9-2008

Patient Care News: September 2008

St. Cloud Hospital

Patient Care News

Volume 29, Number 9
September 2008

St. Cloud Hospital, St. Cloud, MN

Blood Bank Changes

There has been a change in the Blood Transfusion Policy. A copy of the physician's order will no longer be required when issuing blood. Patient identifiers (name, medical record number, and birthdate) will still be required. This information can be confirmed from a sticker from the patient's chart placed on a card or piece of paper. If red blood cells are being requested, the crossmatch band must also be written on the card. If non-licensed personnel are picking up the products, the RN must sign the card, and write the type of product needed.

A deficiency on a recent inspection by an accrediting agency has prompted the Blood Bank to begin doing random audits of transfusions. Blood Bank personnel will be following products to the bedside. Items that will be checked include: immediate delivery of the product to the RN; verification of need with the physician's order; verification of identifying information with the armbands; checking and signing the hangtag; and that the hangtag remains attached to the unit. AABB and CAP standards require that the hangtag remain attached to the unit until the transfusion is complete.

Please call Ext. 55715 if you have any questions.

Submitted by:
Kathy Prodzinski, Lab

Inside This Issue:

Providing Care After Death

There are many steps to follow when a patient dies. The death checklist and policy, “Death, Care Provided After” are resources for you. Below are a few reminders:

- The death checklist serves as your guide. It follows in order of priority. For example, if a death is unexpected or unexplained, you need to sequester equipment and have blood drawn as soon as possible. Therefore, this item is listed at the top of the list.
- The Administrative Nursing Supervisor/Patient Placement Coordinator must be notified of each death. Include the name, time of death, medical record number, funeral home/location if known, and any pending reasons for delaying the release of the body to the funeral home (example: ME case, autopsy, organ/tissue/eye donation). Once everything has been completed, the Administrative Nursing Supervisor/Patient Placement Coordinator notifies Admitting and authorizes the release of the body to the funeral home. Admitting then calls the funeral home to pick up the body.
- Admitting should be called with the name, medical record number and time of death as soon as possible. They maintain a log book of all deaths and are the access point for morticians who pick up bodies. Morticians “sign out” when they leave.
- At times family members have told the funeral home that “everything is done.” Unfortunately this can result in the funeral home director driving a distance only to learn that some things are still pending (example: tissue donation). It would be helpful if you could let family members know that the hospital (Admitting) will notify the funeral home once everything is complete.

Finally, “thank you” for your compassion and sensitivity in the care of the deceased. Families always remember those final moments and the caring manner of staff after death. It is a lasting impression and a testimony of our mission and values.

Submitted by:
Barb Scheiber

Director, Patient Care Support
Ext. 55611

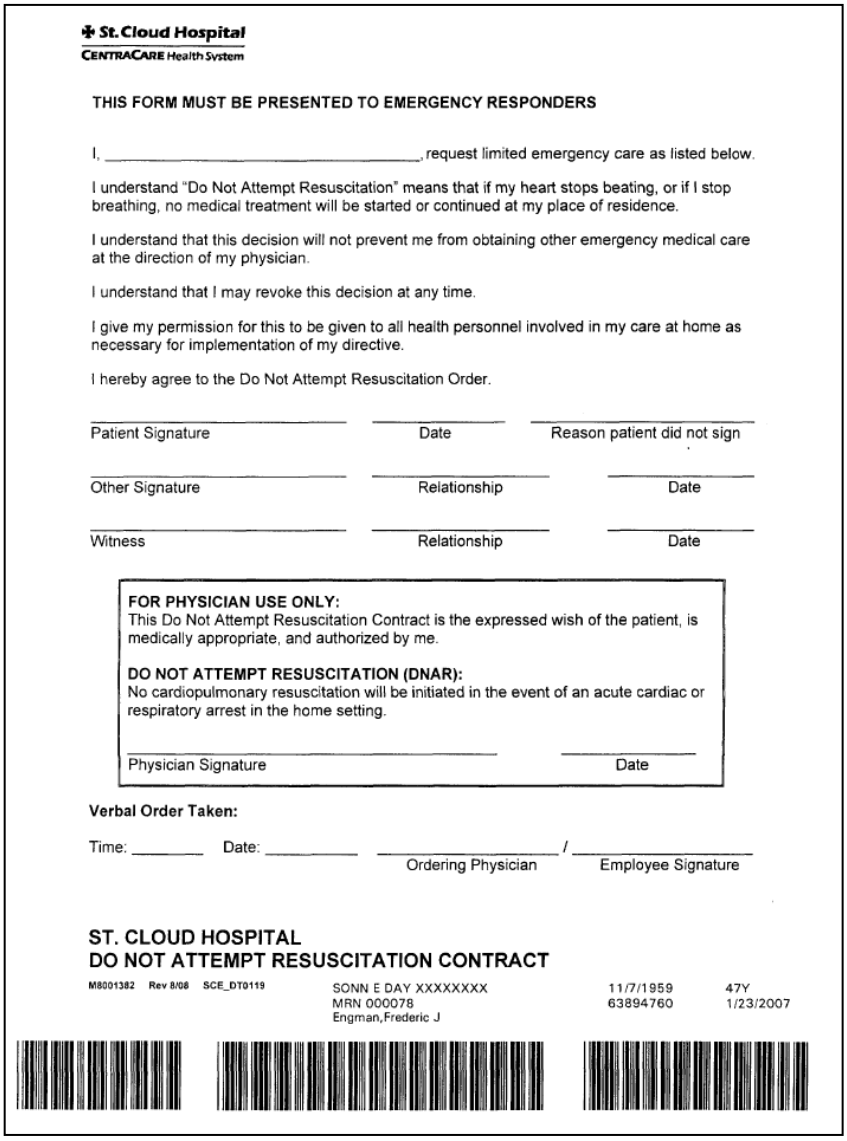
Do Not Attempt Resuscitation/DNAR Orders for Patients Being Discharged

