

Advocate Health - Midwest

SHARE @ Advocate Health - Midwest

Historical Documents - Combined

Advocate Health - Midwest History

Nursing Now, 2012, V11 N2

Advocate Aurora Health

Follow this and additional works at: <https://institutionalrepository.aah.org/alldocuments>

Nursing Now

Communicate, Educate, Motivate!



A bi-monthly news publication written by nurses ... for nurses.

From the Desk of the Vice President, Nursing Services

Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services

Spring is a busy season at Advocate Christ Medical Center and Hope Children's Hospital. We celebrate our associates every April with Associate Week, hear inspirational speakers at President Ken Lukhard's Prayer luncheon, and enjoy our Salute gala, the very best fundraiser in the city of Chicago.

To top it all off, in May, we celebrated Nurses Week — and what a week it was! Our Joyce Woytek evening at Silver Lake Country Club was a spectacular event. This year, 60 stellar nurses were nominated. Congratulations to Diane Murphy, BSN, RN, OCN, from 3 south/infusion center, this year's winner! Interestingly, Diane actually took care of our beloved Joyce many years ago. The Magnet celebration on Tuesday was just as spectacular. Everyone was so impressed with the creative work of our departments crafting their stepping stones. It was phenomenal! We celebrated our 438 newly certified nurses at a luncheon at the Oak Lawn Hilton on Wednesday, which brings our total number of nurses certified to over 700! The week ended with the distribution of new uniforms to all nurses and a fashion show of uniforms from years past, including those of Florence Nightingale and Clara Barton.



Lynn Hennessy, MS, MBA, RN, NEA-BC

The week after Nurse's Week, a group of us had the privilege to attend the Spectrum Award dinner to honor two of our nurses who were finalists for the Nursing Spectrum Nurse of the Year Award. Congratulations to Joanne Regan, adult surgical heart unit, nominated for Clinical Care Inpatient Category, and Ginny Fowler, APN, pediatric pain service nominated for Volunteerism and Service.

Elevating the image of nursing is in our Nursing Strategic Plan. This strategy can and will be achieved in many ways. One tactic to achieve this goal is to ensure all nurses are neat in appearance and easily identified by patients, visitors, physicians and other members of the health care team. New uniforms and uniform policies have been rolled out not only for nurses, but all clinical associates. Many studies have concluded that appearance plays an important role in nurse-patient relationships. In one study, it was noted that patients rated nurses wearing solid scrubs as significantly more skilled and knowledgeable than nurses wearing t-shirt type attire. It also concluded that nurses with tattoos and body piercings were perceived as the least caring skilled and knowledgeable.¹ I have had many, many positive comments about the appearance of our nurses in the short time the new uniforms have been out.

Although extremely important, appearance is not the only attribute that provides a measurement of professionalism. As professionals, we also have an obligation to engage in lifelong learning. We at Christ Medical Center and Hope Children's Hospital support lifelong learning in many ways, one of which is that all eligible nurses will sit for certification by the end of this year.

We are part of the most wonderful profession, a profession that has been named the most trusted for the last 12 years in Gallup's annual Honesty and Ethics survey.² As the most trusted profession, we have an obligation to strengthen that trust every day, with every patient. You have the ability to change someone's life each and every day you come to work, choose to make each patient encounter one of caring and professionalism.

References

¹ Thomas, Christine M. PhD, RN; Ehret, Abigail RN; Ellis, Briana RN; Colon-Shoop, Sara RN; Linton, Jean RN; Metz, Stacie PhD. *Perception of Nurse Caring, Skills, and Knowledge Based on Appearance*. JONA. Nov.2010: 40(11) 489-497.

² Gallup, Inc (2012). <<http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx>>



Transformational Leadership

Magnet Force: Quality of Nursing Leadership

Nurses.com/Nursing Spectrum 2012 Nominees

The following Advocate Christ Medical Center and Hope Children's Hospital nurses were recognized by Nurses.com Nursing Excellence Awards for 2012.



Pictured from left to right are Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services; Sandra Clark, MSN, RN, director, pediatric services; Ginny Fowler, APN, MS, CPNP, CPN, CPON; advanced practice nurse, 4Hope; Joanne Regan, RN, CCRN, nurse clinician II, ASHU; and Ken Lukhard, market president.

Joanne Regan, RN, CCRN, nurse clinician II, staff nurse (award category nominated for: Clinical Nursing, Inpatient)

Joanne Regan is a critical care nurse in the adult surgical heart unit (ASHU). She was a sub-investigator for the unit's progressive mobility research project. The protocol focused on optimizing mobility before and after surgery, with the idea that early ambulation would allow patients to return to their baseline mobility sooner and decrease their length of stay in the ASHU. "Joanne's enthusiasm and commitment to this project was phenomenal," her nominator wrote. "Joanne has the ability to take her patients to a new level." She was part of a team led by the governing council to improve nursing documentation in the unit. She assisted in

the development of a tool for standardizing documentation, the educational rollout of this tool, and the development of a peer-to-peer audit that has been successful at standardizing documentation for the patient population. She also is a preceptor for new nurses and works with student nurses, as well as at the bedside.

Ginny Fowler, MS, APN, CPNP, CPN, CPON, advanced practice nurse (award category nominated for: Volunteerism and Service)

Ginny Fowler is an advance practice nurse who serves general pediatric patients and their families as well as a large population of children with a hematologic/oncologic diagnosis. According to her nominator, Fowler and a physician helped start the Cure It organization. Founded in 2011, the foundation is a not-for-profit organization that supports children diagnosed with cancer and works toward helping to find a cure. The foundation initially was developed to raise funds for CureSearch, a national organization supporting pediatric cancer research. The Cure It mission is to support pediatric cancer care and research at both the national and local levels. Locally, the Cure It team supports communities that sustain their mission by directly giving back to children and families affected by childhood cancer. Through her fundraising work, the foundation has raised more than \$100,000.



Exemplary Professional Practice

Magnet Force: Image of Nursing

Evidence-Based Nursing

Debbie O'Connell, MSN, RN-BC, director, clinical education

This summer Advocate Christ Medical Center and Hope Children's Hospital will access all nursing procedures through Lippincott Nursing Procedures and Skills (LNPS). LNPS is an evidence-based reference that will improve the speed of access to critical health care information. The on-line reference provides step-by-step instructions for performing nursing procedures. Advantages to using Lippincott include:

- Provides nurses with accurate, referenced, up-to-date information at the point of care
- Standardizes procedures/care across Advocate Health Care
- Ensures that hospital's procedures are documented and available to all nurses at all times
- Provides annual review by competent clinical experts
- Provides skill lists and competency tests for each procedure

Advocate Health Care made the commitment to LNPS as a system-wide reference when they noted there was significant variation within Advocate on the quantity and quality of nursing procedures. The chief nurse executives agreed to move forward on a standard evidence-based nursing procedure format.

In 2011, three Advocate sites began the process of reviewing and comparing the Advocate site procedure and the Lippincott procedure. Lippincott currently has more than 1,200 procedures with more added each quarter. It was decided, however, that Advocate would begin with 400 procedures. These include medical-surgical, critical care, maternal/neonatal, pediatrics and pediatric critical care. The remainder will be phased in over the year.

At Christ Medical Center and Hope Children's Hospital, the Policy and Procedure Committee, chaired by Elizabeth Kupczyk, MSN, RN, and Tina Davis-Larkin, APN, MSN, RNC, will serve as content experts and identify any gaps in

practice. This project is led by Dawn Horn, MS, RN, APN, CCRN, ACNS-BC, 8 south, neuroscience unit, Meggan Mikal, MS, APRN, PCNS-BC, CPN, CHPPN, 2 Hope, and Elizabeth Kupczyk, MSN, RN, clinical affiliations liaison and professional clinical practice council (PCPC) chair.

As we are closer to the "go-live" all nurses will have the opportunity to complete on-line education that demonstrates how to access and use the procedures. All procedures currently on the Advocate Policy and Procedure website will either be archived or linked to Lippincott. It will truly be a one-stop reference. If you would like a demonstration, go to <http://procedures.lww.com>.



Exemplary Professional Practice

Magnet Force: Professional Models of Care

Patient Safety

What is Patient Safety?

Debra Kman-Malabanan, BSN, RN, manager, patient safety

Every day hundreds of patients come through our doors and become dependent on us to provide effective and appropriate treatment and to ensure their safety — protecting them from unnecessary risk or harm.

What does ensuring safety mean?

According to the World Health Organization, patient safety means offering “freedom ... from unnecessary harm or potential harm associated with health care.”¹ A focus on safety can also reduce the severity of harm, should it occur. Basically, the concept of patient safety focuses on preventing medical error.

Historically, the medical profession has viewed medical errors as either an inevitable byproduct of complex care or a result of provider incompetence, often seeking to blame the provider rather than examining the systems that may have failed. Over the past 10 years,

health care organizations began to realize that most errors are not due to the performance of the individual and are instead the result of a series of system errors that work together to yield unsafe situations. We have come to the realization that these system errors are often preventable and do not need to occur.

In order to make improvements in patient safety, we will need to commit to redesign systems to achieve significant levels of safety, recognize that most patient harm is caused by bad systems and not bad people, and therefore end the response of finger-pointing and shame. Finally, there needs to be acknowledgement that to improve patient safety everyone on the care team needs to work in partnership with one another and with patients and families.

We can begin to learn from errors and near misses by increasing reporting. If leaders do not know about a defect

in the system or product, they cannot fix it. The next time you walk into a room and almost administer a medication to the incorrect patient, complete a patient safety event form. This is a near miss and it is important that we learn from what almost happened rather than after an error has occurred and potentially caused harm to a patient. As front line staff, you are the final barrier between the patient and a potential error.

References

¹WHO Patient Safety Curriculum Guide for Medical Schools. Geneva: World Health Organization; 2009. Available at http://www.who.int/patientsafety/education/medical_curriculum/en/index.html. Accessed October 27, 2009.



Exemplary Professional Practice

Magnet Force: Quality of Care: Patient Safety

A Story of Hope

Bonnie Blevins, MS, APN, heart and vascular institute

As an advanced practice nurse (APN) working in a hospital setting, I do not always have the opportunity to see how my patients fare after being discharged home. I am not able to follow up with them in the clinic and thereby, I lose touch with their progress.

However, the following story is one where I was able to see a positive outcome from all the hard work of the associates here at Advocate Christ Medical Center.

My name is Bonnie Blevins and I am an APN for the Heart and Vascular Institute. I have worked here for 16 years and currently work for the vascular surgeons, Dr. Govostis, Dr. Ellenby, Dr. Pradhan and Dr. Kang.

In May of 2011, I met a very nice man named Mr. “O” in the surgical vascular thoracic intensive care unit (SVTU). He was a healthy 54-year-old gentleman who developed a clot in his left leg due to a clotting disorder. Dr. Pradhan removed the clot and restored blood flow the same day he was admitted. Unfortunately, he developed another clot and then underwent a bypass to his leg. Again, he clotted off his bypass graft to the leg, resulting in the need for a below the knee bypass amputation.

When Mr. “O” and his family were in the SVTU, I had to inform him of the recommendation for a below the knee amputation. It was then that I found out that he was a soccer coach for his youngest daughter. We all cried, but we knew this was what was needed.

I called the Hanger Company, and asked if they could send a volunteer to speak with Mr. “O” and encourage him, and give him hope for his future. A volunteer who was a bilateral amputee came out and spoke to him, and answered all his questions.

Mr. “O” went on to our rehab on 6 south and learned how to transfer and get around with a walker, while waiting for his prosthesis.

On the day he was going to be discharged, I went to his room and said my goodbyes. He asked if he was going to ever be able to coach soccer again. I told him, that with hard work and dedication, I believed he could definitely coach soccer for his daughter again. We hugged and I asked him if he would please come see me when he had his prosthesis and let me know how he was doing. He agreed, and said he would.

On April 5, 2012, I received a call to go over to the physician office building; there was someone who wanted to see me. I walked over to the office and standing there was Mr. “O” with his workout clothes and prosthesis. He got up and walked around the room, jumping up and down and showing me his new prosthesis that needed to be plugged in at night. He told me he is coaching his daughters’ soccer team again and is doing very well. He said he is going to get another upgraded prosthesis, one that has a flexible foot. He also is going to volunteer for the Hanger Company to go out and speak to other patients who are in need of an amputation.

