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Patient Care News: May 2007

St. Cloud Hospital

Patient Care News

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St. Cloud Hospital, St. Cloud, MN

Nurses Week 2007

Happy Nurses Week! I hope we can all take some time to celebrate our accomplishments and take a deep breath! What a year it has been! I know, I say that every year, but the WOW factor keeps increasing. There is a term that describes it well – complexity compression. We continue to live in an environment where exceeding quality standards, balancing tight budgets, dealing with human resource issues, growing the business and providing service excellence are all a constant. Put EMR implementation on top of all that and we have a year that has been a real challenge to say the least. Oh, I almost forgot, Joint Commission prep, Magnet redesignation preparation and a major facilities project.

Through all of this, we have continued to dedicate ourselves to our Mission and Care Above All. We were awarded the Beacon Award for Intensive Care Excellence, achieved Bariatric Center of Excellence status awarded by the American Society for Bariatric Surgery, and named a Solucient Top 100 Hospital. Our nursing staff published in nursing journals, participated in national research studies, continued work in evidenced based practice initiatives, attended and presented at national conferences, increased numbers of certified nurses, served as faculty for area health care nursing programs. Nurses have played an integral role in the development and implementation of significant patient care protocols; skin, falls, glucose control, VAPs, sepsis, and delirium. We have managed greater volumes and increased acuity.

My work with you during the Epic project has given me a much better understanding of the complexity of your work. I am in awe of what you are expected to learn and to perform. I am humbled by your nursing expertise and your commitment to your patients and colleagues. The EMR is here to stay. I commit to you that I will continue to work diligently to make it a system that we all find value in. The next year will see fewer go-lives and more work on system refinement and optimization. Information Systems and Nursing will devote resources to that end and we will continue to evaluate how the Epic System is impacting our care delivery and make appropriate changes.

Take time to laugh…

> *A clergyman had been invited to attend a party of the Sunday school nursery department. He decided to surprise them. Getting on his hands and knees, flipping his coat over his head like wings, he hopped in on all fours, cackling like a bird. Imagine his surprise when he learned that due to a switch in locations he had intruded on the ladies' missionary meeting!*

Happy Nurses Week!!!!
Linda Chmielewski, MS, RN, CNAA,BC

Inside This Issue:

Vice President, Hospital Operations/CNO

Medmarx: New Medication Safety Event Online Reporting System

St. Cloud Hospital will be switching to a new system of medication safety event (MSE) reporting called MEDMARX with a target implementation date of June 5, 2007. Medmarx will replace the current MSE reporting system in JRS. Medmarx is an Internet-accessible, national database for hospitals to anonymously report, track and analyze key information on MSEs. More than 700 hospitals use MEDMARX to identify harmful trends and implement proactive preventive strategies. Participants can access the national database of over 1,000,000 records.

Medmarx will be accessible for on-line reporting through a green side tab at the CentraNet home page. Please complete the MEDMARX 15 minute on-line tutorial if you haven't done so yet. You may print out a MEDMARX instructional pocket card directly from the tutorial. The pocket card provides step-by-step instructions on how to report an MSE. A Medmarx Education Binder for units will be distributed mid-May. The MEDMARX Education Binder also contains the pocket card and additional information for reference. Please use the pocket-card or Binder the first few times you report an MSE.

MEDMARX is a real-time reporting system so unlike JRS MSE reports, MEDMARX MSE reports will be immediately available for managers to review, do follow-up and implement action plans for prevention of future events. Managers who do unit-based performance improvement reports will be establishing a higher level of access into MEDMARX. Managers will be able to enter follow-up and action plan data directly into the system. MEDMARX will also allow access to enter an MSE retrospectively after patients have left the hospital.

Computerized on-line reporting of Adverse Drug Reactions (ADRs) will be discontinued once MEDMARX is up. To report an ADR (unrelated to an MSE) please call the 5-D-R-U-G hotline (Ext. 53784) and leave a message. Please speak slowly and clearly when leaving a message to describe the ADR and include the patient name and medical record number.