Patients who are on Do Not Resuscitate status while a patient in the hospital may wish to remain on this status after discharge to their home or assisted living. Currently, the patient who is referred to hospice will have the benefit of the hospice personnel assisting them with their wishes regarding dying with dignity. However, many patients on DNR status in the hospital will not be utilizing hospice and may not be aware of the need to take a written physician's order home when discharged. While a health care directive is important, the Do Not Resuscitate notation on a directive is by Minnesota law not utilized at the scene of a 911 response by emergency medical providers.

Patients and their physicians often do not understand that at end of life there is often much confusion and when reaching out for help, they will often dial 911. A call to 911 alerts the emergency medical system that reacts in an all-or-none fashion. That reaction involves CPR and other emergency actions designed to preserve life, UNLESS a written order by a physician is part of the home documentation. The order form titled: **Do Not Attempt Resuscitation Contract** can be found in Optio Forms.

Because of this, the Medical Executive Committee passed the following policy: "Patients who wished to return home on a Do Not Attempt Resuscitation status will have the Do Not Attempt Resuscitation order written by the discharging physician or advanced practice provider prior to discharge. The order is valid unless rescinded." This change is found in the policy titled, "Limited Treatment."

This is such an important issue for patients and their families. Please gently remind the attending physician at the time of patient discharge to sign this form. Part of discharge instruction for the patient and family who have the Do Not Attempt Resuscitation (DNAR) order written is to explain that when 911 is called for medical assistance, have the form readily available to hand to the first emergency responder to arrive at the residence.



St. Cloud Hospital
CENTRACARE Health System

THIS FORM MUST BE PRESENTED TO EMERGENCY RESPONDERS

I, _____, request limited emergency care as listed below.

I understand "Do Not Attempt Resuscitation" means that if my heart stops beating, or if I stop breathing, no medical treatment will be started or continued at my place of residence.

I understand that this decision will not prevent me from obtaining other emergency medical care at the direction of my physician.

I understand that I may revoke this decision at any time.

I give my permission for this to be given to all health personnel involved in my care at home as necessary for implementation of my directive.

I hereby agree to the Do Not Attempt Resuscitation Order.

Patient Signature _____ Date _____ Reason patient did not sign _____

Other Signature _____ Relationship _____ Date _____

Witness _____ Relationship _____ Date _____

FOR PHYSICIAN USE ONLY:
This Do Not Attempt Resuscitation Contract is the expressed wish of the patient, is medically appropriate, and authorized by me.

DO NOT ATTEMPT RESUSCITATION (DNAR):
No cardiopulmonary resuscitation will be initiated in the event of an acute cardiac or respiratory arrest in the home setting.