I do not always get to see the outcome of my patient’s progress. However, this time I did, and I am so glad I did. It brought hope and encouragement to my heart.



Exemplary Professional Practice

Magnet Force: Quality of Care

Magnet

Healing Hearts: It is All a Matter of Teamwork

Paulette Anderson, RN, CCRN, nurse clinician III, assistant clinical manager; Julie Connolly, BSN, RN, nurse clinician II; Tami Rohlf, RN, CCRN, RCIS, nurse clinician III; Troy Smith, BSN, RN, RT, nurse clinician II, assistant clinical manager; Elizabeth Worthan, BSN, RN, CCRN, nurse clinician III, assistant clinical manager, invasive cardiology

You have passed us a hundred times going to the emergency department (ED), x-ray or the conference center and may have wondered, “What goes on inside those closed doors?” The answer is invasive cardiology. This area comprises the cardiac catheterization (cath) lab and the electrophysiology (EP) lab and is part of the Heart and Vascular Institute and the Heart Institute for Children. It is the second busiest lab in the state of Illinois performing more than 6,700 procedures. The staff consists of nurses, radiology technologists, cardiovascular technicians (techs) and physicians from three specialties: cardiologists, interventionalists and electrophysiologists. The nursing staff’s combined experience exceeds hundreds of years with 75 percent of the nurses having 20 plus years of experience, and all nurses are nurse clinician IIIs and hold certifications in the following areas: Critical Care Registered Nurse (CCRN), Certified Pediatric Nurse (CPN), Registered Cardiovascular Invasive Specialist (RCIS) and Registered Cardiac Electrophysiology Specialist (RCES).

The staff thrives on collaboration and teamwork on a daily basis. The lab’s nurses work closely with radiology technologists, cardiovascular techs and physicians to care for patients at a time when teamwork is essential. As with any department, our patients depend on a team that works well together. The cath lab staff has come a long way from the days of only one nurse and one tech being on call for emergencies just 10 short years ago. Our door to balloon times (D2B) were well over 100 minutes as recently as 2005. Data showed that decreasing D2B times in patients that present with an ST elevated myocardial infarction (STEMI) to less than 90 minutes saved heart muscle and decreased mortality. To achieve optimal outcomes and meet our goals we studied evidence-based practices across the country. Based on these findings we improved our process to include four staff members on call, which included two nurses and two techs as well as one primary interventional cardiologist off shift. The most significant process change was our partnership with the centralized telemetry center (CTC) and the ED. This interdisciplinary relationship was formed in 2008 and focused on shaving critical minutes off several key measured areas. In 2009 we achieved our goals and attained D2B times under 60 minutes and today we average D2B times 53 minutes off shift surpassing the national goal of less than 90 minutes and also our stretch goal of less than 60 minutes. Last year our team won the Magnet Clinical Division Award for “Best Clinical Team” for collaboration in delivering outstanding D2B times.

The focus of the pediatric cardiac cath and EP lab is on patients with congenital heart defects. These patients’ ages span from moments after birth until well into adulthood. These nurses provide holistic care from prior to procedure to follow-up after discharge home. They work collaboratively with our adult lab staff as mentors, educating on the many challenging cardiac anomalies.

Since obtaining Magnet in 2005 there has been a positive shift in the staff’s engagement in learning and the most recent challenge of certification has driven the staff to become even more inquisitive. The physicians volunteer their time to educate staff on the multiple cardiac and peripheral procedures as well as the science of electrophysiology. The unit now holds adult and pediatric EP conference once a week. This educational collaboration has given the staff opportunities to learn more every week and affords the physicians opportunities to discuss difficult cases in a round table environment. Our educational partnership with the physicians has provided staff expert knowledge on EP studies, catheter ablation, pacemakers and defibrillators. This educational journey has contributed to the strong professional practice environment in the labs.

As newer and more expansive procedures emerge, it will become ever more imperative for collaboration and teamwork within disciplines to achieve positive patient outcomes in the future. Congratulations to the invasive cardiology unit for demonstrating exemplary professional practice through building interdisciplinary relationships and driving quality improvement through education to achieve top decile quality performance.



Exemplary Professional Practice

Magnet Force: Quality Improvement; Interdisciplinary Relationships

A Heartfelt Thank-You

Carol Pisano, BSN, RN, CCRN, manager, CHF clinic

What an overwhelming day March 1 was at the Leadership Development Institute (LDI)! Receiving the clinical manager of the year award brought forward so many emotions and I know that I forgot to thank everyone. There have been so many people I have learned from in my 33 years here at Advocate Christ Medical Center. If I mentioned all of them it may take up this entire edition of NURSING NOW. So, I will take this opportunity to thank each of you for the mentoring, teaching, partnership and leadership that you have provided me. What wonderful role models you have been for me. I especially thank my team in the CHF Clinic for being such a caring, compassionate and clinically excellent team. I am so proud of all of their accomplishments and appreciate all that they do every day. With sincere thanks to all!

Research

NUPASS Study Finds Guidelines can Reduce Interruptions and Improve Patient Safety

Julie Evanish, BSN, RN, PCCN, nurse clinician II, 9 south

Studies have shown that interruptions are one of the most common causes of nursing related medication errors (Flanders, & Clark, 2010; Westbrook, Woods, Rob, Dunsmuir, & Day, 2010). Administering medications is a critical task and nurses should be solely focused on delivery based on the 1) right patient, 2) right route, 3) right dose, 4) right time and 5) right medication without interruption. Has the following scenario ever happened to you while passing medications?

I prepare my patients' medication in the medication room where it is noisy with nurses talking, I then bring my medications to a computer to check them against the medication administration record (MAR) and a doctor asks me about a patient in a room nearby. I then walk towards the room where I am to administer my patients' medications and a call light goes on. After answering the call light (needed fresh water) I go into my patient's room and begin the process of administering medications to my patient. While I am teaching my patient about the medications, my phone rings and I am asked if another patient can go for a computed tomography (CT) scan. After responding, I continue to administer the medications. When my patient has taken the medications and I have answered his questions, I am asked to help with a boost for the patient in the next bed. During bedside report, while checking the MAR with the oncoming nurse, we notice I have not signed off any of my medications for that patient. Are you surprised?

The interruptions depicted in this scenario are examples of avoidable interruptions (ie. phone call, face-to-face conversation, call light). A team of nurses in the cardiac progressive care units studied the relationship between medication administration errors and interruptions during medication administration in the NUPASS (Nurses Uninterrupted: Passing Medications Safely Using Evidence Based Practice) study. Medication accuracy and interruptions were recorded during specified administration times before and after Medication PassTime-Out guidelines were implemented on two cardiac progressive care units. The time-out guidelines include strategies to minimize interruptions such as regular patient rounding and collaboration with other team members to navigate phone calls or face to face requests. A third unit was used as a comparison group and did not implement the guidelines. The study team conducted 631 naïve medication observations coupled with retrospective chart review on a convenience sample of nurses from all three units.

Our findings showed that while administering medications, nurses were interrupted 15.69 percent of the time. Both experimental units (using the time-out guidelines) decreased avoidable interruptions following the intervention. Also, the unit with the most interruptions and medication errors significantly decreased both interruptions (p value 0.0003) and medication errors (p value 0.022) while using the time-out guidelines. We showed that attention to interruption avoidance can impact the safety of medication

administration. Can this research help more units to increase patient safety by decreasing interruptions and errors? Please picture the next scenario:

Using Medication PassTime-Out guidelines on my unit, I update my charge nurse and inform her I will begin my medication pass for my patients. I don a yellow safety belt and prepare my medications in a quiet medication room, and then I check my medications against the MAR and walk to my patient's room. While walking to the patient's room, other staff does not engage me because they see I am administering medications by my yellow belt. My phone does not ring in my pocket because I docked it before medication pass. I safely administer medications to my patient, performing all the

safety checks, explaining the medications and answering all questions. I walk directly to a computer where I chart my medications immediately. As I walk back to the medication room to prepare for the next patient, I see a doctor for one of my patients. Knowing the guidelines, I ask him if there is anything he needs to know about his patient and ask if there is anything I need to know or do before I start preparing medications for another patient. After I am finished administering all my medications, I take off the belt, retrieve my phone, check in with my charge nurse who informs me a family member called for one of my patients and will call back within the hour.

This scenario is not from a dream but can be reality when patient safety is considered first during medication administration. Implementation of the time-out guidelines can be unique to your care unit. In our study, both experimental units' guidelines started out the same, but they became unique for each unit over time. Participating in the NUPASS study has been quite an amazing experience. The team definitely wants to thank all who have been involved on our units, for the study would not have been able to happen

without everyone's help!



NUPASS Team Members: Julie Evanish, BSN, RN, PCCN, nurse clinician II 9 south; Joy Fernald, BSB, RN, nurse clinician II, 8east/west; Dawn Hart, BSN, RN, nurse clinician II, 9 south; Sue Glavin, BSN RN, PCCN, nurse clinician II, 9 south; Dawn Hutchinson, BSN, RN, PCCN, nurse clinician III, 8 east/west.

References

- Flanders, S. and Clark, A., (2010). Interruptions and medication errors. *Clinical Nurse Specialist*, 24 (6), 281-285.
- Westbrook, J., Woods, A., Rob, M., Dunsmuir, W., & Day, R. (2010). Association and severity of medication administration errors. *Archives of Internal Medicine*, 170 (8), 683-690.



New Knowledge, Innovations and Improvements

Magnet Force: Quality of Care, Research and Evidence Based Practice

Voices

"Voices" is a forum for you to voice your thoughts and opinions on fun, thought-provoking questions that affect your quality of work life. Our goal is to capture the diversity of our nursing staff—we can learn so much from each other! We hope that "Voices" provides you with some food for thought, or some topics for discussion with your colleagues. Enjoy!



Geanette T. Barry, RNC-MNN, 3 east/west, nurse clinician III

My greatest inspiration to be a nurse was my eldest brother. When we were growing up, Joe always said, "I will be the doctor and you will be the nurse in my office." So at a very young age, he would teach me how to care for people. He is a

doctor now. He did his residency at Advocate Christ Medical Center and that inspired me even more to work at Christ Hospital.



Mary Sue Dedic, BSN, RN, CHF clinic, nurse clinician III

My grandma was my inspiration to become a nurse. I used to get on two buses as a young teen to go to her home and help her do the things she could no longer do. She had severe arthritis. She made me love the idea of caring for older

people. My favorite patients are the elderly. I treat them like they are my own grandparents. I am especially aware of patients that do not have family that visit. I try to spend more time with them.



Ryan Gagnon BSN, RN, pediatric emergency department, nurse clinician III

Cindy Pasquerello, RN. She was a diabetes educator that took care of me my entire childhood. She was the kindest and most giving person I have ever met.



Lorena Gilbert, MSN, RNC, 2east/west, nurse clinician II

It was an emergency room nurse that I met as a child. I had fallen and cut myself. The nurse was calm and reassuring. She made me comfortable while I received my stitches.



Melissa Milner, BSN, RN, 8 east/west, nurse clinician II

As a young child I was in and out of hospitals and very sick for several years. The fantastic nursing staff that cared for me inspired me to provide the same care to others. They made me feel safe and cared for.



Katie Naegele, BSN, RN, emergency department, nurse clinician II

My greatest inspiration to becoming a nurse was a young lady named Maureen Ferriter. Maureen was born with Down's Syndrome. As a close family friend, I became involved in many of her

extra-curricular activities such as Special Olympics. Through this volunteer work, I realized how much I love engaging in the lives of others and knew that nursing was the best path to fulfill this need.



Kathleen Nelson, BSN, RN, MBA, performance improvement

My mother was my inspiration to become a nurse. She cared for patients in their homes and nursing homes. She loved taking care of patients and they loved her. She never went on in school so she was

very proud when two of her daughters became RNs. Presently, I have taken what I have learned from working at the bedside for 20 years to working in performance improvement. I am following a passion that I have to try to improve processes and patient outcomes.



