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Patient Care News: January 2010

St. Cloud Hospital

PATIENT CARE NEWS

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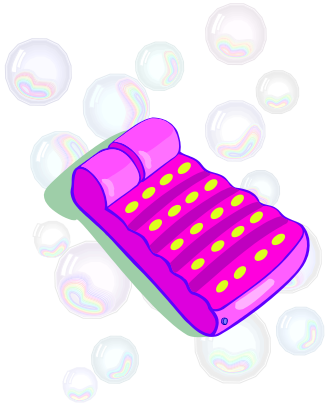
St. Cloud Hospital, 1406 6th Avenue, St. Cloud, MN 56303 *www.centracare.com* *320-251-2700*

INSIDE THIS ISSUE:

Hovermatt Mattress Reminders

Submitted by:
Joannie Nei, RN, BSN
Clinical Value Analysis Specialist
Supply Chain Management Department



Get one! Give one!
Protect each other!

When patient is transferred from Surgery with a Hovermatt mattress, give the Surgery transporter a mattress to bring back to Surgery.

a. This is vital for the process to work.
b. IF a mattress is not returned to Surgery, Surgery will not have a mattress for the next transfer which will negatively impact patient and staff safety.

Protect! Disinfect! Have Available!

a. Always use a sheet or blanket and chux as needed to protect the mattress.
b. Disinfect with Cavicide wipes thoroughly after each use
c. Only send stained mattresses to laundry but take all precautions to avoid staining from happening – laundry process takes 3-4 days.
d. Sending unstained mattresses to laundry severely impacts our supply of mattresses when needed.

We want to PROTECT YOU so please help with the Hovermatt process so that mattresses are in use as much as possible!!!

Palliative Care Program

Submitted by:
Roberta Basol RN, MA, NE-BC
Care Center Director; Intensive Care/Surgical Care and Clinical Practice

Beginning Monday, January 4, palliative care consults will be provided by a physician. Dr. Merryn Jolkovsky will be the palliative care physician for inpatient adults at St. Cloud Hospital. The palliative care team also includes practice nurses Laurie Henkemeyer, RN and Sheila Mehr, RN, Social Worker Kim Dorholt, LSW and Spiritual Care Staff Pastor Ray Arveson and Chaplain Nicole Schmidt.

Palliative care specializes in the relief of pain, symptoms, and stress of serious illness. Palliative care is not the same as hospice care. Palliative care may be provided at any time during a person's illness, even from the time of diagnosis, and it may be given at the same time as curative treatment.

Palliative care aims to relieve symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, anxiety, and difficulty sleeping. It helps patients gain the strength to carry on with daily life. It improves their ability to tolerate medical treatments. Overall, palliative care offers patients support for decision making and comfort related to quality of life during their illness.

Long term plans include working with the community in the continuum of palliative care services as well as promoting pediatric palliative care. Consults may be placed via referral in Epic.

Upcoming Developmental Programs: Educational and Professional

Listed below are upcoming programs offered through the Education and Professional Development Department . Please call extension 55642 to register or for further information.

January 2010

5	Basic Life Support Instructor Recertification Course, 12:30pm-4:30pm, Spruce Room
5	NRP Online/Megacode Renewal Course, 12:30pm-2:00pm, Oak Room
7	EPIC Renew, 8:00 am, 2:00pm, 4:15 pm, or 8:00 pm, Cedar Room
11	Nursing Research Brown Bag Sessions: Shared Decision Making, 12:45 pm-1:45pm, Aspen Room
14	EPIC Renew, 8:00 am, 2:00pm, 4:15pm, or 8:00pm, Cedar Room
19	NRP Renewal Course 9:00am-12:00pm, Birch Room
19	AHA Pears, 8:30am-3:30pm, Skyview Conference Room
21	EPIC Reboot, 8:00am, 2:00pm, or 4:15 pm, Cedar Room
21/22	Basic ECG, 8:00am-4:00 pm, Heart Center Conference Room
28	EPIC Reboot, 8:00am, 2:00pm, 4:15 pm, or 8:00 pm, Cedar Room
28/29	Healing Touch Certificate Program-Class Level 3, 8:30am-6:00pm, Windfeldt Room, CentraCare Health Plaza

Research/EBP Article Review:
Comparing Ibuprofen and Acetaminophen

Summary by:
Carie A. Braun, PhD, RN
Associate Professor of Nursing
College of Saint Benedict/Saint John's University

Submitted by:
Nursing Research/EBP Committee

Drendel, A., Gorelick, M., Weisman, S., et al. (2009). A randomized clinical trial of ibuprofen versus acetaminophen with codeine for acute pediatric arm fracture pain. *Ann Emerg Med, 54*, 553-560.

Drendel, Gorelick, Weisman, and colleagues (2009) compared ibuprofen and acetaminophen with codeine as a method of pain relief for acute arm fracture pain in children ages 4 to 18 years. Although a few studies cited in the article have been completed comparing ibuprofen to acetaminophen with codeine, none to date have explored these two methods as a treatment for uncomplicated fracture in children. The importance of this study rests in both the high prevalence of injuries in children and the need for effective pain management in children as a result of these injuries.[1]

Using a convenience sample of 224 children at one level I trauma center, the research team randomized treatment with either ibuprofen or acetaminophen with codeine for uncomplicated fractures. Treatment was double-blinded and monitored for 72 hours post-discharge. The authors reported no significant difference in treatment failure between the two methods. Both ibuprofen and acetaminophen with codeine managed reported pain most of the time and children needed to take a rescue pain medication at about equal rates. Functional outcomes, such as the children's willingness to play, eat, and rest comfortably, were improved in the children taking ibuprofen for fracture pain. The ibuprofen group had less side effects as well. The authors concluded that "ibuprofen is preferable to acetaminophen with codeine for outpatient treatment of children with uncomplicated arm fractures" (p. 559).