Physician Signature _____ Date _____

Verbal Order Taken:

Time: _____ Date: _____ Ordering Physician _____ / Employee Signature _____

ST. CLOUD HOSPITAL
DO NOT ATTEMPT RESUSCITATION CONTRACT

M8001382 Rev 8/08 SCE_DT0119

SONN E DAY XXXXXXXX
MRN 000078
Engman, Frederic J

11/7/1959 47Y
63894760 1/23/2007

See the attached Limited Treatment policy.

Submitted by:
Dr. Eric McFarling, Ethics Committee Chairperson

Karen Kleinschmidt, PCS Educator

TITLE: Limited Treatment Page 1 of 3

Original: August, 1986 Revised: ***7/08***
Replaced: 2/99; 9/00, 3/03, 6/04
Responsible Person(s): Chair, Ethics Committee
Approving Cmte: Ethics Committee
Category: Patient Care
Cross Reference: Advanced Healthcare Directive Policy;
Informed Consent Policy
Rights and Responsibilities of Patients Policy
Ethical and Religious Directives for Catholic Health Care Services
Ward of State Protocol

I. POLICY:

Treatment becomes ethically unnecessary either when it is of no benefit to the patient or when the burdens to the patient resulting from treatment are disproportionate to the benefits hoped for or obtained. Thus, one can withhold or withdraw treatment that might prolong life, when that life is terminal and treatment only prolongs the dying process. Withholding or withdrawing useless or burdensome treatments does not mean abandoning the patient. In all cases, the patient's dignity, comfort and hygiene must be preserved. The sacredness of human life is upheld at all stages of its continuum.

The physician, nursing and other members of the health care team are responsible to act as patient advocates. Their professional obligation is to assure that the patient's best interests are properly identified and supported.

The physician will have an appropriate knowledge of the patient's medical condition before consideration of limited treatment orders.

A competent and fully informed adult patient or an incompetent patient's surrogate decision maker has the right to accept or refuse, withdraw or continue (in part or the whole) a treatment within the context of reasonable medical practice and institution norms.

Decisions regarding limited treatment care plans must be made on an individual basis with participation of the patient or surrogate and the physician. Additional resource persons such as family, health care team members, clergy, and Ethics Committee members, are available to assist in this decision. ***The patient's health care directive will be reviewed if there is one available.***

If there is no written order regarding Cardiopulmonary Resuscitation status***, the attempt will be made to resuscitate*** all patients. If the physician writes an order for Do Not ***Attempt*** Resuscitat***ion***/No Code Blue, the patient will be on Do Not ***Attempt*** Resuscitat***ion***/No Code Blue status unless order is rescinded. All other modalities and treatments continue as ordered or limited by physician directive.

Do Not ***Attempt*** Resuscitat***ion*** orders are compatible with maximal therapeutic care. The patient may be receiving vigorous support in all other therapeutic modalities and yet justifiably be considered a proper subject for the Do Not ***Attempt*** Resuscitat***ion*** order.

Patients who wish to return home on a Do Not Attempt Resuscitation status will have the Do Not Attempt Resuscitation order written by the discharging physician/advance practice provider prior to discharge. The Do Not Attempt Resuscitation order is valid unless rescinded.

TITLE: Limited Treatment Page 2 of 3

Physician and hospital staff will follow the patient's wishes as expressed verbally or on ***a health care*** directive form within the context of reasonable medical practice and institutional norms. The physician or nurse who believe that carrying out the limited treatment decision of the patient conflicts with their personal/professional integrity, may request to not participate in the limiting/withdrawal of treatment. If there is no alternative caregiver available, the physician/nurse must carry out the patient's wishes. (See guideline #7 on page 3 regarding Chain of Command).

The patient's values, religion, and life philosophy are to be respected and appropriate psychosocial support provided ***for*** the patient and their family.

