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Patient Care News: March 2008

St. Cloud Hospital

Patient Care News

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St. Cloud Hospital, St. Cloud, MN

Certified Nurses Day – March 19th

March 19, 2008 has been designated by the American Nurses Credentialing Center (ANCC) and a consortium of Nursing certification organizations and other stakeholders as the first national Certified Nurses Day. Certification is offered through a variety of professional Nursing organizations, and certification is available for nearly every type of Nursing practice (Medical / Surgical, Oncology, Critical Care, Operating Room, Emergency, Nursing Administration and Nephrology are some of the common ones). National certification in a Nursing specialty indicates RN expertise in an area of practice.

Inside This Issue:

Why is certification important?

- It indicates a level of clinical competence and enhances professional credibility.
- It validates a nurse's skills, knowledge and abilities.
- It empowers nurses within their professional sphere of activity.
- It contributes to better patient outcomes.
- Research has linked certification to decreased medical errors, increased nurse confidence and increased job satisfaction.

St. Cloud Hospital has promoted national certification as a way to develop our nurses and to provide the best possible care for our patients. Approximately 40% of our Nursing management staff and 13% of our direct care RNs are currently certified. Our policies provide for financial support to offset the cost involved in the certification process. If you are interested in certification please contact Vickie Ruegemer in the Education department. Congratulations to our nationally certified Nursing staff – we are proud of you!

Linda Chmielewski, MS, RN, CNAA, BC
Vice President, Hospital Operations/CNO

News Flash….Easter Holiday Signup Sheets for Cut/Call

The Easter Holiday falls on Sunday, March 23, 2008. Sign-up sheets for cut/call requests are due to arrive on the units Thursday, March 6th and will remain posted until 8:00 am. on Thursday, March 20th. Once the sheets have been collected from the units, any additional requests will be considered late. The sign-up sheets are for the holiday only.

According to policy, the holiday starts at 11:00 pm the night before and ends at 11:00 pm the day of the holiday. These cut/call sign-up sheets include scheduled shifts starting at 11:00 pm March 22nd and run through 11:00 p.m. March 23rd. If any part of your scheduled shift is outside of this timeline, you will need to call the Staffing Office to request cut/call for that portion of your shift.

Just a reminder, please make sure you write legibly and provide a phone number where you can be reached. If you have any questions, please call me at extension 55705.

Terri Krause
Coordinator, Staffing/Scheduling

Final Decision on the BSN/BAN Educational Requirements

After considerable review and discussion with key stakeholders regarding the BSN/BAN educational requirements, the final decision is that current staff in the positions noted below will be grandfathered into the new educational requirements. If these individuals apply for another position, they will be required to have a BSN/BAN.

Kelly Thomton in Human Resources will begin updating the job descriptions then send to directors for their signature. Effective February 1, 2008, all new hires for these positions will be required to have a BSN/BAN.

	New Hires (Internal or External)	Current Staff
Director	BSN/BAN – Required Masters – Preferred	All current nursing staff are being grandfathered into the new educational requirements. They will not be eligible to move into any other position requiring a BSN/BAN without having a BSN/BAN.
Coordinator	BSN/BAN – Required Masters – Preferred	
Educator	BSN/BAN – Required Master – Preferred	
Case Manager	BSN/BAN – Required Masters – Preferred	
Admin Nursing Supervisor	BSN/BAN Required	
Core Charge	BSN/BAN Required	
Specialist	BSN/BAN Required	
Clinical Resource Nurse	BSN/BAN Required	