MEDMARX uses a new way of categorizing MSEs as listed in the table below to classify them according to severity of outcome according to the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). The system uses nine categories to classify an event according to the severity of the outcome. The purpose of the index is to help practitioners and institutions trend MSEs in a consistent, systematic manner. All people that report MSEs should become familiar with this new system. Broadly, the Index is broken into four major groupings as shown below:

Medication Error Index:

Error Category	Category Result
1. No Error	
Category A	Circumstances or events that have the capacity to cause error.
2. Error, No Harm	
Category B	An error occurred but the medication did not reach the patient. (An "error of omission" does reach the patient).
Category C	An error occurred that reached the patient but did not cause patient harm.
Category D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.

Error Category	Category Result
3. Error, Harm	
Category E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
Category F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.
Category G	An error occurred that may have contributed to or resulted in permanent patient harm.
Category H	An error occurred that required intervention necessary to sustain life (a near-death event, e.g., anaphylaxis, cardiac arrest).
4. Error, Death	
Category I	An error occurred that may have contributed to or resulted in the patient's death

Examples From Each Category:

CATEGORY A: Staff member notices similar appearance of packaging/labeling of drug product, or similar sounding drug name, or an error in reference material, or a medication is administered as ordered but was not documented on the Medication Administration Record.

CATEGORY B: Wrong product is sent by Pharmacy to floor/unit, but detected before given, a PCA order is incompletely filled out by a physician, Pharmacy incorrectly filled an Omnicell, a physician writes an illegible order

CATEGORY C: An improper dose of insulin was administered to a patient with diabetes. No additional monitoring of blood sugar level or change in treatment was required.

CATEGORY D: An improper dose of insulin was administered to a patient with diabetes. Monitoring of the patient's blood glucose levels was increased to every hour. No treatment was required.

CATEGORY E: A patient is administered an extra dose of a non-steroidal anti-inflammatory drug, complains of dyspepsia, and required an antacid. (Category E events require a change in therapy or active medical/surgical treatment).

CATEGORY F: An improper dose of insulin was administered to a patient with diabetes. The patient experience CNS disturbances and required a prolonged hospital stay for treatment.

CATGORY G: Examples include neurologic impairment, loss of limb.

CATEGORY H: An improper dose of insulin was administered to a patient with diabetes. The patient was found unresponsive and required CPR. The patient fully recovers. (The intervention is vital/heroic and without this the patient would die, however the patient fully recovers. The vital/heroic intervention is the differentiating fact from Category E).

CATEGORY I: A terminally ill patient was given 20 mg instead of 2 mg morphine; death was imminent, but uncertain if morphine was cause of death.

Deb Miller, Pharm.D.
Medication Safety Pharmacist

Medication Review in Overdose Management Pharmacy Procedures

1. ETC will contact Charge Pharmacist requesting a pharmacy consult for patients with poly-substance, unknown, or unusual medication overdose.
   - ETC will identify patient by name, birth date, and indicate urgency of consult.
2. Charge Pharmacist will:
   a. Day shift:
      - Contact Medication Reconciliation pharmacist and provide ETC consult information.
   b. Evening shift:
      - Determine availability of pharmacist to report to ETC and provide ETC consult information.
   c. Night shift:
      - Inform ETC of earliest time consult may be available.
      - Record ETC consult information and provide to Charge Pharmacist and/or if patient admitted to pharmacist covering patient care unit.
3. Consulting Pharmacist will:
   a. Report to ETC Charge nurse, unless patient admitted to patient care unit.
   b. Obtain non-permeable lab coat. (available on unit)
   c. Consult with patient/family to obtain list of medications ingested and complete a medication profile.
      - Pharmacist will review contents of patient medication containers when/if available for medication identification and quantity.
      - Pharmacist will contact patient's pharmacy to validate information and obtain date and quantity of last refill.
      - Pharmacist will provide pill count to estimate quantity of medications ingested (when/if information available)
      - OTC /Herbal medications will be included in medication profile, but pill count will not be provided unless consulting pharmacist determines adequate information is available.
   d. Notify attending physician immediately of findings.
   e. Document in Progress Note medications involved, estimated quantity ingested, and any potential problems or concerns regarding drug interactions with other medications used in management of case.
   f. Document patient home medications into Epic Home Medication file.
   g. Document home medication on Pharmacy Medication Identification Form as indicated.
      - White copy to chart, yellow copy to pharmacy.
   h. If patient admitted communicate progress of medication profile review to decentralized pharmacist or medication reconciliation pharmacist using SBAR process.