Lindsey Schnoor, RN, 8 south, nurse clinician II

My greatest inspiration to become a nurse was my dad. He had a couple of health scares that really opened my eyes to the health care field. I realized I wanted to be the nurse caring for him in those difficult times or at least become

knowledgeable to what was happening to him. I know he was very proud when I told him "I passed the test. I am a nurse."



Structural Empowerment

Magnet Force: Image of Nursing

And the Winners are ... 4th Quarter Daisy Award Winners



"Unsung heroes," and "Angels on our shoulders" ... these are some of the terms used by Tena Barnes to describe a Daisy Award Winner. In each issue of NURSING Now, Advocate Christ Medical Center and Hope Children's Hospital celebrates the achievements of these standout associates.

Jessica Maier, ADN, RN, PCCN, nurse clinician II, 9 east/west

Jessica is consistently great with her patients. She pays attention to details and knows who to call and what to do if there are changes in her patients' condition. There was recently a left ventricular assist device (LVAD) patient who she was going to discharge. She happened to check the patient's back up controller and found out that the rotations per minute (RPMs) were not the same as the patient's current speed. This would have been a potentially big problem if the rehab facility where he was being transferred had to use his back up!



Jessica Maier, ADN, RN, PCCN, nurse clinician II, 9 east/west.

She is an excellent LVAD nurse who has spent many hours organizing the VAD equipment and paperwork on our floor. She initiated a binder with the various LVAD patients' history, last admission, along with LVAD settings prior to discharge. This expedites the admission process when they return to our unit. She will also come in on her day off to do patient/family education classes to assist in the discharge. She is often utilized as a clinical coach because of her expertise and pleasant attitude. Her orientees have all praised her coaching and stated she was a great mentor who they would continue to ask for clinical advice once they would be working independently. She received her PCCN re-certification this year and is currently pursuing her nurse clinician III status. She is a treasure to have on our unit and we feel fortunate to have her.

Jeff Redican, ADN, RN, CEN, nurse clinician II, emergency department

Jeff Redican, RN, is the quintessence of the compassionate, skilled professional nurse who is the model for receiving the Daisy award. He shares his skills and knowledge with his peers as well as through a mentoring role as a clinical coach to new nurses. He remains calm and even keeled even in the most stressful, chaotic situations.

He demonstrates his caring on a daily basis but there is one recent instance that I think describes Jeff's



Jeff Redican, ADN, RN, CEN, nurse clinician II, emergency department, Joan Kelley, BSN, RN, TNS, nurse clinician III, emergency department, Wendy Micek, PhD, RN, market director nursing science and Magnet.

action, preparing what was needed for intubation, gathering supplies and starting two IVs, administering the needed medications, inserting a Foley catheter, all the while speaking conversationally to the man to reassure and comfort him. Jeff bathed him because in his toxic state the man had lost control of his bodily functions; with Jeff reassuring him he was going to make him feel better and comfortable. Within a very short time, the man's vital signs were stabilized; he was breathing with the assistance of a ventilator, and was settled comfortably in clean sheets and a patient gown.

Such actions by Jeff are part of his daily routine. He passes no judgment, looks at the here and now of the patient's condition and determines what he needs to do in the best interest of his patients. Through demonstration of clinical judgment and compassionate care, Jeff Redican, RN, is a fitting recipient for the Daisy award.

Maggie Lee, BSN, RN, CCRN, nurse clinician III, pediatric intensive care unit (PICU)

Nominating Maggie for just one award is not enough. She deserves to be recognized for all the following: compassion, equality, excellence, partnership, stewardship along with the Daisy award. Maggie is a PICU RN. I have had the pleasure of working with her side by side in the PICU for many years. Each time I have worked with her, I have felt she is always on top of everything. A certain situation made me want to nominate her for her excellent care. Not only an MVP award but for the Daisy award as well.

We were both caring for a patient who was so sick that at any given time the patient could pass. The whole family was with "Jack" by his bedside praying and trying to figure out what was best for him.

From the beginning of Maggie's shift to the end she made sure the parents and family were informed on everything from changes in "Jack's" care to



Maggie Lee, BSN, RN, CCRN, nurse clinician III.

helping and bringing the family anything they needed. The patient ended up passing away peacefully in his mother's arms. Maggie kept composed, giving her healing hand at all times. Maggie never left the mother's side unless it was to inform the doctor or to change a medication. She gave many encouraging words and also prayed with the family.

The care Maggie gave that night to "Jack" and his family was extraordinary! She went above and beyond to make this family comfortable. I truly believe in my heart that Maggie has a healing touch when it comes to patients and their families. Her kindness and excellent nursing skills shined that night and I will never forget it!



Exemplary Professional Practice
Magnet Force: Professional Models of Care

Daisy Award Nominees

4th Quarter, 2011

Donna Marzullo, 7 west
Nancy Hernandez, 7 west
Colleen, Surgery*
Kaitlyn, Surgery*
Terri Merrion, Fetal Diagnostics
Lynn McDermott, Day Surgery
Jill Hillman, 3 east/west

Jessica Maier, 9 east/west
Latanya Jackson, 6 east/west
Nicole Coleman, 6 east/west
Latonya Holley, 6 east/west
Jeff Redican, Emergency
Julie Cabrera, 8 east/west
Jennifer Lange, 4 east/west
Tsisi, 7 south*
Charlie Hildebrand, CDU

Candy Micheals, 7 south
Mary (Sue) Dedic, CHF Clinic
Kelly Kupiec, 3 south
Caitie Cross, 9 south
Maggie Lee, PICU

*RN's nominated by patients and a last name is not given.

American Nurses Association: Test Your Diversity IQ

Nurses are trained to meet the care needs of patients from all walks of life, but what exactly does it mean to be diversity aware? Below are ten questions to test your diversity awareness. The answers to the questions are provided right on this page (no peeking!).

1. Individuals from ethnic and racial minority groups account for approximately one third of the U.S. population today. **True or False?**
2. Nurses from minority backgrounds represent half of the registered nurse workforce. **True or False?**
3. Registered nurses from minority backgrounds are more likely than their white colleagues to pursue advanced degrees in nursing. **True or False?**
4. Identify the percentage of adults in the United States who are obese:
12% 26% 34% 72%
5. Asian Americans use more herbal medicines than other Americans. **True or False?**
6. A patient who speaks only Spanish and has been given written instructions to take medication once a day. **What is the potential harm?**
7. Black women have higher average blood pressures compared with white women. **True or False?**
8. JCAHO accreditation standards define "family" as individuals related by blood or marriage. **True or False?**
9. Both the Muslim and Jewish dietary practices prohibit the consumption of pork and pork products. **True or False?**
10. The ANA envisions diversity awareness as the acknowledgement and appreciation of the existence of differences in attitudes, beliefs, thoughts, and priorities in the health-seeking behaviors of different patient populations. **True or False?**

Answers:

1. True
2. False. Nurses from minority backgrounds represent 16.8% of the registered nurse workforce according to the 2008 National Sample Survey of Registered Nurses.
3. True. According to the 2008 National Sample Survey of Registered Nurses, nurses pursuing degrees beyond the associate level are white (48.4%), African American (52.5%), Hispanic (51.5%), and Asian (75.6%).
4. According to the Centers for Disease Control and Prevention, 33.8% of U.S. adults are obese. Nursing care must consider obesity-related issues like mobility challenges, drug absorption, and skin conditions.
5. False. According to a 2001 Commonwealth Fund factsheet on Quality of Health Care for Asian Americans, Asian Americans are less likely than Americans in general to use herbal medicine (20% versus 23% overall).
6. "Once" in Spanish means eleven. This patient may understand the directions to read take the medication eleven times a day.
7. True. The National Health Lung and Blood Institute states that about 37% of black women have high blood pressure.
8. False. JCAHO states that hospital policies should define "family" as any individual that plays a significant role in the patient's life, such as spouses, domestic partners, significant others (of either same-sex or different-sex), and other individuals not legally related to the patients.
9. True.
10. True!

So, how did you do? If your score is less than perfect, the American Nurses Association has an on-line resource bank of materials available as a resource for cultural competency at <http://nursingworld.org/DiversityAwareness>.

Hospital Security: Passing the Test

Kathleen Stahl, BS, MA, director of customer service

The Advocate Christ Medical Center and Hope Children's Hospital Department of Public Safety is honored to share information about our team and the training and actions that our department has adopted for both crime prevention and the tracking of incidents that occur on our campus.

It is the mission of the Department of Public Safety to protect life and property in support of the mission of Christ Medical Center and Hope Children's Hospital. We are seriously committed to the safety of everyone on our campus. The first step in our journey to enhance our department was to do a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis in partnership with an outside consultant.

Among our strengths were a system-wide zero tolerance for violence policy, highly trained officers, and a strong relationship with local law enforcement. Some of our weaknesses were a need to increase education on managing violent behavior to house-wide front line staff; and a challenging physical layout of our campus with multiple entrances.

As a recommendation from The Joint Commission, we also performed a self assessment consisting of 247 points provided by The Joint Commission of potential security risks and responses. We are happy to report that 202 of the points listed have already been addressed for our campus; 13 of the points did not apply to us, and 32 of the points we did not have in place. This is where we are currently focusing our attention.

Some risk factors facing all health care facilities today include:

- Increasing prevalence of weapons among patients, their families or friends
- Increasing use of hospitals by the police for criminal holds and care of acutely disturbed, violent individuals
- Increasing number of acute and chronically mentally ill patients released from hospitals without follow up care who now have the right to refuse medicine and who can no longer be hospitalized involuntarily unless they pose a threat to themselves or others
- Availability of drugs and money at hospitals, clinics and pharmacies making them likely robbery targets, increasing volumes of members of the public coming into the hospital and lower staffing levels with the health care teams

At Christ Medical Center and Hope Children's Hospital we have identified some specific risk factors such as:

- Staff's lack of situational understanding and background of patients/visitors (boyfriend/husband, dysfunctional families, gang members) and just not knowing how to handle the situation in order to de-escalate
- Cultural situations: fear of violence or retaliation
- Domestic violence: patients and associates
- Traumatic behavior of patients when informed of their medical situation
- Traumatic behavior of family members
- Lack of knowing where and how to use security equipment in the area or department such as panic buttons, phones, yelling for help or just walking away from the situation
- Associates lack of self-confidence in handling some situations
- Physical location of some departments

Several years ago, we took a proactive stance on what needed to be done and have already put many things in place to address the security needs of our campus.

Prior to 2006

- Officers carry an expandable baton
- All officers trained in pressure point control tactics

In 2006, Public Safety began implementing training in:

- OCAT (pepper foam)
- Tasers: electronic Control Devices (supervisors and key officers, only)
- Expansion of bike patrol

In 2008

- All officers were required to receive MOAB (management of aggressive behavior) training
- Partnership formed between Oak Lawn Police Department (OLPD) and Public Safety for Active Shooter Events (ERT team)
- Use of community policing model (zone patrols)
- Gang awareness/security threat analysis
- Police response to mental illness
- Investigation techniques for internal crimes and follow up to violent crimes
- Communication connection with the OLPD. Our radio frequency is on their radios allowing for quick connections and immediate assistance.
- Upgrade of our surveillance system

In 2009

- ERT Partners with 5th District Special Weapons and Tactics (SWAT) instructors to increase training standards
- Officers are trained in hostage barricade incidents
- Active shooter/armed intruder incidents
- Civil disturbances that may impact the facility requiring a strategic lockdown

2009 campus training

- Public Safety partnered with Human Resources (HR) to provide a recommended training to all front line leaders and managers regarding workplace violence and response
- Chief training officers working with the nursing residency program to provide workplace violence and MOAB training to all nursing residents

2010 present contract with tactical operations (TACOPS) 5th District SWAT instructors

- ERT officers are required to have four phases of training completed annually
- ERT members are required to qualify twice per year and spend additional two days on the range for skill development in shoot/do not shoot scenarios (Illinois State Law requires one annual firearms qualification)
- Drills using Airsoft (simulated firearms for training) are also held quarterly
- Pepper ball gun/impact weapon (chief training officer has been certified as an instructor in this new weapon which can be used to help disburse a crowd of people who are causing a civil disturbance.)

Our Public Safety Team consists of a manager of public safety and parking, a chief of training and regulatory compliance, two lieutenants that oversee the second and third shifts and three sergeants, one for each shift.