Linda Chmielewski, MS, RN, CNAA, BC
Vice President, Hospital Operations/CNO

Upcoming Developmental Programs: Educational and Professional

April

8 NRP (Neonatal Resuscitation Initial Course), 8:15 am – 3:15 pm, Aspen Room

8 Pain Management in the End-of-Life Patient: Brown Bag Session, 3:30 - 4:30 pm, Hoppe Auditorium

10 CPAN Review for Certification, 7:30 am – 4:55 pm, Windfeldt Room, CentraCare Health Plaza

11 CAPA Review for Certification, 7:30 am – 4:55 pm, Windfeldt Room, CentraCare Health Plaza

15 The Noncompliant Brain Conference, 7:45 am-4:15 pm, Windfeldt Room, CentraCare Health Plaza

15 NRP (Neonatal Resuscitation Renewal Course), 9:00 am – 12:00 noon, Family Birthing Center Classroom

16 Living With Hope: Child and Adolescent Grief Conference, 7:30 am-4:30 pm, Windfeldt Room, CentraCare Health Plaza

22 Diabetes: It's Everywhere! A Health Professional Update Conference, 7:30 am-4:30 pm, Windfeldt Room, CentraCare Health Plaza

24/25 Basic Electrocardiography, 8:00 am – 4:00 pm, Kremers Room, CentraCare Health Plaza

29 Tailoring Care for Obese Patients: Bariatric Surgeries and Nursing Care Conference, 7:45 am-4:30 pm, Windfeldt Room, CentraCare Health Plaza

29 NRP (Neonatal Resuscitation Renewal Course), 9:00 am – 12:00 noon, Family Birthing Center Classroom

Please contact the Education Department at Ext. 55642 with questions or for additional information.

Kate Hoelscher, Administrative Asst.

Education & Professional Development Dept.

Policy Revisions Related to Death

1. Autopsy Authorization:
   - Autopsies are no longer performed at St. Cloud Hospital. The Anoka County Medial Examiner's office performs the autopsy. (effective 8/07)
   - If the autopsy is requested by the physician, the cost of procedure and transportation is absorbed by the hospital.
   - When family requests an autopsy, they need to pay for the procedure via the estate/family members prior to the autopsy being performed, including transportation.
   - For stillborn infants and babies that die within 24 hours, there is a specific form titled "Comprehensive Evaluation of Stillborn Infants and Babies that die within 24 hours". Parents sign this to decline an autopsy. This form is still in revision and more information will be forthcoming.

2. Death Care Provided After:
   - #3 lists all deaths reportable to the medical examiner's office which pertain to hospitalized patients. The Minnesota statute was updated last year and additional deaths were added.
   - Anything "accidental" needs to be signed off by an ME/Coroner. Falls and fractures are "red flags". Solid organ donations need to be reported. When in doubt, contact the ME/coroner to sign-off (i.e. deaths within 24 hours of arrival which are unexpected).
   - Patient belongings and valuables should be sent with family whenever possible (except for ME cases – then send with body)
   - The death checklist was revised to follow the order in which tasks are done and calls are made. The checklist was renamed to reflect the common term: "Death Checklist" (see attached).

     All information needed by the Admissions Department is listed at the bottom of the Death Checklist. It is imperative that they know about ALL deaths and whether or not a release has been obtained. Funeral directors rely on this information to know when they can pickup the body.

3. Organ/Tissue Donation:
   - #5 – The next of kin is offered the opportunity to authorize donation by the Donation Coordinator. It is acceptable for the nurse to offer this option when delegated or requested to so by the Donor Coordinator.
   - Added statement (#10) regarding notification of Medical Examiner for Solid organ donations.

4. Death of a Patient, Unexpected and Unexplained:
   - This policy was reviewed and updated by Dr. Whitlock. The Medical Staff office will follow-up and place this on the system.
   - Whenever there is a question/concern regarding cause of death, involve the Administrative Nursing Supervisor.

All policies will cross-reference the other "death" policies.

Submitted by:
Barb Scheiber, RN
Director, Patient Care Support

CPOE Enhances Patient Safety
By Fred Engman, M.D.