After consideration of the above policies, the physician may then elect to write orders to either initiate, continue, withhold or withdraw care which includes but is not limited to the following:

A. Resuscitation
   1. External Cardiac Massage
   2. Cardiac life support drugs
   3. Intubation with Respiratory assistance short of mechanical ventilation

B. Respiratory Assistance
   1. Respiratory Therapies
   2. Endotracheal intubation
   3. Mechanical ventilation continue, withdraw or weaning protocol

C. Nourishment
   1. IV fluids
   2. Enteral feedings
   3. Total parenteral feedings

D. Medications
   1. Antibiotics
   2. Antineoplastic
   3. Cardiovascular
   4. Other Medications

E. Invasive Diagnostic and Therapeutic Procedures
   1. Arterial, venous catheters
   2. Kidney dialysis
   3. Cardiac pacing
   4. Transfusions
   5. Lab, imaging/scanning or other tests

II. GUIDELINES FOR DO NOT RESUSCITATE

1. The Do Not ***Attempt*** Resuscitat***ion*** decision will follow the guidelines of the Minnesota Medical Association.
2. If a Do Not ***Attempt*** Resuscitat***ion*** decision has been made, by the competent patient or the incompetent patient's proxy decision-maker this directive shall be written as a formal order by the attending physician.
3. Discussion with the patient, family/surrogate decision maker regarding all relevant facts,

TITLE: Limited Treatment Page 3 of 3

information and circumstances about the individual case and plan of care will be documented by the physician/nurse or social worker in the medical record.

4. The Do Not ***Attempt*** Resuscitat***ion*** order is reviewed by the physician and a decision to rescind the order can be made any time by the competent patient or the incompetent patient's proxy decision-maker.
5. ***For patients being discharged home, the Do Not Attempt Resuscitation form (obtained in Optio Forms) will be completed by discharging physician and given to patient/family.***
6. Patients on a Do Not ***Attempt*** Resuscitat***ion*** Order ***(DNAR)*** who receive anesthesia/ sedation or radiographic contrast will be informed by the anesthesiologist/radiologist that the ***DNAR*** order is rescinded while the effects of anesthesia/sedation are in effect.
7. If the patient is a limited treatment code blue, i.e. no intubation, a blue striped band will be placed on the patient's wrist with the limited treatment written on the band. All resuscitation will be done except the limited orders. (see Patient Identification Policy for the blue band)
8. Patients who undergo diagnostic testing or treatment where there is risk of patient reaction due to chemical agents (such as contrast media) will be provided the necessary resuscitation support to overcome the effects of the agent.
9. The Chain of Command policy should be utilized if conflicts regarding Limited Treatment cannot be resolved or resolution is needed before a care conference can be arranged. Ethics Committee members can be consulted and involved in the conflict resolution by calling the Administration Office, ext. 55723, Monday - Friday, 8:00 - 4:30 p.m. or contacting the Administrative Nursing Supervisor.

III. REFERENCES:

- American Hospital Association (Right to Refuse Treatment Statement)
- ANA (Code of Ethics)
- CHA (Statement on the Dying Patient)
- Minnesota Medical Association (DNR Guidelines)
- Mission Statement & Philosophy of Saint Cloud Hospital

Addition to the "Fall Management, Adult Policy, Addendum 2"

Because of the patients who are freely ambulating on the Adult Mental Health Unit (AMHU) as part of their milieu *and* are on fall prevention, we have implemented an *alternate* external indicator to the red slippers. Many of these patients are allowed to wear their shoes to stabilize their gait and balance. For that reason, **the external indicator for fall protection and prevention on AMHU will be the yellow arm band rather than the red slippers.**

This addition has been entered as, letter "t", under interventions on the fall assessment tool.

Joyce Salzer, RN
Lori G. Johnson, BSN, RN, BC
Adult Mental Health Unit

The following two signs MUST be present on the exterior of the door frame.

CONTACT PRECAUTIONS

(In addition to Standard Precautions)