Paul Schoenberg, RN, Director, ETC
Roberta Basol, RN, Director, ICU
Arne Tilleson, Pharmacist, Coordinator of Clinical Pharmacy Services

(Please review new policy on Page 5)

TITLE: Medication Review In Overdose Management

Original: 4/07 Revised:
Replaces:
Responsible Person(s): Director, ETC
Approving Cmte: Clinical Patient Care Committee; Pharmacy & Therapeutics Committee
Category: Patient Care
Cross Reference: Medication Brought From Home Policy

PURPOSE :
To make every attempt to identify the drug product and quantity ingested.

POLICY:

1. Medication identification of all poly, single, unknown, or unusual medication overdose patients will be done as soon as possible following presentation to the St. Cloud Hospital.
2. Poison Control may be contacted for medication overdose cases.

IMPLEMENTATION:

1. All attempts possible will be made to identify the drug product and quantity ingested.
2. The patient and/or family will be asked to provide as complete a list as possible of the medications ingested.
3. Medications will be positively identified to the extent information is available.
   a. Patient and/or family members will be included in this process
   b. Patients/family will be asked to bring in medication containers
   c. Pharmacy will be consulted to conduct medication reconciliation for all poly, unknown, or unusual medication overdoses
   d. Patient's pharmacy will be contacted for medication reconciliation.
   e. Pill count will be done to estimate quantity ingested and communicated to the patient care unit.
4. Poison Control will be contacted for all poly, unknown, or unusual medication overdoses within 6 hours, and for single medication overdoses as needed
   a. National Poison Control Center 1-800-222-1222
   b. Hennepin County Poison Control 612-347-3141
5. The healthcare provider positively identifying the medication will document in the progress/ED notes the drug product and quantity ingested. The attending physician will be notified immediately of the findings.
6. All medications brought to the hospital will be handled by the patient care unit per the Medications Brought from Home policy.
7. Hand off (SBAR) communication to the receiving unit will include progress of medication profile review.

REFERENCES:

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- Branagan, O. & Grogan, L. (2006). Providing health education on accidental drug overdose. Nursing Times. 102(6): 32-3.
- Mackay, Roberts D. (1999) A nursing model of overdose assessment. Nursing Times, 95(3): 58-60.
- Maruja, B.; Marija, B.; Klancar, S.; Zmaga S. (2005). Monitoring for cardiac arrhythmias in patients with acute self poisoning. Critical Care Nursing. 4(3): 82-3.
- Pohler, H. F. (2006) A little goes a long way: clinical management of calcium channel blocker overdose. Journal of Emergency Nursing. 32(4), 347-9, 360-5.

Saline for Reconstitution of Medications: Use Vials Rather than Pre-Filled Saline Syringes; Joint Commission Labeling Standard

Practice changes for reconstituting of medications and labeling of syringes have been approved by CNPC. Please see the recently updated Medication Administration Policy for reference.

New SCH Medication Safety Practices:

Single-use vials of 0.9% sodium chloride injection will be used for diluting and reconstituting medications. Pre-filled 0.9% sodium chloride flush syringes will only be used for flushing. They are never to be used as a diluent. Pre-filled syringes should no longer be used for reconstitution of medications. There are several reasons for this:

1. Use of pre-filled saline syringes to dilute drugs creates this patient safety problem: The syringe that is labeled "0.9% Sodium Chloride Injection" could actually contain something else. If the syringe leaves the preparer's hands before administration, it might be mistakenly used by another practitioner as a saline flush. This could be lethal when the label for dilutions with high-alert drugs such as fentanyl or vecuronium doesn't get applied and the printing on the syringe shows that the syringe is a saline flush.
2. Another rationale for not using pre-filled saline flushes for reconstitution is that parts of the pre-filled saline syringes aren't sterile. It is easier to explain this by looking at the difference in the packaging of a pre-filled saline syringe versus a regular empty syringe. The plunger of the pre-filled syringe isn't sterile between the end of the plunger and the finger-grip while regular syringes are enclosed in a sterile wrapper and are sterile along the entire plunger. This is why our current pre-filled syringes are labeled on the package: "Do Not Place Syringe on a Sterile Field and the new flushes state "Not for Sterile Field. Sterile for Injection." When injecting the pre-filled saline into a vial to reconstitute a drug, the non-sterile portion of the plunger enters the syringe barrel as the saline is injected contaminating the syringe barrel. Then, when drawing the reconstituted drug back into the syringe, the medication is exposed to a non-sterile surface on the inside of the syringe. So to clarify, the solution inside the pre-filled syringe is sterile, and the barrel area where the solution is touching is sterile. However, this barrel area becomes contaminated after the plunger is pushed forward once as described above. It is also important during medication reconstitution with a regular sterile syringe that the sterile plunger isn't contaminated by the hand. Do not touch the part of the plunger that gets into the barrel when reconstituting vials of medications.
3. A third rationale is that pre-filled syringes aren't licensed by the manufacturer for reconstitution of medications. The syringes are designed to be flushed forward ***once*** for line flushes only. FDA approval for the pre-filled syringes was for flushing only and not to be used as a diluent. None of the manufacturers have received approval for it to be used as a diluent and doing so would be off-label use.

New Addition to Medication Administration Policy – JCAHO Labeling Standard

In accordance with a Joint Commission Medication Standard, medications need to be labeled in a standardized manner. Any time one or more medications or solutions are removed from their original container but are not administered immediately, the medication container (plastic bag, syringe, bottle, or box, medicine cup or basin) must be labeled (including contrast media). Labels must include drug name, strength, amount, and expiration time when expiration occurs in less than 24 hours.

NOTE: Blank labels should be obtained from Distribution Center. Write on the label the information required. Please see the policy also for requirements when the person preparing the medication is not the person administering the medication.

Joannie Nei, RN, Clinical Value Analyst Specialist
Roberta Basol, RN, Director, ICU
Deb Miller, Pharm.D., Medication Safety Pharmacist

Look-Alike/Sound-Alike Medications

One of JCAHO's 2007 National Patient Safety Goals is the following requirement: *"Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs."*

Here is a list of potential problematic drug names that were identified by the Pharmacy and Therapeutics Committee at its annual review of the look-alike/sound-alike drug list. This list is available in Addendum B of the Medication Administration Policy on CentraNet:

1. EPHEDrine and EPINEphrine
2. Lipid-based DAUNOrubicin and DOXOrubicin products vs. conventional forms of DAUNOrubicin and DOXOrubicin. Use the brand name for the lipid-based product:
   - DOXOrubincin (use DOXIL)
   - DAUNOrubicin (use DAUNOXOME)
3. vinCRISTine and vinBLASTine
4. CELEBREX (celecoxib) and CELEXA (citalopram) and CERBYX (fosphenytoin): Use the brand name in addition to the generic name
5. cloniDINE and clonaZEPAM
6. buPROPion XL and buPROPion SR
7. morphine and HYDROmorphone
8. tramADOL and traZODONE
9. metFORMIN and metroNIDAZOLE
10. hydrOXYzine and hydrALAZINE

Actions that have been taken to prevent the interchange of these drugs includes the use of TALLMAN lettering which helps to emphasize the letter characters in each name that are unique to that drug name. TALLMAN lettering is used for these drugs in EPIC drug pick-lists, on the medication administration record, and on EPIC drug labels. The above drugs are also listed using TALLMAN lettering in the Omnicells and on the Pharmacy's drug shelves to assist with proper drug identification and selection.

Deb Miller, Pharm.D.
Medication Safety Pharmacist

New TACs System:

Sometime during the month of July, 2007, we will go live with a new time and attendance system called Kronos. During the month of June, time processing auditors will be scheduled for mandatory training on the new system by their Scheduling Associate.

With the new Kronos system, patient care staff will no longer clock their own PTO, PTX, HTO and On Call. We are putting in place a two-way interface between the time and attendance system and the ANSOS One Staff scheduling system. PTO, PTX, HTO, and On Call will automatically transfer from ANSOS One Staff (what has been entered by your Scheduler or the Staffing Office) into Kronos, the time and attendance system. When you view the clocked transactions on the computer, you will see these shifts along with the clocked time. As in the past, staff will fill out a time adjustment form, if they find a discrepancy in their record.