You may hear physicians ask, “Why are we doing Computerized Physician Order Entry?” You may have asked that question yourself. The most obvious answer for why we are implementing CPOE: *We believe it is safer for our patients.*

The impetus comes from the Institute of Medicine’s 1999 report, *To Err is Human: Building a Safer Healthcare System*, which indicated that there were between 44,000 and 98,000 preventable deaths in the United States caused by medical errors. That report spawned the Leapfrog initiative. Leapfrog is a consortium of Fortune 500 companies that want to ensure the best health care for their employees. The consortium came up with Leapfrog benchmarks that hospitals of excellence must obtain before they are Leapfrog compliant. These benchmarks include full-time Intensivist, evidence-based hospital referral, Leapfrog safe practice scores and physician order entry. If used, these benchmarks could save an estimated 65,000 lives each year with a cost savings of $41 billion. In addition, roughly one million medication errors could be avoided.

We already have seen the benefits of Intensivist at St. Cloud Hospital. They have improved morbidity and mortality rates in the critical care areas while decreasing the cost of care. Now it is time to institute CPOE.

Other key reasons for implementing CPOE:

- In 2004, President Bush proclaimed that within 10 years, all American should be on an electronic medical record.
- The Center for Medicare & Medicaid Services says that by 2009, all hospitals must have CPOE.
- Dr. Uwe Reinhardt, a renowned medical economist from Princeton University, estimates that EMRs will save the United States $80 billion per year.
- A 2006 *Annals of Medicine* article cited a study of 257 EMRs, which concluded that information technology has been shown to improve quality by increasing adherence to guidelines, enhancing disease surveillance, and decreasing medication errors.

Physicians are being trained in CPOE one to two weeks before their departments go live. The training, which takes four hours or less, is specialty specific.

We are encouraging all physicians to view a CPOE video on CentraNet, under the EMR/Epic tab. Nursing staff and others are welcome to view it as well.

Submitted by:
Jeanine Nistler, Communications

Have a Happy St. Patrick’s Day!

Literature Review
Healing Touch: A Low-Tech Intervention in High-Tech Settings

Author: Eschiti, VS
Dimensions of Critical Care Nursing (DCCN), Jan/Feb 2007; 26(1): 9-14.

Patients in critical care may be anxious in a high-tech unfamiliar setting. The use of simple, human touch has been used by nurses to help patients feel calmer and more comfortable.

Patient Use of Complementary Therapies
Complementary therapies are used in conjunction with mainstream treatments. Healing touch lies under the category of Human Energy Field. Healing touch can be defined as an energy therapy that uses heart-centered care in which the practitioner uses gentle non-invasive touch to restore harmony, energy, and balance within the human energy field. Healing touch many involve touching the client's energy field, rather than the physical field. It is unknown precisely how energy field modalities influence health.

Use of Healing Touch in Critical Care Settings
In a national survey of critical care nurses, researchers reported that nurses viewed healing touch as a positive intervention. There is very little research regarding use of complementary therapy in critical care.

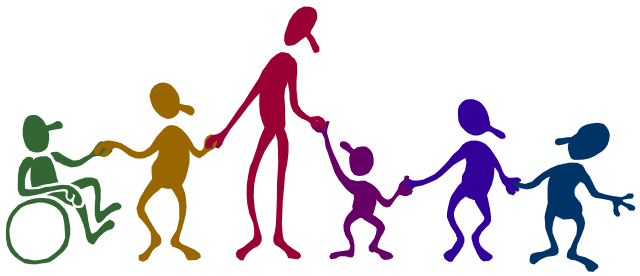
Quantitative Research
32 studies were examined which included pain reduction, relaxation, and improved mood. Many of the designs contained flaws particularly lacking internal and external validity. One randomized, controlled research involving 150 patients awaiting percutaneous interventions, studied stress management, imagery, off-site intercessory prayer, and healing touch. The patients receiving healing touch reported reduced worry in comparison to the control group.

Qualitative Research
There have been excellent qualitative research related to healing touch, but not with critical care patients. In a convenience study of 23 patients with abdominal pain, patients gave graphic descriptions of positive changes.

Mixed Methods
Opened ended questions were used in a research of 39 hospice patients. There were 21 in the healing touch group and 18 in the control group. Findings in the healing touch group indicated increased relaxation, increased pain relief, spiritual benefit, increased calmness, and improved breathing.