Visitors -- Report to Nurses' Station Before Entering Room

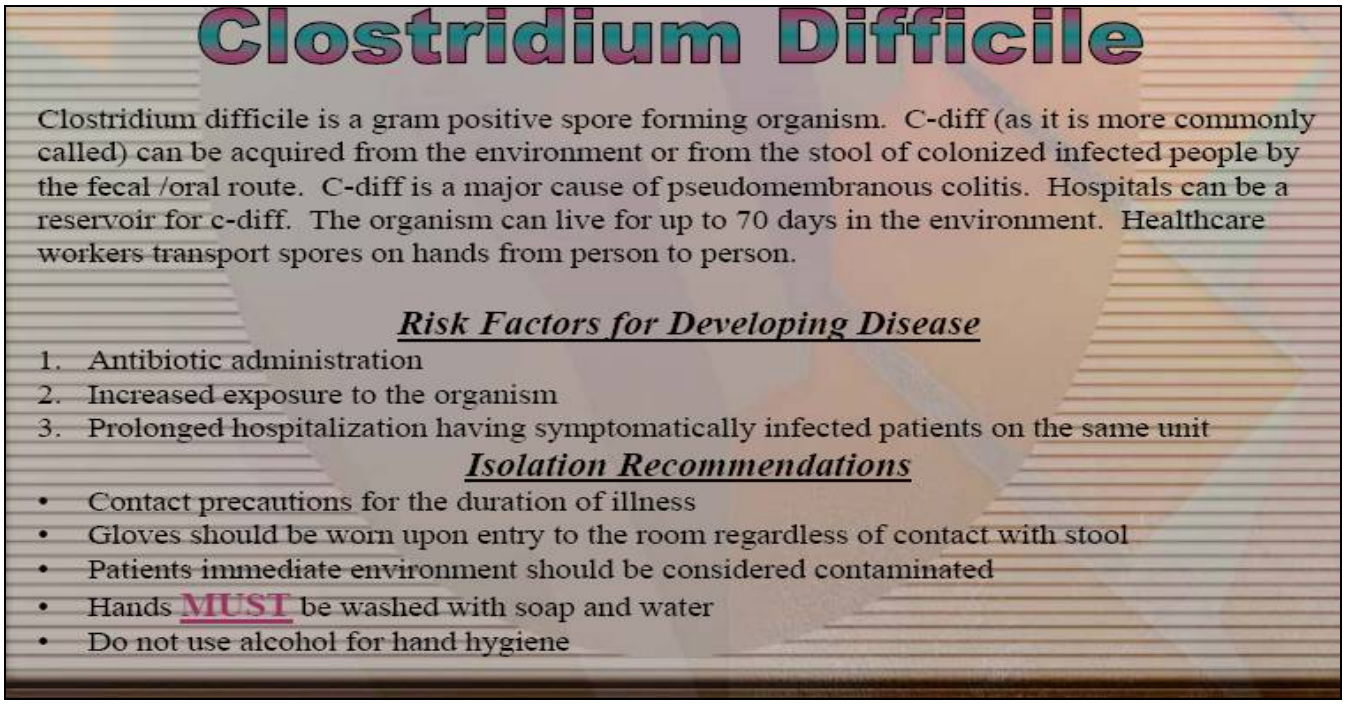
1. **Private Room** - When a private room is not available, **cohort with patient(s)** who have active infection with the same microorganism **but with no other infection.**
2. **Gloves** - wear gloves when entering room. Change **gloves after contact with** infective material. Remove gloves before leaving patients's room.
3. **Wash hands** - with antimicrobial agent immediately after **glove removal and** before leaving the patient's room.
4. **Gown** - wear if you anticipate that your clothes will have **substantial contact with** the patient, environmental surfaces, or items in the patient's room, or if the patient has any of the following: *** Incontinent * Diarrhea * Colostomy * Ileostomy * Wound Drainage not contained by a dressing**
   Remove gown before leaving the patient's environment.
5. **Transport** - Limit the movement/transport of patients from room to essential purposes only. During transport, **place surgical mask on the patient, if possible.**
6. When possible, dedicate the use of noncritical patient-care **equipment to a single patient.** If common equipment is used, clean and disinfect between patients.

Please don't remove these signs from the door frame until after housekeeping has cleaned the room.

- Bleach is used to clean the rooms upon discharge

When should isolation be discontinued?

- Isolation should not be discontinued until diarrhea has subsided for at least 48 hours.



Submitted by:
Sally Petrowski, Infection Control

Christmas is Coming! Christmas is Coming! Mark Your Calendars!

Believe it or not, it's getting to be that time of the year again. Summer has barely come to a close and the Thanksgiving, Christmas and New Years holiday schedules are fast approaching. We wanted to allow you adequate time to look at your calendars to make requests regarding the holidays so please keep in mind the following important dates:

Schedule Dates	Requests Due	Schedule Posted
November 16- December 13 (Thanksgiving November 27)	Friday, October 3*	Friday, October 31
December 14 – January 10 (Christmas and New Years Holiday Schedules)	Friday, October 31*	Friday, November 28

*In order to determine the Thanksgiving, Christmas and New Years holiday rotations, **some areas may require the request due dates for <u>both</u> schedules on the same date** (refer to unit guidelines or ask your scheduling associate for further details). However, schedules will be posted separately.