Another new feature to the two-way interface, will be the ability to see the scheduled work shifts in the lower right-hand corner of the Kronos time and attendance computer screen. The schedule will be updated daily with changes that are occurring in the schedule. For this reason, we are reminding staff how important it is to fill out an Exchange of Hours form in a timely manner for any exchanged shifts.

As with any new change, we expect their will be some bumps along the way, but we hope the end result will be something we can all appreciate!

Sue Laudenbach
Quality Improvement Analyst

Blood Transfusion Policy Update

The *Blood and Blood Component Transfusion Policy* was recently revised. Most of the changes, such as the addition of Factor VIIa, and the use of tubing for albumin infusion for up to four hours, were made to update the policy to our current standards of practice. However several changes were made in the interest of patient safety. Important additions to the policy include:

- The requirement that the patient be under continuous observation for the first fifteen minutes of the transfusion.
- Requiring the use of the *Blood/Blood Product Infusion Protocol Order Sheet* for all outpatient transfusions. The use of this order sheet springs from an FMEA analysis. The form is available on both the CentraNet, and at www.CentraCare.com. On the CentraNet, go to Medical Staff; Standing/Preprinted Orders; and then Pathology(Adult) or Pediatrics. At www.CentraCare.com, go to Our Services; Laboratory; then choose Adult or Pediatric.
- Information on the *Preventions of Tubing Misconnections*.

Also, just a reminder, that the Blood and Blood Component Transfusion Policy does require the signature of two nurses, and the recording of “pre” and “post” transfusion vital signs on the Product Administration form. Please call the Blood Bank at Ext. 55715 with any questions.

Kathy Prodzinski
Clinical Lab Scientist

Communicating with the Administrative Nursing Supervisor/PPC

Have you tried to reach the nursing supervisor only to get a busy signal for the umpteenth time? Or, the phone rings and rings (we are on another line, or have our hands tied up with an IV start, etc.)?

There are several ways to reach the Administrative Nursing Supervisor/Patient Placement Coordinator. Our **Spectralink** extension is **59413.** We also still carry our voice **pager 89-0221**. The voice pager is a good way to give us short, non-confidential messages if you can't reach us by phone.

Examples would be: *"please call 00000 stat"; "come to room 00000 stat"; "new admission from ETC to room OOO"; or "please call the Med 2 charge nurse at your convenience", etc.*

If you are unable to reach us on our Spectralink phone after 5-6 rings, we would appreciate it if you would hang up and wait a few minutes, then try again, rather than letting the phone ring 15-20 times. If we are busy with a patient, family, physician, staff member, etc., the constant ringing of the phone is disruptive. If you are unable to wait for a few minutes to call us back due to the urgency of the situation, this would be a good example of where a short message on our voice pager would be another way to reach us.

For other informational needs, each of the nursing supervisors have individual e-mail via Outlook. If you would like to e-mail something to the entire group, you may use the group address **ADMSUP** on Outlook. Please keep in mind that we generally only check our e-mail once per shift – usually at the start of our shift.

Cari Wilder, RN
Administrative Nursing Supervisor

Balance & Dizziness Program

One-third of people older than 65 will experience a fall and some will become disabled as a result. But many falls could be prevented with improved balance. The Balance & Dizziness Program at St. Cloud Hospital's Adult Rehabilitation Center was established in autumn 2006 to help people concerned about their balance. Evaluations are done by a comprehensive care team, which includes physical and occupational therapists.

For more information about the Balance & Dizziness Program, call 229-4922.

Submitted by:
Cheri Tollefson Lehse
Communications Specialist, CentraCare Health System

Revised Guest Tray Policy in Effect

On Wednesday April 4th, a revised guest tray policy was approved by the Clinical Patient Care Council. Up until now, the practice was for the unit to send a voucher to Nutrition Services for guests who desired a tray delivered to the patient's room. These charges were placed on the patient's bill. If this bill went unpaid, the cost ended up coming out of the unit account. As a result, many units have had to police the use of guest trays to avoid abuse of the process.