Recently, we restructured our department into two levels for our front line officers. Officer I, basic security duties, is trained in defensive tactics and management of aggressive behavior. These officers may carry a less lethal weapon such as pepper foam or a baton. The Officer II level

consists of officers who have the previous training listed but are also officers who have been specially trained in the use of firearms and special skills such as base dispatch. Moving forward, it is our goal to hire candidates that already qualify at the Officer II level.

Our focus for 2012 is to look for alternative methods to secure the campus. In addition, we will put in place new measures to maintain the same number of training hours while reducing the cost of training.

Every member of our department takes on this responsibility with enthusiasm, dedication, professionalism and personal commitment. The primary responsibility of every one of our team members is to assist the medical campus to establish a safe and peaceful environment in order that the campus's mission of health care, education, research, public service and patient care can take place in an open and welcoming environment.

The Power of Public Safety

- All officers are required to be PPCT Defensive Tactics Certified and all attend MOAB De-Escalation Training (Management of Aggressive Behavior and Workplace Violence)
- 25 officers certified and trained with firearms
- 19 graduates of the 40 Hour Rapid Deployment Training
- Six officers completing basic training
- 25 officers certified and trained with taser devices
- 20 officers certified with FN-303 Less Lethal Launcher
- 35 officers certified with pepper gel
- Certified closed circuit television (CCTV) and dispatch officers constantly monitoring in excess of 200 alarm access points and CCTV surveillance camera points
- All training classes are law enforcement level classes as they are held to a higher standard than the Illinois Security Requirements
- There are currently seven law enforcement officers on our staff
- There are 11 bi-lingual officers on our team (Spanish, Arabic, Polish and Slovak)
- Memberships and certifications include: ILEETA International Law Enforcement Educators and Trainers Association, National Rifle Association Law Enforcement Division, and International Hospital Safety and Security Association



Exemplary Professional Practice

Magnet Force: Interdisciplinary Relationships



Classroom training includes topics such as gang violence, management of aggressive behavior and working with patients with behavioral health issues.

Public Safety Leadership



Ray Samoska, manager (MA, BA, 30+ years)



Dan Lempa, chief training and compliance (BS, MS in progress, 17+ years)



Rich Kuchyt, lieutenant, 2nd shift (BS, 5+ years)



Vernell Jordan, lieutenant, 3rd shift (21+ years)



Gloria Sanders, sergeant, 1st shift (23+ years)



Will Ross, sergeant, 3rd shift (22+ years)

Not pictured: Walter Bergstrom, sergeant, 2nd shift (21 years)

PCPC Corner

Professional Clinical Practice Council (PCPC) January Meeting Update

Nancy Hernandez, BSN, RN-BC, nurse clinician II, 7 west

At the latest Professional Clinical Practice Council (PCPC) meeting held on January 19, uniform colors for each discipline were revealed. Over 75 percent of staff voted. The colors chosen are as follows: nursing (navy blue), PCA/ED tech/support associates (teal blue), medical diagnostics (caribbean blue), rehabilitation therapy (hunter green), respiratory therapy (pewter), behavioral health (wine), and phlebotomy (red). Scrubs will be embroidered with your specialty and shirts worn underneath scrub tops will be limited to white, gray or black in color and must be either turtle neck or crew neck style.

Patient safety was also discussed in respect to using least restrictive devices and restraints. It was stressed that violent versus nonviolent restraints should be based on the patient's behavior and not the type of restraints used. It was also discussed that roll belts be transitioned into use as a form of least restrictive restraint in place of vest restraints unless contraindicated. We were also informed that current trials also being done within the hospital regarding use of lap belt alarms that go off when patients

attempt to stand up while in a chair. Please remember also that there are no trial releases. Once restraints are discontinued, a new order is required if restraints need to be placed back on again. Education among patients and staff is also one of the top ways to minimize use of restraints.

Nurses from 9 south and 8 east/west also presented results from their Nurses Uninterrupted Passing Medications Safely (NUPASS) research study. Nurses on these floors had a designated time to pass medications without being interrupted unless absolutely necessary, and results showed there were less nursing medication errors and avoidable interruptions were decreased from 80 percent to 57 percent.

Other topics of focus at the PCPC meeting were the journal club article and Magnet re-designation. The journal club article comparing two peripheral intravenous catheter stabilization systems was reviewed during the meeting. The article discussed a study actually done by the VAD team at Christ Medical Center. A brief presentation was

given regarding the Magnet recognition program since submission for Magnet re-designation is due in 2013. Documentation regarding social policy, scope and standards, code of ethics and bill of rights were also briefly reviewed.

Debra Desmond, a leadership development consultant, spoke to us regarding finding the leader within you. She stressed that leaders are not born but that being a leader requires you to find your own voice, make decisions and finding a right balance. Overall this first meeting of 2012 was a very interactive session that brought unit council chairs a wealth of information to take back to their individual units.



Exemplary Professional Practice

Magnet Force: Interdisciplinary Relationships

Ask the Expert

Do you have a clinical question related to patient care? Submit your question to Nursing Now and we will share it with the appropriate clinician for a response. You may fax your question to ext. 41-5640, or e-mail to Nursing.Now.CMC@advocatehealth.com.

Fast Fact: SCIP and Beta Blockers

Jackie Murauski, MSN, RN, APN, Pre/Post Surgery

What is SCIP? Surgical Care Improvement Project

GOAL: decrease surgical complications by 25 percent

Who's leading SCIP?

The Agency for Healthcare Research Quality, American College of Surgeons, American Hospital Association, American Society of Anesthesiologist, Association of PeriOperative Nurses, Centers for Disease Control and Prevention, Medicaid Services, The Joint Commission, Institute for Health Care Improvement.

What is SCIP measuring?

Cardiac Care – BETA BLOCKERS

Surgical patients on beta blocker therapy should receive the beta blocker during the perioperative period. This includes the day prior to surgery or day of surgery through post operative day 2.

In the event that a beta blocker is not given an appropriate rationale must be documented. This can include heart rate and blood pressure (BP) parameters (i.e. less than 50 beats per minute (bpm), systolic BP less than 100mm/Hg or documentation of the patient receiving intravenous (IV) inotropic medications.

Other SCIP measures include:

Infection prevention

- Prophylactic antibiotic within one hour prior to incision and discontinued within 24 hours after the surgery (48 hours for cardiac patients)
- Appropriate antibiotic selection
- Controlling blood glucose
- Appropriate preoperative hair removal
- Perioperative normothermia
- Removal of urinary catheters

Venous thromboembolism (VTE)

- Surgery patients with recommended VTE prophylaxis ordered.
- Surgery patients who receive appropriate VTE prophylaxis within 24 hours after surgery

Why beta blockers?

- The literature shows that patients who are maintained on beta blockers are at lower risk for post-operative myocardial infarction and have decrease mortality.*

How does SCIP affect nursing practice?

- **NPO** is not a reason to hold some medications. Check with the physician especially if your patient is on a beta blocker.

- Obtain an accurate patient history related to medications used for high blood pressure, in particular beta blocker use, and provide a complete and updated medication history.
- Look up medications you do not know. There are many new beta blockers, although the generic name of beta blockers will end in **olol**, watch out for trade names!

Questions?

Contact Jackie Murauski at extension 41-5931 or at jacqueline.murauski@advocatehealth.com

References

SCIP: The surgical care improvement project. *Strategies for perioperative leaders*. (2007). Supplement to *OR Manager*.

Vanklei W., Bryson, G., Forster, A., & Yang, H. (2009). Effect of beta blocker prescription on the incidence of postoperative myocardial infarction after hip and knee arthroplasty. *Anesthesiology*, 111(4), 717-724.



Structural Empowerment

Magnet Force: Exemplary Professional Practice, Quality of Care Patient Safety

Beta blocker list as of 2/20/2012

Beta Blocker Trade Name

Betapace & Betapace AF (sotalol)
 Blocardren (Timolol)
 Brevibloc (Esmolol)
 Bystolic (Nebivolol)
 Cartrol (Carteolol)
 Coreg (Carvedilol)
 Corgard (Nadolol)
 Corzide 40/5 (Nadolol/bendroflumethiazide)
 Corzide 80/5 (Nadolol/bendroflumethiazide)
 Inderal & Inderal LA (propranolol)
 Inderide & Inderide LA (propranolol/HCTZ)
 InnoPran XL (propranolol)
 Kerledex
 Kerlone (Betaxolol)
 Levatol (Penbutolol)
 Lopressor (metoprolol)
 Lopressor HCT (metoprolol/hydrochlorothiazide)
 Normodyne (Labetalol)
 Ocupress (carteolol)
 Sectral (Acebutolol)
 Sorine
 Tenormin (Atenolol)
 Trandate (Labetalol)
 Toprol XL (Metoprolol)
 Viskin (Pindolol)
 Zebeta (Bisoprolol)
 Ziac (Bisoprolol/hydrochlorothiazide)

Advocate
 Christ Medical Center
 Hope Children's Hospital
 Inspiring medicine. Changing lives.

NursingNow

Communicate, Educate, Motivate!

Nursing Now is published for nurses at Advocate Christ Medical Center and Hope Children's Hospital. Readers are encouraged to submit stories, suggestions and ideas. Editor reserves the right to edit and/or refuse submissions.



Debbie O'Connell, MSN, RN-BC, MS, editor-in-chief, director of clinical education, Advocate Christ Medical Center and Trinity Hospital

E-mail: NursingNow.cmc@advocatehealth.com
 Phone: 708-684-4032
 Fax: 708-684-5640

Editorial Board

Lynn Hennessy, MS, MBA, RN, NEA-BC, vice-president, nursing services

Judi Cavanaugh, MSN, RN-BC, managing editor, professional nurse educator, clinical education

Lynn Curran, BSN, RN, professional nurse educator

Susan Cusack, BSN, RN, manager of clinical operations, 7 west

Eileen Golden, RN, nurse clinician II, congestive heart failure clinic

Suzanne Heslop, RN, CCRN, TNS, manager of clinical operations, surgical vascular thoracic unit

Colleen Leake, MSN, RN, manager, clinical education
 Cheryl Lefaiver, PhD, RN, nurse researcher/educator

Joanne Mazurski, education coordinator, clinical education and research

Irene Tranowski, MSN, RN, CRRN, clinical practice partner, 6 south

Risky Business

Interpreting Requirements in Title VI of the Civil Rights Act of 1964

Martha Winter, RNC, MJ, director, risk management

Safety concerns are associated with patients that are not provided proper interpreter services. Consider this situation that occurred in a Chicago-area hospital: A non-English speaking patient on anticoagulants was admitted and required reversal to prevent a possible bleed. She was deconditioned and bedrest was ordered. Nursing staff did not speak her language, nor were they aware of how to access the services that were available for overcoming the language barrier. A problem ensued when the patient got out of bed to use the bathroom. She did not understand why she was put back to bed against her desire. The patient became increasingly frustrated and upset. The nurse believed the patient was developing a medical agitation. The nurse called the resident and obtained an order for benzodiazepine to calm the patient and keep her in bed. The patient experienced a serious adverse reaction to the medication that required an ICU transfer and extended her hospital stay. In addition to a patient safety concern, the management of the situation was illegal because Title VI was violated.

Providing language access is a legal responsibility which is exacerbated by the nature and importance of the services being provided. In the federal arena, the 1964 Civil Rights Act is the single most important piece of legislation providing limited English proficient (LEP) individuals a legal right to language assistance. Any organization or individual that receives federal funds (i.e. Medicare/Medicaid) is subject to the oversight and requirements of the Office of Civil Rights (OCR) to ensure programs are free of discrimination. Patient/family complaints regarding inadequate interpreter services may result in a federal investigation by the OCR. Fines are

excessive and cases have been known to result in million dollar settlements.