When making requests, please keep in mind for scheduling purposes, if you are scheduled to work the Christmas holiday you will be scheduled to work both Christmas Eve and Christmas Day. If you are scheduled to work the New Years holiday you will be scheduled to work both New Years Eve and New Years Day. (Please refer to your unit specific guidelines for exceptions.)

Terri Krause
Coordinator, Patient Care Support
Ext. 55705

Summary of PTO Scheduled/Unscheduled Policy Changes

The PTO Scheduled/Unscheduled policy was recently revised and approved by Resource Management. The policy has been reformatted and streamlined which we believe will help you better understand how we apply these definitions when approving and/or denying requests for PTO. Listed below for your convenience are highlights of the recent policy changes (new policy changes are indicated in ***bold italics***).

Definitions: A Definition section has been added to help clarify how we apply these definitions when approving and/or denying requests for PTO.

- A weekend is defined as Friday, Saturday and Sunday – please keep this in mind when requesting. We cannot grant single days over your weekends to work.
- Definition of requests that will be pre-approved in advance of schedule development need to meet the following criteria: you must be requesting a minimum of a 7-day stretch of time off and the PTO hours needed to cover this time off will be equal to half of the employee's hired hours.
- Definition of requests that will not be pre-approved in advance of schedule development would be requests for single PTO days or requests for less than a 7-day stretch of time and/or less than half of your hired hours.
- "Weekend Only" (formerly referred to as flex weekend) is a weekend of PTO not associated with a stretch of PTO time off. You can check to see if you are eligible for this by referring to policy guideline #4.
- The amount of PTO that you are eligible for is based on your length of service, your job classification and actual hours worked. The PTO accrual charts included with this policy have been moved to the end of the policy and included as an addendum. These charts will help you determine the amounts of PTO you can accrue based on your FTE status. If you have questions on your accrual rates, you should contact the Human Resources Department and they will be glad to assist you in figuring out your projected balances. Please keep in mind your PTO hours are used to cover your requested time off for holidays, vacations and also must be used for any unplanned illness or absence.

Guidelines for Unscheduled PTO:

- PTO hours must be used when calling in ill/absent for scheduled shifts. Once you have picked up a shift, it is considered scheduled. Picking up a different shift to meet hired hours does not negate the need to use PTO hours.
- ***For those areas that are part of the two-way interface between Kronos and ANSOS/One Staff, ill/absent time is entered by the Staffing Office and paid automatically from the schedule in ANSOS/One Staff.***
- ***Employees in areas not part of the two-way interface between Kronos and ANSOS/One you may need to enter their ill/absent hours into the Kronos System.***
- ***In Kronos the code for ill/absent hours are indicated as PTX (unplanned/unscheduled time off). It is the responsibility of each employee to review their timecard for accuracy prior to Time Card Mondays.*** The hours to cover your absences are taken from your PTO balances.
- If you have missed half of your hired hours for the pay period due to illness, you may qualify for short term disability. It is your responsibility to contact Human Resources for appropriate processing of benefits.

Continued on next page…

Guidelines for Requesting Scheduled PTO Annual First Choice PTO Requests:

- Planners for schedule dates January 11, 2009 through January 10, 2010 are currently posted on your unit. These planners remain posted until 8:00 a.m. on Monday, October 6, 2008. A cover letter has been posted with the planners outlining the timelines for posting and picking up along with how to submit your requests.
- You must submit a First Choice PTO Request form in order for your request to be considered. **Requests should never be placed in the unit locked boxes**. Your requests should be sent directly to your unit Scheduling Associate.
- First Choice PTO Requests are approved and granted based on seniority.
- During prime-time months of June, July and August all staff are limited to a two-week block of time for your selection.
- Please refer to the policy guidelines to determine if you are eligible to request a "weekend only". Please note that "weekend only" is never granted for holiday weekends or weekends on either side of the holiday, especially weekends on either side of Christmas, New Years and the 4th of July. During the First Choice PTO Process, a "weekend only" will not be granted if it would result in "bumping" someone from taking a 2-week stretch of PTO.
- You need to make sure you will have the adequate number of PTO hours needed for your requested time off. If the entire amount of PTO hours needed to cover your request are not available in your PTO bank, your time off will not be scheduled.
- ***Employees who received pre-approval for their PTO request may not cancel their time off at a later date without approval from the director/designee.***
- ***Staff that originally submitted a First Choice PTO request and did not receive approval of their First Choice and/or Alternate Date will be notified by their Scheduling Associate either by phone or email. A one week timeframe (Monday-Monday) will be set aside for those notified individuals to select PTO from time still available. It is the employee's responsibility to set up an appointment to meet with their Scheduling Associate. No verbal requests will be allowed.***