Conclusion:
Nurses need to be knowledgeable about healing touch and its effectiveness. Nurses need to know how to make referrals for patients that request complementary therapies. Nurses have voiced barriers of lack of knowledge, time, and training. Despite such barriers, nurses are still eager to use complementary therapies. Nurses also need to be supportive and instrumental in conducting research in complementary therapy.

Submitted by:
Joyce Simones, RN, EdD, Associate Professor
St. Cloud State University



St. Cloud Hospital's HCAHPS Results to be Posted on National Web Site

(Results of a new survey of St. Cloud Hospital patients will be available later this month at www.hospitalcompare.hhs.gov)

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a nationwide survey developed by the Center for Medicare and Medicaid Services. HCAHPS is required for Inpatient Prospective Payment System hospitals to receive full Medicare reimbursement. (Hospitals that do not participate are subject to a 2 percent decrease in reimbursement.) Hospitals have the option of suppressing public reporting until December 2008. St. Cloud Hospital is allowing its results to be posted.

St. Cloud Hospital distributes the survey to a random selection of 4 percent of all inpatient discharges. HCAHPS reports the percent of patients answering "Always" to several questions.

For the initial reporting period (October 2006 through June 2007), St. Cloud Hospital scored better than the state and national means for eight of the 10 measures:

- Communication with nurses
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Bathroom cleanliness
- Quiet environment around room
- Overall hospital experience
- Likelihood of recommending St. Cloud Hospital to friends and family

On the following two measures, St. Cloud Hospital scored lower than the state mean and equal to the national mean:

- Communication with doctors
- Discharge information

In making comparisons, HCAHPS adjusts survey results to account for differences across patient populations, including age, education and self-reported health status. The adjustments will be updated every quarter. In addition, because state and national means will be adjusted for hospitals electing not to participate in public reporting, it is possible that our final standing in relation to state and national means may change.

Jeanine Nistler
Communications

Perianesthesia Nurses' Pain Management After Tonsillectomy and Adenoidectomy: *Pediatric Patient Outcomes*

Article from Journal of Perianesthesia Nursing (JOPAN), 22:2 (2007) 91 – 101, Rodica Simona Pop, BSN, RN, Renee C.B. Manworren, MS, RN, BC, CNS, Cathie E. Guzzetta, PhD, RN, AHN-BC,FAAN, Linda S. Hynan, PhD

The purpose of this descriptive-comparative study was to evaluate the effects of post-anesthesia analgesic treatments on self-reported pain intensity, incidence of nausea and vomiting, and amount of oral fluid intake among pediatric patients after tonsillectomy and adenoidectomy (T&A). After evaluating a systematic review of 36 studies that investigate various analgesics to treat children's pain after T&A; it was found that no analgesic provides superior pain relief compared with any other and there was a recommendation for further studies to identify the optimal analgesics.

This study was conducted in a 15 bed PACU and the 20 bed extended care unit of a 322 bed, university-affiliated, free standing, pediatric medical center in the southwest United States.

There were 7 questions posed for study:

1. Are there differences in pain among patients who receive five different analgesics?
2. Are there differences in the amount of pain medication between patients who report no pain versus those who report any pain?
3. Are there differences in the incidence of nausea and vomiting among patients who receive five different analgesics or based on the amount of opioid analgesics?
4. Are there differences in pain intensity scores between patients who have nausea and vomiting and those who do not?
5. Are there differences in the amount of oral intake among patients who receive five different analgesics?
6. Is there a relationship between pain scores and the amount of oral intake in patients?
7. Is there a relationship between the amount of oral intake and the amount of pain medication received in patients?

The study enrolled a total of 92 patients (n=92). Participant demographics ranged in age from 3 to 13 years old, 51% white, 26% Hispanic, 15% black, and ranging in weight from 15.0 to 52.4 kg. Whereas the treatment regimens began with one of two analgesics, ultimately five different analgesics were administered. Pain perception was measured using the Wong-Baker Faces Pain Scale (0-5).