It is imperative that staff become familiar with the Interpretation and Translation Services for Languages Other Than English policy (CMC 01.054.002). This policy applies to all departments and off-site locations. When presenting for care at the hospital, and ideally at scheduling, every patient should be asked "Is English your primary language?" If the answer indicates a language other than English proceed to ask "What is your preferred method of communication? And, do you need assistance with an interpreter?" The patient must be informed of the right to a language interpreter at no cost. Interpreters may be available on the medical center campus or are accessible by telephone (Pacific Interpreters) 24/7. Patients must never be told an interpreter is not available. Lack of an interpreter is a violation of the law. Staff must not suggest or encourage a patient's friends or relatives to serve as interpreters, and minors are always excluded. Family members, friends and other "informal" interpreters are more likely to modify what the patient actually said in an effort to be helpful. If the patient refuses interpreter services the Interpreting Services Form, attached to the policy should be completed and filed in the medical record. According to the OCR, an inquiry regarding interpreter refusal should take place in the patient's language to be certain the patient understands what is being waived.

In addition to patient rights, the care team has the right to an interpreter to ensure proper communication is occurring. The use of an interpreter is vital many times throughout the hospital stay (i.e. obtaining history,

communicating a diagnosis/prognosis, procedure information and discharge instructions, etc). Informed consent should always take place with an interpreter. If an interpreter is not present, it can be argued that informed consent never took place.

In the event an associate serves as an interpreter during an emergent situation, the Language Interpreter Competency Form (attached to the policy) should be completed. The form identifies the level of competency by the interpreter: level I is for social conversation; level II is for non-medical information, such as demographics; level III indicates an ability to interpret all levels of medical information. Staff that interpret are held legally responsible for their actions. Staff should avoid interpreting and refer to the special services website to obtain translated documents and review the interpreter guideline. Just because an individual is bilingual it does not mean he/she is qualified to be a medical interpreter. Certification classes are available in Illinois for interpreters. Remember, failing to have an appropriate interpreter is an OCR violation and professional liability insurance does not usually cover civil rights violations.

All events related to interpreter issues should be entered into the MIDAS RDE incident reporting program, available on the Advocate Home Page. Risk management is a resource department if you have questions or concerns. A risk management associate is available 24/7 through the page operator.



Exemplary Professional Practice
Magnet Force: Quality of Care

Professional Organizations

Research Organizations: Society of Clinical Research Associates and Association of Clinical Research Professionals

Cheryl Lefaiver, PhD, RN, CCRP, professional nurse researcher and Laura Wrona, BS, RN, CCRC, manager, clinical research

What is the Society of Clinical Research Associates (SoCRA)?

SoCRA is a non-profit, professional organization dedicated to the continuing education and development of clinical research professionals. A clinical research professional is someone who works in any field of research and is involved in one or more aspects of clinical trials research, including data collection, analysis or monitoring. The SoCRA mission is to provide training, continuing education, and an internationally recognized certification program that promote quality clinical research to protect the welfare of research participants and improve global health. SoCRA offers a certification examination intended to evaluate the applicant's level of knowledge and skill in comparison to the demands on a clinical research professional as they are found in clinical practice. Certification applicants must be current members of SoCRA working with good clinical practice (GCP) guidelines under institutional review board (IRB) approved protocols.

- What are some of the benefits to joining SoCRA?
- Subscription to the SOCRA Source journal that is published four times per year
 - Discounted registration fees for the annual meeting and other educational activities
 - Access to free and discounted continuing education (CE) programs and webinars
 - Membership is \$75 per year

The 21st Annual SoCRA Conference "Using Clinical Research to Improve the Lives of Patients Worldwide" will take place September 21-23 in Las Vegas, Nev. This conference offers educational opportunities to meet a variety of objectives such as to discuss the importance of adhering to GCP regulations and guidance in ensuring successful clinical research outcomes and discuss current issues in translational research. Additional information on SoCRA and the Clinical Research Professional (CCRP) certification exam can be found at <http://www.socra.org/>. For more news on the 2012 annual meeting, visit the SoCRA Conference website at http://www.socra.org/html/SoCRA_Annual_Conference.htm.

What is the Association of Clinical Research Professionals (ACRP)?

ACRP is a non-profit, global, professional organization that was founded in 1976. Over the last 30 years it has grown in size to now over 20,000 members worldwide and is

dedicated to ensuring quality clinical research, promote global protection of research participants, and to offer clinical research professionals educational opportunities and resources. A clinical research professional is someone who works in any field of research and is involved in one or more aspects of clinical trials research, including data collection, analysis, or monitoring. The ACRP mission is to provide global leadership to promote integrity and excellence for the clinical research profession. ACRP offers certification examinations in three branches of the clinical research realm: clinical research coordinator (CRC); clinical research associate (CRA); clinical physician investigator (CPI). ACRP certification is the formal recognition of clinical research professionals who have met the eligibility requirements and demonstrated job-related knowledge and skills.

- What are some of the benefits to joining ACRP?
- Subscription to the MONITOR, a peer reviewed journal that is published bi-monthly
 - ACRP WIRE, a bi-weekly e-newsletter that delivers current news specific to clinical research via email
 - Access to free and discounted continuing education (CE) programs and webinars
 - Membership is \$150 per year

The ACRP 2012 Global Conference and Exhibition took place April 14-17 in Houston, Texas. This conference features more than 125 sessions covering 12 topic areas, all delivered by leading speakers. The educational opportunities are designed to meet the needs of the clinical research team and cover topics such as finance, study management, communication, ethics, technology and innovation. For additional information on ACRP and the clinical research coordinator (CCRC) certification exam as well as the 2012 annual meeting, visit the ACRP website at <http://www.acrpnet.org/>.



Structural Empowerment
Magnet Force: Professional Development

Nurses Improving Care for Healthsystem Elders: NICHE

Fely Ong, MSN, APN, CCNS, advance practice nurse-geriatrics, coordinator for NICHE

Advocate Christ Medical Center along with three other Advocate hospitals (Good Samaritan Hospital, Lutheran General Hospital and South Suburban Hospital) has decided to join Nurses Improving Care for Healthsystem Elders (NICHE). NICHE is a national program aimed to improve care for older hospitalized adults. More than 43 percent of Christ Medical Center's patients are over the age of 65 and face a variety of health risks specific to older adults.

In 1994, the Hartford Institute for Geriatric Nursing, based at the New York University College of Nursing,

launched the NICHE program to help hospitals improve geriatric care. It was created in recognition of the aging of hospital patients, the ongoing national shortage of nurses trained in gerontology and the need for hospitals to contain costs while improving patients' health care experiences. NICHE is now being implemented in more than 300 hospitals nationwide and in Canada.

By joining NICHE, we expect to significantly advance our understanding of the needs of our older patients, educate our nurses to meet those needs, and launch several new protocols to prevent the health care problems

that can beset older people in the hospital. For more information about NICHE, contact Fely Ong, APN, NICHE coordinator at 684-1187 or email her at fely.ong@advocatehealth.com



Exemplary Professional Practice
Magnet Force: Quality of Care; Professional Models of Care

Education

What Can You Do to Foster Effective Nurse/Physician Communication?

Lynn Curran, BSN, RN, professional nurse educator, clinical education

How do we as nurses ensure that our communication with physicians is optimal for patient safety? Most of us can immediately describe interactions that have been responsive, courteous, timely, and promoted patient advocacy. Some of us may also be able to describe interactions that may have been less than optimal. Developing respect, trust and effective communication methods with physicians helps ensure that communication is clear and has the patient's best interests at heart. Collaboration, collegiality and interdependence between health care team members should be the established culture of the organization.

Patient outcomes are best accomplished with standardized reporting tools such as using the situation background assessment and recommendation (SBAR) format. At Advocate Christ Medical Center and Hope Children's Hospital, the use of SBAR is strongly recommended as a means to ensure clear communication and timely treatment. Regular use of SBAR becomes a mechanism whereby the physician or nurse can easily organize the information needed or determine if information is missing. Suggestions to physicians allow them to understand additional pertinent information which will benefit patients and improve outcomes. Incomplete or hurried communication may result in patient safety events or near misses.

The New Graduate Nurse Residency program implemented an ongoing nurse-physician communication forum in collaboration with Dr. Brian Sayger, vice chair of emergency services, and Dr. William Adair, vice president of clinical transformation. Dr. Sayger is the chair of Advancing Physician Excellence (APEX), the purpose of which is to improve collaboration and communication between physicians and health care professionals for best patient outcomes. Research has shown benefits of nurse/physician collaboration including an increase in patient, physician and nurse satisfaction, which also promotes increased nursing retention, physician career satisfaction, and ultimately decreased costs and patient length of stay.

Each cohort of the nurse residency program meets with either Dr. Sayger or Dr. Adair for an open discussion that promotes positive strategies for communication. Both effective and non-effective communication strategies are discussed in the open forum so that new nurses can learn from effective forms of communication and put them into practice. Did you know that hostility, aggressiveness or defensiveness, a tremendous challenge for anyone, may actually be a sign of insecurity? Ineffective or negative communication is not tolerated at Christ Medical Center. Therefore, the forums with Drs. Sayger and Adair also

address accountability and reporting systems. In addition, the forum provides the nurses with strategies to manage challenging interactions with physicians and barriers to effective communication.

Nurses should feel comfortable calling a physician even overnight as patient safety is at the forefront of the care we provide. Common communication threads discussed in the residency and suggestions for successful interactions include:

- Have SBAR information available
- State your name, title, department, and the patient you wish to discuss. You may find that the physician is covering for a colleague and is not familiar with the patient. A brief, pertinent background will then be necessary to ensure appropriate care for the right patient.
- Ensure that you have the correct physician. Many physician names may be similar sounding or may have one letter spelling difference.
- Have information available that may be useful to the current situation so there is no need to put the physician on hold or call them back, especially in the middle of the night.
- Bullet point information followed by question, request, or recommendation. Stick to the matter at hand.
- If you are a new nurse and/or unfamiliar with a specific physician practice, tell them and let them know it will help you to work with them more efficiently.
- Understand that a physician may have been in house all day, covering for a colleague's patients as well as their own, and have now received a number of intermittent calls throughout the night.
- Remember: The "Advocate Experience" Behaviors of Excellence are expected of all associates including physicians. We have a reporting mechanism in place for adverse and repeated behavioral issues.

The nurse-physician forum is extremely beneficial for new graduate nurses to describe personal communication experiences and delineate the best strategies to utilize in each circumstance. Several goals have been realized since the forum began in the New Graduate Nurse Residency program, the first is a successful effort to implement strategies to better communicate patient's needs to physicians. Program participants return to the residency sessions with positive examples of how the tools from these forums helped them feel more at ease and more empowered to successfully collaborate with physicians.

Some of the changes in practice as described by residency nurses:

- "What I learned from the education is to write out key information on my admission order set sheet especially care given in the emergency room (ER) so that I have all of the information in front of me on one sheet of paper. I then call the doctors and the conversation is better for both. I am more prepared."
- "It was really good to hear about the physician and nurse relationship. I think it would be great to have a place to report positive interactions with doctors so they could get that positive feedback. It might help them continue good communication with nurses and know nurses appreciate it."
- "I had to call Dr. Diamond at 3 a.m. for a patient who was a new consult. I took my time, used SBAR, and explained the situation. After receiving orders, Dr. Diamond complimented me and now I have more confidence. He was very patient and very nice."
- "When I had to call an attending in the middle of the night I made sure I had all of the patient's information readily available and I had all of my questions written down so that I did not forget anything which prevents having to call them back. I make the conversation short and to the point."
- "I always use SBAR now. I sound more professional and therefore physicians are more likely to listen to my concerns and recommendations."
- "Dr. Sayger helped me to understand how to get to the point. Doctors are more understanding and helpful."

The nurse-physician communication forum is incorporated into each residency cohort. The tools discussed during the sessions and the answers to real life challenges have proved invaluable to the new nurses.

Do you have a question regarding nurse-physician communication? Send questions to Linda.Curran@advocatehealth.com. Please note: names will not be published with questions. We will ask a variety of physicians to respond to as many questions as possible in future issues of NURSING NOW.



Structural Empowerment

Magnet Force: Professional Development

Profiles in Learning

Innovation in Perioperative Nursing Orientation

RebeKah Jaensch, MSN, RN, CNOR, assistant clinical manager, perioperative services

In September 2011, four new graduate nurses began their orientation in the operating room and went ... back to school! Yes, back to school. The surgical service department was looking for ways to improve the orientation program for non-experienced

perioperative nurses. The newest additions to our team have classes in and out of the hospital.