Additional Full Week PTO Requests:

- Additional PTO requests are accepted after the First Choice PTO requests have been approved.
- PTO requests **should never be placed in the unit locked boxes** as PTO requests are awarded on a first-come; first-served basis. Seniority is not a factor unless more than one request is received on the same day for the same time period.
- You can expect a response from your Scheduling Associate within 14 days of submitting your request whether it is approved or denied.

PTO Requests for Single PTO Days:

- PTO requests **should never be placed in the unit locked boxes**. Please send them directly to your unit Scheduling Associate.
- You **will not receive formal approval and/or denial** for Single PTO Requests; you will need to wait until the schedule is posted to see if their single day PTO request has been granted or denied.

You are encouraged to review this policy in detail by accessing the policy on CentraNet. If you have any questions or would like further explanation of these policies, please contact your unit Scheduling Associate or myself and we will be glad to review these guidelines in more detail with you.

Terri Krause
Coordinator, Staffing/Scheduling/Secretarial Services
Ext. 55705

Clinical Ladder

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

Level IV

Jason Foos, RN — Emergency Trauma
- Transfer Protocol Module
- Preceptor
- ACLS Teaching Stations
- ETC Code Blue Response Policy
- Certified Emergency Nurse

Level III

Melanie Borgert, RN — Pt Care Support
- United Way Representative
- Preceptor
- Sigma Theta Tau Member

Amanda Francs, RN — Medical II
- MPCU Medications & Monitoring Frequency Inservice
- EPIC Super User
- Team Building: Team Work Inservice
- Co-chair Equipment Task Force
- EBP Committee

Jeni Hansen, RN — Ortho/Neuro
- Collar Care Documentation PI Project
- Halo Pamphlet
- EPIC Super User
- Patient Education Committee

Joan Johnson, RN — Dialysis
- Preceptor
- Staff Certification: Buttonhole Technique
- Inservice on Leadership
- Clinical Ladder Representative

Kathy Klaustermeier, RN — Pt Care Support
- Obesity Poster
- EPIC Super User
- New Grad Inservice – Central Line
- Injury Prevention Committee

Jill Lageson, RN — Ortho/Neuro
- Orthopedic Conference Committee Chair
- Preceptor
- Total Joint Class Instructor
- Orthopedic Nurse Certification

JoAnn Olson, RN — Inpt. Rehab
- Team Building Inservice
- Preceptor
- FIM Poster
- Gerontology Certification

Level III cont'd.

Kelsey Thompson, RN — Dialysis
- KDU Monthly Lab Draws – Resource Sheet
- PI Committee/PI Audits
- Staff Support Committee Chair
- Suction Set-up Inservice

Upcoming Developmental Programs: Educational and Professional

October, 2008

1	NRP (Neonatal Resuscitation Renewal Course), 9 am-12 pm, FBC Classroom
7	Lessons for Professionals: Optimizing Care for the Dying, 7:30 am-4:30 pm, Windfeldt Room, Plaza
9	Writing for Professional Publication, 8:30 am-3:30 pm, Windfeldt Room, Plaza
10	Adv. Writing for Professional Publication, 8 am-3:30 pm, Windfeldt Room, Plaza
13/14	Gen'l Hospice and Palliative Nurse Certification Review Course, 7:30 am-4:30 pm, Windfeldt Room, Plaza
20	NRP (Neonatal Resuscitation Renewal Course), 12:30-3:30 pm, FBC Classroom
23	S.T.A.B.L.E. (Sugar & Safe Care, Temperature, Airway, Blood Pressure, Lab Work & Emotional Support), 7 am-5:30 pm, CentraCare Health Plaza Education Center
22/23	ONS Cancer Chemotherapy Course, 8 am-4:30 pm, Hughes/Mathews, Plaza
23/24	Basic Electrocardiography, 8 am-4 pm, Heart Center Conference Room
29	Harvest the Fruits of Orthopedic Nsg 2008, 7:30 am-4:15 pm, Windfeldt Room, Plaza

To find out what other programs are offered through the Education and Professional Development Department, please call Ext. 55642.