The study of pain treatment in children is of critical importance. Pain reduction can reduce anxiety and promote healing. The main objective of this study was to determine the superior analgesic for fracture pain in children. Although the study design was suited to the research questions, pain level, measured with a modified FACES scale, was reportedly analyzed as ordinal data thereby making it difficult to see *at what level* the pain medications were effective. The rationale for use of nonparametric statistics in the analysis is unclear. The sample has met the power analysis provided and normality of the distributed data can be assumed. Other similar pain studies in children using the same pain scale have articulated pain severity scores at the interval and even ratio level of measurement.[3-4] What this means is that the researchers only assumed that a pain level of 4 was greater than 1, 2, or 3. They did not assume that there is equal spacing between a level 1 to a 2 and from a 2 to a 3, which is what is more commonly assumed in pain research in children. Increasing the level of data is conducive to parametric statistic application, such as with a *t* test, and allows for better comparisons of pain reduction between the two analgesics.[4] Mean difference scores are mentioned in the results but there is no indication of which parametric tests were used. In future studies, the researchers should consider bringing parametric statistical analysis to the forefront whenever possible in order to compare the level of pain reduction between various pain relief measures.

Statistical and clinical significance statements were also noteworthy. Throughout the study, the researchers make several statements of "significance" and "correlation" without providing the specific data, such as p values. For example, "the proportion of children who had any of these functions affected by pain analyzed by date after injury was significantly different in the 2 study groups" (p. 557). Is this clinical significance or statistical significance? Judged against what standard? The above assertion is reportedly analyzed with "survival analysis" but it is unclear what is meant by this as most studies using survival analysis are looking at cancer survival rates. In another section, statements of "there was little difference between groups" and "significantly more dysfunction overall" and "suggests a correlation" are not supported with an adequate statistical analysis to scaffold these assertions. Later within the results, mean difference scores are articulated in the results but there is no indication of which parametric tests were used to determine statistical significance or the accompanying p value. Future reports need greater statistical clarity to effectively support conclusions.

The researchers discuss the limitations of the study to be the use of a convenience sample and standardization of the medication dosages. These limitations may impact generalizability. The efficacy of the medications could certainly be impacted by under-dosing the children and not individualizing administration based on patient response. Some children just require a higher dose within a safe range in order to get the pain relief required. Although the study of outpatient administration of pain medication is valuable, self-report was also a potential limitation. Without direct observation, it is difficult to know for sure that families followed the instructions and interpreted instructions appropriately. Future studies could look at individualizing the dosages based on response in a more controlled setting to further support the evidence around efficacy of the comparison medications. Despite these limitations, the report has important clinical and nursing implications. Reported improvements in functional outcomes and a decrease in adverse effects in the ibuprofen group are notable. Nurses are constantly seeking to select medications well-tolerated by children and functional performance is equally important to actual pain levels. For families, the convenience of purchasing ibuprofen over-the-counter and ease of administration allow for greater family control over pain management with this medication.

Literature cited in this article:

1. CDC. Childhood injury report.2008. http://www.cdc.gov/.
2. Gemma, M., Oriella Piccioni, L., Gioia, L., et al. (2009) Ropivacaine peritonsillar infiltration for analgesia after adenotonsillectomy in children: A randomized, double-blind placebo-controlled study. *Annals of Otology. Rhinology & Laryngology, 118*, 227-231.
3. Migdal, M., Chudzynska-Pomianowska, E., Vause, E., et al. (2005). Rapid, needle-free delivery of lidocaine for reducing pain of venipuncture among pediatric subjects. *Pediatrics*, *115*, e393-398.
4. LoBiondo-Wood G, Haber J.(2006). *Nursing research: Methods and critical appraisal for evidence-based practice*. St. Louis, MO: Mosby.

Clinical Ladder

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

LEVEL IIIs:

Amy Anderson, RN KDU/Alexandria
- Member KDA Heartwalk Team
- Infection Control Poster for Patients on "Hand Hygiene"
- EPIC Super User

Amy Junes, RN Family Birthing Center
- Perinatal Loss Support Group Facilitator
- Preceptor
- Policy Revision on "Cord Care"

Elyse Kreger, RN KDU/Litchfield
- Presentation for Volunteers: "R.O.S.E = Reach Out to Seniors Effectively"
- Performance Improvement Member
- Preceptor

Colleen Layne, RN Center for Surgical Care
- Magnet Hostess
- Revision to CSC Patient Booklet
- Bair Paws Research/Implementation

Janelle Maciej, RN Telemetry
- Trendelenberg Position Module for Staff
- Preceptor
- Skill Station on Temporary Pacemakers for Telemetry Ed Day

Jenny Moores, RN Emergency Trauma Ctr
- Instructor for "Managing Care of the Critically Ill Medical Patient"
- Instructor for "Rapid Sequence Intubation"
- CCRN, CEN and CFRN Certifications

LEVEL IIIs (cont'd):

Terri Nicoski, RN Family Birthing Center
- Clinical Ladder Representative
- Poster Presentation to Staff on "Blood Administration"
- Perinatal Nursing Certification

Carol Primus, RN Coborn Cancer Center
- FIT Testing for Staff
- PI Chairperson
- OCN Certification

Carla Vanderpool, RN Pediatrics
- Preceptor
- Member of ANA and AACN
- Member of PICU Core Group

Tracy Velander, RN Pediatrics
- Minnesota Buddy Walk for Down Syndrome
- Neonatal Resuscitative Program Instructor
- Member Evidence Based Committee to Design New NICU

Patient Care News articles should be sent to Deb Kaufman in Patient Care Support by the 25th of each month.