The perioperative orientation is eight months for non-experienced surgical nurses. It includes learning both the circulating and scrub roles in four services: general, gynecology, orthopedics and vascular/thoracic.

The first four to six weeks, the orientees attend classes on the basics of perioperative nursing. They attend lectures, have reading assignments and homework, and participate in skills practice sessions. They participate in Association of Operating Room Nurse's Periop 101 online courses, observe in areas that impact

*Jennifer Hines, BSN, RN, nurse clinician I;
Lisa Rochon, ADN, RN, nurse clinician I;
Heather Renken, BSN, RN, nurse clinician I;
and Ruth Jracewski, ADN, RN, nurse clinician I.*

surgery (holding room, day surgery, PACU, sterile processing), and are in operating rooms putting their newly learned skills into practice. For the next six weeks, the orientees attend classes at Prairie State College three days a week. Prairie State College has a year-long program where students learn how to be surgical technologists. Working with Advocate Christ Medical Center, Prairie State College provides classroom training in:

- Basic scrub skills including aseptic technique
- Opening sterile supplies
- Preparing the surgical field
- Gown and gloving self and others
- Assisting the scrub team during the case

The program focuses on the instrumentation and set-ups for general and gynecologic procedures as these are the first services in the orientation program. At the end of the six weeks, students must pass their final exam which includes opening, scrubbing and preparing the surgical field.

Our second class of students finished March 2, and the third class began March 28. Shirley Muhammad, an instructor at Prairie State and certified surgical technologist at Christ Medical Center, feels the program is going well and the students are eager to learn. She believes this innovative program helps the orientees prepare for the scrub role in a less stressful environment.

This program provides the opportunity for 16 new graduate/cross-training nurses a year. The department of surgery currently has openings and there is an incentive for those

interested in joining our team. Give us a call or send us a note. We would love to have you join our team!



*Lisa Green-Fuller, BSN, RN, nurse clinician I;
Sarah Borgetti-Ebenezer, BSN, RN, nurse clinician I;
Mandy Arias, BSN, RN, nurse clinician I; and Jinex Vattakattu, BSN, RN, nurse clinician I.*



Structural Empowerment

Magnet Force: Professional Development

Spotlight On

Fely Ong Finds Her NICHE

Lynn Curran, BSN, RN, professional nurse educator, clinical education

As the age of the geriatric patient population increases, so too will the need arise to have more effective resources to provide advanced care. We can better develop the most appropriate, evidence-based plan



Fely Ong, MSN, APN, CCNS, advance practice nurse-geriatrics, coordinator for NICHE

of care with the expertise of Nurses Improving Care for Healthsystem Elders (NICHE). NICHE is a program of the Hartford Institute for Geriatric Nursing at the New York University College of Nursing, the only national nursing-led program designed to improve the care of the hospitalized older adult patients.

Fely Ong, MSN, APN, CCNS, is one of four coordinators of Advocate Health Care (Good Samaritan Hospital, Lutheran General Hospital and South Suburban Hospital are the other three NICHE hospitals in the system). As the coordinator of Advocate Christ Medical Center's own NICHE program, Fely is responsible for the implementation of the NICHE program and ensures that evidence-based geriatric care is embedded at the unit level. The goal of NICHE is to provide exemplary and sensitive care to hospitalized older adult patients. NICHE is a national movement to improve geriatric care. The NICHE program at Christ Medical Center is supported by a steering committee that oversees how the program is implemented. The steering committee members are comprised of physician and nursing leadership and include the following:

- Dr. H. McGrath, physician champion
- Mike Moonan, BSN, RN, MBA, director, medical-surgical/psychiatry/procedure services and administrative leader support

- Debbie O'Connell, MSN, RN-BC, NEA-BC, education director support and administrative leader support
 - Kathy Nelson, BSN, RN, MBA, performance improvement coordinator
 - Sophie Kwak, BSN, RN-BC, nurse manager champion
- Other departments such as rehabilitation services, pharmacy, volunteers, care management and the chairpersons of falls and wound care committees are ad hoc members.

Fely, Mike and Debbie completed a six week online leadership training module. The next step is to assess the institution's geriatric care practices through the Geriatric Institutional Assessment Profile (GIAP). The institutional needs assessment or GIAP will determine site specific strengths and weaknesses as well as gaps in processes. The GIAP will include the four most common types of geriatric syndromes including sleep disturbances, pressure ulcers, incontinence and use of physical restraints. It will provide an identification of the site perceptions, attitudes, knowledge, barriers and ability to care for the geriatric patient. Geriatric Resource Nurses (GRN) will use the established evidence-based practices through the resources of NICHE to coordinate care more specific to the geriatric population.

Fely will recruit GRN from the inpatient adult units. These GRNs will serve as resources to other nurses and will complete self-learning modules to improve their knowledge on geriatric care. Fely will meet with these GRNs monthly to discuss unit priorities and concerns about geriatric care.

An example of a case scenario might be a patient with delirium who is climbing out of bed. Is medication causing the delirium? The GRN nurse can help by determining if this might be a gerontologic specific medication issue and they will screen and teach the

difference in interventions between delirium and dementia. They can draw from lessons already learned in field testing, develop and implement nursing interventions, and then evaluate the effectiveness of the interventions. Patient and family education may include information more specific to delirium and dementia.

According to Fely, patient surveys from patients who are 75 years and older show that health care professionals are not speaking to or explaining to patients, in a manner that they understand. This lack of clarity may lead to higher 30 day readmission rates, and lower patient satisfaction.

Next steps in the initiation of NICHE are to:

- Perform the needs assessment through GIAP
- Recruit unit GRN nurses
- Identify system, site and unit priorities
- Implement NICHE evidence-based protocols
- Evaluate interventions

Our participation in NICHE provides an opportunity to become involved in a national movement to improve geriatric care. There will be access to resource materials, services, technical assistance, and the collegial relationships between other NICHE hospitals as resources. Fely will meet with the steering committee regularly and the GRN nurses monthly and looks forward to the advances in care for our elderly patients. Fely Ong may be reached at 41-1187 or fely.ong@advocatehealth.com

For more information on NICHE, visit <http://www.NICHE.program.org>



Exemplary Professional Practice

Magnet Force: Quality of Care

Physician Code of Conduct

George Harris MD, medical staff president, Advocate Christ Medical Center and Hope Children's Hospital

Four years ago, a nurse-physician leadership forum was held in the auditorium. At the event, an overwhelming majority of nurses and managers indicated, that while nurses were clearly responsible for their behavior through the human resources process, physician behavior was not consistently nor satisfactorily addressed in a timely manner. Nurses felt there was not a clear process for perceived bad behavior to be reported and adjudicated. Medical staff leadership under my predecessors, Gopal Madhav, MD, and Tony Razma, MD, initiated the process of development of a Medical Staff Code of Conduct. Best practices from around the country were reviewed with outside consultants. In May 2010, the Code of Conduct was presented to the Medical Executive Committee and was unanimously approved.

The loose network of reports and complaints through nurse managers and medical department heads was unified and standardized. In October of 2010, the first Code of Conduct complaints were reviewed and adjudicated. Medical staff leadership has now become more comfortable with the purpose and workings of the Code of Conduct. Reporting, adjudicating and follow-up has

now become predictable for medical staff leadership, the medical staff office and the physicians who have complaints filed against them.

After a Code of Conduct complaint is filed in the Midas (RDE) system through Advocate Online, Patient Safety Event Form, Complaints, an independent investigator is assigned to evaluate and investigate the complaint for validity. If a complaint is found valid it must be assessed to be either egregious or non-egregious. If non-egregious (but valid), the physician is sent a formal letter reminding them of the medical staff expectations through Code of Conduct. If the physician has no further non-egregious events for a period of 12 months, the matter is closed. If multiple non-egregious events occur within 12 months, then a mandatory intervention with the department chairman and the president of the medical staff will occur. If an initial event is ruled egregious, then an immediate intervention with the department chairman and medical staff president is scheduled. Repeated violations result in escalating interventions and/or suspensions.

As president of the medical staff for Christ Medical Center and Hope Children's Hospital, I would like to now

report to you the first complete calendar year of statistics from our Code of Conduct.

■ Number of incidents reported	62
■ Number of incidents with insufficient information	22
■ Number of incidents considered valid	40
■ Number of letters sent to physicians	33
■ Number of interventions	10
■ Number of physicians with greater than 2 code of conduct violations	8

George Harris MD
Medical Staff President
george.harris@advocatehealth.com



Exemplary Professional Practice

Magnet Force: Interdisciplinary Relationships

In the News

Promotions (non-STEPS):

- Maureen Sheehy, BSN, RN, promoted to coordinator of care management
- Kristina Shine, BSN, RN, promoted to clinical practice partner, 7 south

Presentations:

- Michelle Tracy, MBA/MPH, RN, CPN – manager, clinical operation, 4 Hope and Jennifer Davies, BSN, RN, CPN, nurse clinician III, 4 Hope presented: CUSP: Comprehensive Unit based Safety Project at the Society of Pediatric Nurses Conference in April in Houston, Texas.

External Awards/Recognition:

- Jessica Maier, ADN, RN, nurse clinician II, 9 east/west is the recipient of the Daisy Award.
- Daisy Award Nomination: Lauren De La Torre, BSN, RN, nurse clinician I, 9 south
- Patient Safety Award Winner: Julie Evanish, BSN, RN, PCCN, nurse clinician II, 9 South

MVP nominations:

- Jessica Maier, ADN, RN, nurse clinician II, 9 east/west was nominated for Partnership
- Ginny Fowler, MS, APN, CPNP, 4 Hope, MVP Value Leader for Compassion
- Halina Harnik, patient care associate, 7 west, MVP Winner Partnership for March
- Mary Vila, BSN, RN, nurse clinician II, 7 west, MVP Winner Compassion for March
- Marissa Guerrero, RN, 7 south, MVP nomination by a patient for her concern and responsiveness to patient needs.
- John Natividad, patient care associate, 7 south, MVP nomination by a patient for his attentiveness and care.

- Kathleen Karns, BS, RN, CCRN, assistant clinical manager, heart failure clinic, MVP for Excellence, March 2012

Leader of the Year Awards:

- Carol Pisano, BSN, RN, CCRN, manager, heart failure clinic; Clinical Leader of the Year
- Letty Losurdo, MA, RN, manager, performance improvement; Clinical Support Leader of the Year
- Beth Gorman, MPT, C/NDT, coordinator, physical therapy for rehabilitation and technician team; Front Line Leader of the Year
- Meg Adorno, BA, MA, manager, communication resources and diversity services; Non-Clinical Support Leader of the Year



Structural Empowerment

Magnet Force: Professional Development

Performance Improvement

7th Floor Mobility Initiatives

Susan Cusack, BSN, RN-BC, manager, 7 west

In late 2010, Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services, approached the managers of 7 east, 7 south, and 7 west about ideas to increase mobility of patients on these medical-surgical units. In the hustle and bustle of the day, caregivers were not making the mobility of our patients a priority. Patient care and outcomes suffered, and this led to de-conditioning of patients, and a few had to be discharged to nursing homes for rehabilitation because they became so weak during the course of just a few-day hospital length of stay. The managers of these units, Diana Wittle, Kathy Koch and Susan Cusack, met and created a daily leading indicator for mobility. This tool was used by all three units on the 7th floor to increase consistency and accountability with mobility on these units.

The charge nurse or outcomes coordinator is responsible for completing the mobility daily leading indicator each day. The census of the unit is reported, along with the number of patients who have orders to get out of bed, whether it is to be up to the chair or ambulation. Any patient with an order for bed rest must have a justification. For example, a valid justification would be a new lower extremity fracture, new onset deep

vein thrombosis (DVT), or that the patient is extremely contracted and has not been out of bed in years. Nurses are expected to critically think and question the doctor if an order for bed rest is given. Our goal is to help the patient maintain their functional level or return to their pre-hospitalization functioning level. Because we always want to ensure that pressure ulcer prevention is a priority as well, nearly all patients with an order for bed rest must also have an order to be turned every two hours. Finally, the daily leading indicator addresses how many patients with an order to get out of bed actually did. If patients did not get out of bed, a comment must be made as to why they did not, for example, if they were experiencing respiratory distress. Patient refusal to get out of bed is not necessarily a valid reason. If a patient refuses, the charge nurse or manager is brought in to further educate the patient on the risks of immobility as well as to provide support and encouragement for the patient. Nursing can no longer employ the statement of "waiting for physical therapy (PT) to get the patient up." If PT is consulted, nurses and patient care associates (PCAs) on the unit are expected to attempt to get the patient out of bed before PT even sees the patient. The only time the nursing staff

waits to get the patient up is if the patient is so weak it poses a danger.