Here are the highlights of the new policy:

1. Guests must pre-pay if they desire a tray to be delivered to the patient's room. The guest can go to the Riverfront Dining Room to purchase a voucher for $8.00. At the time of purchase, the guest will indicate what room and what meal they would like delivered.
2. The cashier will give a copy of the voucher to the catering associates who will then deliver the tray with the patient tray. A regular diet will be served.
3. Guests will need to purchase their trays before the designated cut off times. Breakfast 6:30, Noon Meal 10:00, and Evening Meal 3:30.
4. If a guest is physically unable to travel to the Riverfront Dining Room, nursing can contact a supervisor in Nutrition Services to assist the guest in completing the transaction for a guest tray.

Also, please remember to document in the medical record if a patient is eating food brought in from outside the Saint Cloud Hospital. We cannot guarantee the safety of the foods being consumed. We do not want the liability if a patient gets a food borne illness. This is part of the "Food from Sources Outside SCH" policy, also approved at the April meeting.

Shari Nusbaum
Patient Services Manager
Nutrition Services

Magnet Force #10: Community and the Healthcare Organization

This force looks at how nurses are involved in their communities and how communities recognize them for that involvement. We need examples and stories about:

- Names of nurses who are involved as volunteers in their home communities. This can be with schools, churches, sports teams, anything. We need to make a list.
- Names of nurses who have received awards or recognition for their community support or involvement.
- Partnerships that your unit has with a community based group that helps staff to meet the health care needs of the special populations that you serve.
- Tell us if and where there are written expectations for your nurses to be involved in their communities.

Call or email your stories to:
Carolyn Neubauer, Force Leader and Educator
Emergency Trauma Center
Ext. 57298

Clinical Ladder

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

Level III

Naomi Gertken, RN — OR
- Preceptor
- Chair of Employee Satisfaction
- Member of RDE Committee
- Placed Teaching Boards in Family Waiting Lounge

Desiree Fuecker, RN — OR
- OR Open House Committee Chair
- PI Committee Member
- Preceptor
- Super User for Epic

Chuck Kalkman, RN — MHU
- National Certification in Psychiatric Nursing
- Instructors for AMP Classes
- Taught Mental Ill Patients on Your Unit
- Code Green PI Audit

Sherri Reischl, RN — ETC/ICU
- Epic Super User
- ROE Committee
- Chair of PI Committee for ICU
- Coordinated ICU Education Days

Jill Harris, RN — Kidney Dialysis, Brainerd
- Preceptor
- ANNA Member
- PI Committee Member
- Developed the Buttonhole Method Module

Melissa Nagengast, RN — CCC
- Safety Week Poster
- Preceptor
- Safety Committee Member
- PICC Port Certification

Sue Janey, RN — Ortho
- Preceptor
- Teaches Total Joint Class
- Ortho Workshop Committee
- Bard Urimeter Inservice

Mike Johnson, RN — Pediatrics
- Preceptor
- Infection Control Task Force
- Participates in National "Swaddle Study"
- PCA/Epidural Hospital Committee

Karen Bandar, RN — CSC
- Surgery Open House Tours
- Marking Incision Resource Manual
- Co-Chair of Perioperative Practice Committee
- Pain Protocol Research Committee

Angie Moscho, RN — Ortho
- Preceptor
- Staff Education Committee
- Presented stations at Fall Education Day
- NAON Member

Submitted by:
Clinical Ladder Committee

Developmental Programs: Educational & Professional

May 2007

May 1	Trauma Nursing Core Course Renewal, 8:00 am – 4:30 p.m., SCH Conference Center
May 8/9	ONS Cancer Chemotherapy Course, 8:00 am – 4:30 pm both days, Hughes/Mathews Room, CentraCare Health Plaza
May 11/12	(CNOR) Perioperative Certification Preparation Course, Windfeldt Room, CentraCare Health Plaza
May 15	Nursing Research Conference, 8:00 a.m. – 4:45 p.m., Windfeldt Room, CentraCare Health Plaza

For more details, call:
Education Department, Ext. 55642