction tubing) (AMHU)

Roberta Basol
Director, Intensive Care Unit

Congratulations to the Nursing Research Award Winners!

The St. Cloud Hospital Nursing Research Committee would like to announce the recipients of the first annual Nursing Research and Scholarly Activity Awards. These awards have been initiated to recognize nursing accomplishment in research and application of research and evidence in the arenas of practice and education. Recipients were selected from applicants and nominees that were current nursing employees or affiliated faculty members meeting the specific award criteria. The awards were given at the St. Cloud Hospital Nurses' Week breakfast on May 4, 2006. The work of the following nurses is commended.

- **Overall Award for Excellence in Nursing Research**
  Roxanne Wilson, RN, MSN. For the development of a hospital nursing research plan and framework, development of research collaboration, development of evidence based projects, and affording a vision accompanied by commitment and endless energy.
- **Outstanding Achievement in the Application of Evidence Based Practice**
  Kirsten Skillings, RN, MA, CCNS, CCRN. For leadership in the application of research and evidence in the evaluation, redesign, and implementation of the glucose control protocol to achieve tight glucose control in the intensive care unit population.
- **Outstanding Achievement in Nursing Research Education**
  Carrie Braun, RN, PhD, CNP. For development of nursing research projects that facilitate interaction between staff nurses, students, patients, and families. Her most recent research involves animal assisted therapy as a pain intervention for children.

- **Outstanding Achievement in Evidence Based Practice Education**
  Joyce Simones, RN, EdD. For teaching nursing students the principles of evidence based practice and partnering hospital staff nurses with nursing students to address areas of clinical concern.
- **Outstanding Achievement in Use of Evidence in Nursing Practice**
  Joy Plamann, RN, BSN, BC. For implementation of evidence in the development of fall assessment and intervention practices, a pressure ulcer reduction protocol, progressive care unit glucose control practices, and her current project of Patient Care Assistant retention.

  Amy White, RN, BSN, CCRN. For implementation of evidence, standards and guidelines in the reduction of ventilator associated pneumonia through development of oral care and subglottic suctioning protocols, and her application of evidence in the development of the ART/CART teams.
- **Outstanding Achievement in Use of Evidence in Nursing Management**
  Teri Houle, RN. For vision in utilizing evidence to establish shared governance on the medical oncology units, championing staff leadership development, and leading a team through the modeling and application of shared governance principles.
- **Outstanding Achievement in Use of Evidence in Patient Education**
  Terri McCaffrey, MA, RN, CNS. For utilization of evidence in development of craniofacial education, establishment of craniofacial collaborative care plans, an advisory board, and policies, including allowing parents to be present in the operating suite when their child receives anesthesia.
- **Outstanding Achievement in Mentorship**
  Donna Kamps, RN, CCRN. For incorporating evidence into staff orientation to provide a practice foundation for nurses, and applying evidence through observation of coworker practice and in the development of standards for continuous renal replacement therapy.

Submitted by:
Nursing Research Committee

Surgery Delays

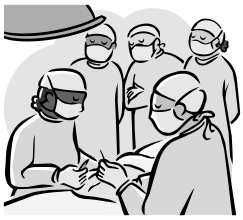
To avoid delays and/or cancellation of surgery, it is very important to call Pre-Operative Holding (POH) at least 30 minutes prior to sending a patient for surgery. This allows the POH nurse to ask questions, and if needed, action can be taken to complete preparations for a safe surgical outcome.

Be sure lab results are obtained with time allowed to inform the doctor of abnormals so appropriate action can be taken, prior to sending the patient to POH. Pregnancy test results on women of childbearing age are needed before we can proceed to Surgery. The only exception would be post-menopausal women with no menses for one year. (Patients with tubal ligations **DO** need a pregnancy test). Be sure to report the presence of pacers/ICDs to allow for appropriate care and follow up. Other important items include any contact precautions or any other special needs (e.g. confusion, etc.).

Inform the POH nurse of all pre-op meds that have been given on the unit and also those that need to be administered in POH. Pre-op antibiotics are to be given within one hour before surgical incision time (most antibiotics will be started in the Alcove). Antibiotics requiring longer infusion times (e.g. Vancomycin) should be started on the floor. When calling report to the POH nurse, please also address scheduled antibiotics, in some cases, a dose may need to be sent to surgery to continue proper dosing schedules. Heparin Subcutaneous on call should be given on the nursing units prior to sending the patient to POH.

Please complete the surgical checklist completely to avoid any problems. If you have any questions, please call POH day/evenings at ext. 54462 or nights beeper 89-0232. Thank you!

Submitted by:
Pre-Operative Holding Staff



High School Internships at Saint Cloud Hospital

Nearly seventy-five High School students (mostly Juniors and Seniors) completed 25 hour internships at Saint Cloud Hospital this academic year (50 in the Fall and 25 in the Winter/Spring) through the Mississippi River STW Partnership Health Care Internship Program.

This program has grown from one student in 1998 and thirteen students in 1999 to the number and variety of internships available today. Here are just a few comments the students made when asked what they learned about themselves through this experience:

- "When an opportunity comes around, take full advantage of it and make the most out of it. I learned a lot and now know with more confidence, I know I want to become a pediatric physical therapist."
- "I can learn to be more open to new people, surroundings, and asking questions. I learned to come out of my comfort zone so that I can learn better from people I never met before the experience."
- "I learned that I really do want to go into the medical field because I love everything about it. I also learned that I have a lot of choices and there are places that would be a good fit for me."
- "I learned that the medical field is a place that I can see myself having a life long career."

High School students were placed in a multitude of areas including Respiratory Therapy, the Emergency Trauma Center, Social Services, Imaging and several Patient Care Units as well as many other areas throughout the hospital.

Thank you to the mentors who made this program possible for tomorrow's Healthcare Professionals.

Pamela Rickbeil RN, MS, APRN,BC
Education Department

Clinical Ladder

Congratulations to the following individuals for achieving and/or maintaining their Level IV and Level III Clinical Ladder status!

Level IV

June Bohlig, RN — Surgery
- OR Open House
- PI Committee
- Member of AORN
- Certified Nurse Operating Room
- H Works Committee
- Preceptor
- Perioperative Core Class

Level III

Joyce Belanger, RN — Rehab
- PI Committee
- Preceptor
- IV Class
- Skin FEMA Committee

Melissa Dummprope, RN — Surgery
- OR Open House
- Preceptor
- DaVinci Evidenced Based Practice Committee
- Employee Satisfaction Committee
- CCP Development Team
- AORN, Sigma Theta Tau

Jason Foos, RN — ETC
- Super User EmSTAT
- Preceptor
- Nurse Practice Committee
- ACLS Instructor

Brenda Hommerding, RN — Med/Onc
- Regional Co-Chair Relay For Life
- PI Committee
- Practice Council
- National Oncology Society
- OCN Certification

Teresa Klaphake, RN — Telemetry
- Teaches Basic ELG Class
- Wrote Module on Methamphetamine Abuse
- Heart Center Practice Committee
- Validations for Telemetry Ed Day

Jennifer Klick, RN — Pediatrics
- SMILES Committee for Staff Satisfaction
- Parent Child Expo
- Preceptor
- Natal Patient Safety Handoff Subgroup

Jeanie Olson, RN — Family Birthing
- Taught IV Class
- Preceptor
- Chair of DAD (Depression After Delivery) Committee

Mary Ann Rennie, RN — Ctr. for Surgical Care
- Med Surg Certified
- PI Committee
- Preceptor
- Same Day Surgery Association