Our units have seen a tremendous increase in the amount of patients out of bed daily. Before the focus on mobility, on average, our units would only see a handful of patients out of bed, and these usually were very independent patients who needed little assistance. Now, depending on the census and diagnoses of the patients, about 70 percent of patients get out of bed, and we are nearly 100 percent compliant when there is an order to get the patient out of bed. This is first and foremost due to the dedication of the bedside nurses and PCAs. However, charge nurse, outcome coordinator, and manager accountability is also a big factor in the success. It is a collaborative effort, and everyone works together to keep our patients moving so we can keep them in a state of optimal health.



Exemplary Professional Practice

Magnet Force: Quality Improvement

Portraits of Excellence

Deborah Kadich, BSN, RN, CCRN, adult surgical heart unit

A nurse in the adult surgical heart unit for more than 10 years, Deborah exemplifies nursing excellence, compassion, dedication and the mission and values of Advocate. She is a member of local and national professional organizations and actively participates in the community, serving as the "Ask the Expert" at local school fairs and performing routine blood-pressure screenings at her church. On her unit, she is a performance improvement liaison, outcomes specialist, preceptor and educator. As a member of the education committee, unit council and professional development council, Deborah promotes nursing excellence through competencies, in-service training sessions and educational boards; works to improve clinical outcomes through use of leading indicators; and promotes professionalism. She also assisted in developing insulin infusion orders, a quality improvement project designed to decrease surgical infection rates.

**Diane Kirn, RNC, labor and delivery**

Certified in inpatient obstetrics, Diane is a nurse clinician III, past member of the Career Advancement Board, member of the unit's education and policy and procedures committees, and current chair of the unit council. In this latter position, she has helped the unit initiate "Snack Bowl," "Biggest Loser," and "Employee of the Month" and set aside specific days on which to recognize various professional and support groups within the department. Her contributions to improving the quality of patient care include serving as instructor for the neonatal resuscitation program, teaching certification and re-certification classes, conducting mock drills, and working with an anesthesiologist to develop in-service training on arterial lines. Her community efforts include development of a recycling program for supplies that would be normally discarded. The supplies are used to benefit churches, shelters and other organizations.

**Patricia Kovacs, MS, BA, RNC, labor and delivery**

Patricia is recognized as a team player – always willing to trade shifts and pick up extra calls to help co-workers, work extra shifts when the department is busy and volunteer for difficult assignments, sharing what she has learned with other staff. A certified lactation specialist who also is certified in inpatient obstetrical nursing, Patricia makes sure the mothers of NICU babies are able to see their infants before the mothers are transferred to the postpartum unit and works with interdisciplinary teams and social services to ensure the best possible care for her patients. She is the only labor and delivery associate to earn "Employee of the Month" twice in 2010.

**Jennifer Leary, BSN, RN, radiology**

Recognized for going out of her way to help patients, Jennifer works consistently to make improvements within her unit. She serves as performance improvement chair for her unit and, as such, encourages excellence by striving for maximum team performance. Jennifer is respected by the staff for her compassion for patients, her volunteer efforts, her knowledge and her willingness to share that knowledge by mentoring staff.



The nurses featured in this section were recently nominated for the 2011 Joyce Woytek Award for Nursing Excellence.

Diane Lelo, RN CCRN, SINI unit

Promoted to Step III in 2003 and certified in both TNS and CCRN, Diane has been a positive influence in encouraging other staff members to move ahead in their professional careers. She also is considered the "expert" involving assessment of complex neurological patients and is frequently called on by her peers to assist in emergency patient situations. An active member of the unit council, she is noted for her willingness to be a preceptor to new nursing graduates and experienced nurses alike. She even coordinated a lunch program on the unit to enhance communication between physicians and nurses. Diane participates in many community activities, such as serving food to the residents of St. Blase and decorating the Ronald McDonald House near Hope Children's Hospital for Halloween.

**Deena Martin, RN, ADN, 4-Hope**

Ever since Deena began working on 4-Hope, first as a patient care associate and later as a new nursing school graduate, she constantly searched out learning opportunities to advance in her career. She learned about skin and wound care from one of the advanced practice nurses and served as the unit's flu-shot champion. On her own time, she contacted the Chicago Bears' Charles Tillman Foundation to receive a donation of television game systems for Hope Children's Hospital. She is frequently recognized for her caring and compassion by patients and families alike.

**Barbara Mayher, RN, neonatal intensive care unit**

Certified to insert peripheral central venous catheters (PCVC), Barbara is well known for her clinical skills. She is frequently asked by her colleagues – and other departments – to provide assistance in starting IVs, obtaining venous draws and inserting PCVCs. She is a preceptor for new nurses, a PCVC-insertion trainer on the night shifts, a performance improvement monitor and, when needed, a charge nurse as well. She is a past recipient of the Advocate system's safety award and has been nominated for MVP awards.

**Sandra McIntyre, BSN, RN, pediatric surgical heart unit**

Noted for her patience and understanding in teaching parents about their child's heart defect, Sandy recently joined the unit's surgery team, which provides care for a child while the child is in surgery. Throughout a surgery, she updates the parent's on the child's progress and develops a close and trusting relationship with the family. She also has been serving as the unit's performance improvement liaison for the past two years and has demonstrated particular efficiency and accuracy in her data collection and entry. When she finds shortcomings in the data collection process, she re-educates staff to ensure proper future charting. She recently joined the pediatric mock code/ECPR team and teaches nurses the process of performing ECMO CPR.



Structural Empowerment

Magnet Force: Image of Nursing

Nurse Recognition

STEPS Promotions, Certification and Research Recognized

In addition to recognizing STEPS promotions and nursing certifications, the nurse recognition ceremony recognizes nurses who have recently completed their nursing degree, institutional review board application approval and nurses acknowledged for other reasons.

NCII STEPS Promotions

- Family Care Center: Elizabeth Roberson
- MICCU: Paulina Swieczka
- PICU: Casey Gralewski
- Procedure Recovery: Ma Josefina Velasco
- 2 Hope: Christine Swiatek
- 4 Hope: Jennifer Davies and Kimberly Duback

Daisy Award

- Jeff Redican, Emergency Department
- Jessica Maier, 9 EW
- Maggie Lee, PICU

Newly Certified Nurses

Critical Care

- MICCU: Ray Duque, CCRN
- SINI: Elizabeth Berls, CNRN, and Sonya Ducharme, CNRN
- 8 east/west: Laura Lipkie, PCCN, Nicole Madia, PCCN, and Megan Tollios, PCCN
- 9 South: Sue March, PCCN, and Cynthia White, PCCN

Emergency Department

- Emergency room: Erin Cummings, CEN, Kristin DiBenedetto, CEN, Larry Evancho, CEN, Mary Golden, CEN, Holly Jarzemboski, CEN, Stacy Prskalo, CEN, Karen Raica, CEN, Jamie Reynolds, CEN, Nick Roszak, CEN, Deb Shepherd, CEN, Kara Thomas, CEN, Heather Vuletic, CEN, and Barb Zwicky, CEN
- Peds Emergency Room: Dory Mleczo, CPEN, and Karen Vranicar, CPEN

Heart & Vascular Institute

- ASHU: AnnMarie Britten, CCRN, and Emily Schmidt, CCRN

- Cardiodiagnostics: Amy Butz, RNBC, and Patricia Rogers, RNBC
- Congestive Heart Failure Clinic: Sue Dedic, PCCN, Pat Menke, PCCN, and Mary Grace Samardzich, PCCN
- SVTU: Charmaine Pelayo, CCRN

Medical Surgical

- 4 East/West: Mercy Thomas, RN-BC, and Amy Gill, RN-BC
- 7 East: Lindsey Bailey RN-BC, and Ryane Schuman, RN-BC
- 7 West: Diane Cayton, CMSRN, Don Domingo, CMSRN, Nancy Hernandez, RN-BC, William Hizon, CMSRN, Deangela Newell, CMSRN, Nathasa Wallace, CMSRN
- Venous Access Device: Janet Coughlin, VA-BC, Kelli Cummins, VA-BC, Melissa Davilo, VA-BC, Jill Hayes, VA-BC, Laura Lenz, VA-BC, Phyllis Sink, VA-BC, and Cheryl Wilson, VA-BC
- Neurosciences Institute: Dee Behrens, CNRN, Karen DeRe, CNRN, Lorri McCourt-O'Donnell, CNRN
- 6 South Rehab: Jocelyn Anderson, CRRN, Elaine Butkus, CRRN, and Brigitte Malobabic, CRRN
- 8 South: Dawn Neumann, RN-BC, and Diane Zervos, RN-BC

Bone & Joint Institute

- 6 East/West: Marcia Chemino, ONC, Angie Lenart, ONC, and Barbara Reich, ONC

Pediatrics/Hope

- 2 Hope: Jennifer Koss, CPN, Meggan Mikal, CHPPN, and Janice Pearson, CPN
- 4 Hope: Cali Arundel, CPN, Desiree Carney, CPN, Lauren Fishback, CPN, Samatha Hernandez, CPN, Anne Mullane, CPN, Amy Podobnik, CPN, and Susan Vujovic, CPN
- NICU: Jean Smith, NE-BC, Lisa Bandstra, RN-BC, Peggy Burke, RN-BC, Dawn Barth, RN-BC, Lisa Forde, RN-BC, Dorothy Gut, RN-BC, Kari Hollandoner,

- RN-BC, Susan Hollandsworth, RN-BC, Ann Malfeo, RN-BC, Barb Saabs, RN-BC, Jaclyn Schuld, RN-BC, and Nicole Sinovich, RN-BC

- PICU: Elizabeth Lawrence, CCRN, Maggie Lee, CCRN, Nina Ortegon, CCRN, Samantha Synoweicki, CCRN, Cynthia Rahilly, CCRN, and Andrea VanSteenis, CCRN
- PSHU: Tracey Curtner, CCRN, Christina Deacy, CCRN, Trina Dvorak, CCRN, Korynn Jellema, CCRN, and Katie VonAlmen, CCRN

Surgical Services

- PACU: MaryBeth Sheehy, CPAN
- Surgery: Kathy Puhr, CNOR, and Beth Roberts, CNOR

Women & Infants Health Services

- Family Care Center: Terri Altenberg, RNC, Lauriann Oziernowski, RNC, Amanda Rappelt, RNC, Pat Sedrick, RNC, and Phyllis Vandervelde, RNC
- Labor & Delivery: Danielle Ancich, RNC OB, Monika Dobrzynski, RNC-OB, and Katherine Teran, RNC-OB
- 3 East/West: Jillian Hellmann, RN-BC

Cancer Institute

- 3 South: Kelly Kupiec, OCN

Care Management

- Cathy Pacholik, RN-BC

Clinical Education

- Colleen Leake, RN-BC

Clinical Informatics

- Terese Shomody, NE-BC

Clinical Research

- Cheryl Lefaiver, CCRP

Imaging Center

- Radiology Patient Care Center: Joan Mizwicki, CRN

Degree Completion

Critical Care

- Hemodialysis: Tom Blicharski, MSN
- MICCU: Sherron Johnson-Boyd, MSN, Kristin Lesinske, BSN, Jen Vermeulen,

- MSN, and Ryan Yamat, BSN

- 8 East/West: Julie Antonio, BSN, and Lalchon Tyre, BSN

Emergency Department

- Emergency Room: Leah Burns, MSN-FNP

Heart & Vascular

- ASHU: Jennifer Dole, MSN, and Meghan Slade-Smith, MSN
- Cardiac Rehab: Lynne Schipma, BSN

Medical Surgical

- 4 East/West: Adrienne Grant, BSN

Pediatrics/Hope

- NICU: Edythe Pettenger, BSN

Surgical Services

- Surgery: Vicky Frenz, BSN

Women & Infants Health Services

- 3 East/West: Sogebi Adekemi, BSN

Nursing Research - IRB Submission

- Live ... From the Heart Program Study, Principal Investigator: Gail Prokop, MSN, RN, ANP-BC
- Implementation of Evidence-Based Practice for Pediatric Pain Assessment Tool, Principal Investigator: Jennifer A. Obrecht, RN, PCNS/BC, MS (University of Illinois Chicago), Sub Investigator: Kimberly Eiden Wittmayer, MS, RN, PCNS/BC



Structural Empowerment

Magnet Force: Image of Nursing



STEPS Case Study

Pericardial Effusion

Ma Josefina B. Velasco, BSN, RN, nurse clinician III, procedure recovery

Patient Demographics

R.E. is a retired 69-year-old caucasian male. He is married and lives with his wife and has three adult children. He quit smoking 40 years ago with history of one pack a day smoking not greater than eight years, drinks occasionally a small amount of beer or wine, and has no history of substance use. He has a family history of hypertension (HTN) and cerebral vascular accident (CVA) on his maternal side. R.E. was diagnosed with spinal stenosis in 2007, right hip degenerative joint disease (DJD) in 2008, atrial fibrillation (AF) in November 2010 and surgical history of right hip replacement (RHR) in November 30, 2010.