Findings indicated that children reported adequate pain control after T&A with all five analgesic regimens:

1. IV Fentanyl alone
2. IV Fentanyl plus oral combinations (OC),
3. IV Morphine alone,
4. IV Morphine plus OC,
5. OC alone (Hydrocodone/Acetaminophen or Codeine/Acetaminophen).

These data support the need for pain medication titration and validate that the amount required to relieve pain differs from child to child. Almost 30% of the patients had nausea and vomiting, which is consistent with the literature for children after T&A. However there was no difference in the incidence of nausea and vomiting among the five analgesic groups. Results indicate no significant difference in oral intake among the five groups. Self-report is the single most reliable indicator of pain. Yet, 44% of study patients did not provide pain scores before leaving the PACU, 14% before leaving the ECU, and 8% not at all. This finding has significant practice implications because it suggests that self-report pain intensity scores are not the only assessment data Perianesthesia nurses rely on to guide their analgesic administration.

The limitations of this investigation begin with starting the study by comparing two analgesic regimens and then it developing into five groups. As a result, the investigators ended up with data from five groups with an uneven number of subjects and statistically smaller than ideal sample size. Some variables that were not controlled and may have had an influence on the results of the study included surgical technique and intraoperative management such as the administration of local anesthetics, steroids, analgesics, and antiemetics. There was also no control for non-pharmacologic interventions like bio-behavioral comfort measures provided by nurses or family members.

In conclusion, children reported pain relief with the use of commonly administered analgesics despite variations in analgesics and the amount of analgesics administered. In this study, self-report pain intensity scores indicated that children were effectively managed for relief of T&A pain during the post-anesthesia period. Self-report pain intensity scores influenced nurses' decisions to medicate patients for pain. However, when children were unable to provide subjective reports of pain, nurses must have used other unidentified pain assessment strategies. These strategies influenced analgesic administration so were categorized as "critical clinical judgment". The use of valid and reliable pain scales, systematic pain assessments, critical clinical judgment, and analgesic titration resulted in relief of T&A pain. Pain assessments, rather than the amount of analgesic administered, should be the outcome of choice to evaluate children's postoperative pain management.

Submitted by:
Dick Beastrom, RN, POH-PACU
Center for Surgical Care

Clinical Ladder

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

Level IV

Sue Daniels, RN — Ortho/Neuro
- Epic Trainer
- Joint Class Instructor
- Epic Super User
- Ortho/Neuro CNPC
- ONC

Level III

Christa Wagner, RN — Kidney Dialysis
- Preceptor
- Buttonhole Technique/Constant Cannulation
- PI Committee
- Fistula First Co-Chair

Sharon Klimek, RN — Kidney Dialysis
- PI Committee
- Remember your Binders – Patient Poster
- Preceptor
- Plan of Care – Staples NH Patient

Robert Davidson, RN — Intensive Care
- Glucose Control Protocol
- Nurse Process Core Group Leader
- Epic Super User
- AACN

Terri Nicoski, RN — Family Birthing
- PI Quarterly Newsletter
- Inpatient Safety Audit
- Clinical Ladder – Chair
- RNC – Perinatal Nursing

Janelle Maciej, RN — Telemetry
- Coronary Artery Vasospasm Learning Module
- Preceptor
- Lucas Device Poster
- Education Day – Biphasic Defibrillator

Level III (cont'd)

Curt Devos, RN — Ortho/Neuro
- Preceptor
- Short-Stay Audit
- PI Committee
- CNPC

Alisha Fouquette, RN — Telemetry
- Preceptor
- Continuous Renal Replacement Therapy Poster
- Telemetry Patient Safety and Satisfaction Committee

Karla Lavigne, RN — Radiation Oncology
- Preceptor
- PI Committee
- Mammosite Protocol/Policy/Patient Teaching
- Protocol Resource Binder