Overview of Patients Disease

AF is the most common cardiac arrhythmia. It is considered a disease of the elderly population and is usually seen in those older than 65. The increase in the number of patients with advanced age, an estimated 2.3 million Americans have AF and over half a million cases are diagnosed yearly (Stanley, 2011).

The normal electrical pathway of the heart starts from sino-atrial node called the natural pacemaker of the heart which is located in the right atrium. The signal then goes to the atrio-ventricular (AV) node and travels down to the ventricles. During AF the heart gets multiple electrical signals from the atrium that can deliver a rate over 400 beats per minute causing the atria to quiver. A properly functioning AV node will only allow so many electrical impulses so the ventricles have a slower rate from 110 to 180 beats per minute (McDonough, 2009). This fast rate causes the heart to ineffectively pump and can cause heart failure and CVA to occur. The most devastating complication of AF is thrombo-embolic episodes that can happen in the brain, heart, lungs and extremities (Lee, 2006).

AF has multiple classifications: paroxysmal, persistent or permanent. In paroxysmal AF, patients can have repetitive episodes of AF but spontaneously return to normal sinus rhythm (NSR). In persistent AF, the patient can remain in AF more than seven days and will only return to sinus rhythm until given medication or cardioversion (CV) is done. In permanent AF, the patient remains in AF even after all effort is done to stop the arrhythmia (Stanley, 2009).

Prior to November of 2010, R.E.'s medical condition is unremarkable and he has no cardiac history. A pre-operative cardiac evaluation was required prior to his hip replacement surgery, so on November 5, 2010 he went for routine treadmill stress test. That day, right after the test, he developed atrial flutter which evolved into AF.

He was sent to the emergency room by his cardiologist for CV procedure. The procedure was unsuccessful in converting him back into normal sinus rhythm (NSR). He was admitted to the hospital for observation and was started on a beta-blocker, Metoprolol. On the night of admission, R.E. spontaneously converted to NSR. He was discharged from the hospital the next day.

R.E. underwent successful RHR on November 30, 2010. The following day, while recovering from surgery, he had a recurrent episode of AF confirmed by 12 lead electrocardiogram. He was symptomatic, complaining of palpitations. A second CV was performed and was successful. He was started on an anti-arrhythmic medicine, Amiodarone, and an anti-coagulant medicine, Coumadin. Use of anti-arrhythmic medicine after conversion to NSR has shown to prevent the return of AF, while anti-coagulant therapy is necessary in patients with AF to prevent thrombo-embolic complication (Stanley 2011).

R.E. continued to experience paroxysmal episodes of AF with concomitant symptoms that included palpitations, shortness of breath, and fatigue. He decided to consult an electrophysiologist in March of 2011. He was given an option by the physician to continue the use of an anti-arrhythmic therapy or to undergo a radio frequency catheter ablation (RFCA) procedure to treat his AF. R.E. chose to have the RFCA but he did not follow through to schedule the procedure. He continued to have symptomatic AF, so he decided to see the electrophysiologist again in June of 2011. During the visit, the procedure was discussed with him in detail by the physician. This time he agreed to have the RFCA and it was scheduled in August 2011.

Having AF for a few months, R.E. had a higher risk of clot formation in his heart. During AF there is chance of blood pooling due to ineffective pumping, this pooling of

blood can cause clot formation. Before RFCA can be done R.E. needs to have a transesophageal echocardiogram (TEE) to evaluate any presence of clots.

TEE is an endoscopic procedure using a probe attached to a flexible scope, the scope then is passed through the patient's esophagus. The esophagus lies directly behind the left side of the heart; this position makes it easy to visualize the aorta, atria and atrial appendages. TEE is done to determine the proper heart function and to evaluate certain disease conditions of the heart such as, presence of a clot that can lead to embolic event and infections of the valves and inner lining of the heart. (Marchiondo, 2007).

TEE was done on August 11, 2011, it confirmed absence of clots, and this finding cleared him to have the RFCA. After the TEE, R.E. was discharged the same day and needs to come back the next day for RFCA.

Nurse Patient Relationship

I had a very brief encounter with the patient and his wife. R.E. was in Procedure Recovery (PR) area after his TEE. His wife approached me asking for a blanket and inquiring about when her husband can resume his diet. I provided R.E. with warm blanket then I explained to him and his wife that after TEE patients have to wait two to three hours before resuming eating or drinking for safety precaution. The reason for waiting is to prevent any choking episode after having his throat numbed for the test. R.E.'s wife mentioned that he is to come back in the morning for his RFCA, of which I responded that I will be seeing them again tomorrow, not realizing that I will eventually be the primary nurse assigned to him the next day. On the day of the RFCA, I took care of R.E. in procedure recovery then I had to transfer him to the cath lab for emergency pericardiocentesis.

Overview of Treatment Plan

RFCA has become a treatment option in an attempt to correct AF after using pharmacology and electrical therapy and the patient still continues to experience paroxysmal AF. Low frequency alternating current is delivered through a catheter electrode; this heats up and burns the heart tissues around the pulmonary veins and inside the atria. This burning creates lesions in the tissues and thus stops the re-entry pathway of fibrillatory waves and prevents AF from happening. During RFCA, the patient is anticoagulated with the use of heparin. Clotting level is monitored intermittently throughout the duration of the procedure using activated clotting time (ACT). It is maintained above 300 seconds to prevent any thrombo-embolic event (Zak, 2010).

I received R.E. at 13:18 after his successful RFCA. It is normally done under general anesthesia due to the length of the procedure which lasts 5-6 hours. Bedside post-procedure report was given to me by the electrophysiology nurse and by the anesthesiologist. He was attached to a cardiac monitor which showed NSR with a heart rate (HR) of 79 beats per minute (bpm), respiratory rate (RR) of 16 per minute, oxygen saturation (SPO2) of 94 percent on 2 liters of oxygen per nasal cannula (NC), but his blood pressure (BP) was significantly low at 65/51. R.E. was slightly sleepy but coherent, oriented to name, place and time. He was breathing without difficulty and lung sounds were clear. He denied any chest pain but had complaints of "severe" 8 out of 10 left shoulder pain and described it as "joint stiffness." His abdomen was soft, non-tender and had positive bowel sounds, bilateral flank areas were also checked for tenderness or pain. Last ACT level at 12:35 was 345 seconds; both inguinal areas had 2 venous sheaths still sutured into place. Both sites were assessed for any bleeding or presence of hematoma. Pedal pulses were also assessed and were present on both feet. He also had an intact indwelling foley catheter with 100 ml of clear yellow urine noted to be draining in the collection bag. Our institution has a standing post procedure order of ACT level 150 seconds or less before removal of any venous or arterial sheaths to prevent bleeding from puncture sites.

The first treatment I decided to do is to give an intravenous fluid (IVF) bolus of normal saline solution to help increase his BP within acceptable range. Vital signs are routinely done every 15 minutes in PR but in R.E.'s situation it was done more frequently. R.E. was given comfort measures for his shoulder pain such as warm blanket was applied under his left shoulder and the affected area was massaged. He was also instructed to

take some slow deep breaths, this was done as a diversion for his pain. R.E. was informed that the use of narcotics for pain control at this time is inappropriate because it can further lower his BP. After 25 minutes of continued IVF bolus, R.E. still had low BP, his lips were looking pale, skin was cool and clammy and jugular veins were noted to be distended. At this time the physician was paged and he was notified of the patient's present condition.

One of the major complications of RFCA is cardiac tamponade, others are stroke, injury to the phrenic nerve, stenosis of pulmonary vein, fistula formation between aorta and esophagus (Zak, 2010). Classic signs of impending cardiac tamponade are low BP, distended jugular veins, quiet heart sounds (Beck's triad) and a decrease in systolic BP of more than 10 mmHg with inspiration (pulsus paradoxus) (Bradbury-Golas, Campo & Chiccarine, 2010).

In anticipation of the arrival of the physician, I instructed our unit secretary to request an echocardiogram (2D echo) STAT to rule out pericardial effusion. While I stayed at the bedside to continue constant monitoring of the patient, I also asked the assistance of my fellow nurses to prepare a Dopamine drip, a vasopressor used to correct hemodynamic imbalances. This corrects hypotension by increasing the cardiac output.

As soon as the physician arrived, he was updated again of the patient's condition. He ordered to continue IVF bolus infusion. The use of isotonic crystalloid solution is ideal for patient who needs to increase their fluid volume. This increases the hearts filling pressure and overcome the constricting effect of pericardial effusion (Bradbury-Golas, Campo & Chiccarine, 2010). He also ordered a 2D echo, Dopamine drip, Protamine sulfate and a repeat ACT level after administration of Protamine Sulfate, which is a heparin antagonist. R.E. is continuously informed of his condition and the reason for all the medications that are being administered to him. Furthermore, I asked our unit nurse liaison to keep R.E.'s wife updated of her husband's condition while she's in the waiting area. Due to R.E.'s unstable condition post-procedure we were not able to accommodate his wife inside the room.

Echocardiography is the definitive test to confirm pericardial effusion, an abnormal accumulation of fluid inside the pericardium. The heart is enclosed within a sac called the pericardium that has an outer and an inner layer. The space in between the two layers is called the pericardial cavity, which normally contains 30-50 ml of serous fluid that helps in the lubrication of the heart. The heart can adapt to a gradual fluid accumulation as much as 1 liter. However, if fluid accumulates very rapidly even as small an amount as 50 ml, it can immediately affect the pressure around the heart and cause a life threatening condition (Humphreys, 2006).

At 14:10, the 2D echo technician arrived and immediately performed the diagnostic test at bedside. The physician confirmed our suspicion of pericardial effusion. The patient was informed of the findings and it was explained to him that he has fluid accumulated around his heart. This is preventing his heart to pump properly resulting in his low BP. The physician explained to R.E. that he needs to drain the fluid out of his heart so it can function properly and his BP can return to an acceptable range. Emergency pericardiocentesis is the treatment of choice for signs of cardiac tamponade (Humphreys, 2006). R.E. was transferred to the cath lab at 14:30 when a suite became available to undergo emergency pericardiocentesis. At the time of transfer, he still had left shoulder pain 8/10, his BP was still low at 72/53, his repeat ACT was 119 seconds which is within normal range. In addition, Neosynephrine drip was ordered and was started as an adjunct to Dopamine.

I learned from the physician that he drained 300 ml of blood from the pericardial cavity and his vasopressors were turned off after the pericardiocentesis. R.E.'s BP was 119/78, HR 78 bpm, RR 16 per minute, SpO2 100% on 3L/NC and his left shoulder pain was resolved after the procedure. R.E. was transferred to the medical intensive care unit (MICU) after the procedure with a pericardial drain to monitor any further effusion. Our nurse liaison accompanied R.E.'s wife to the MICU after the physician updated her of her husband's condition.

See "Pericardial Infusion," page 14

CareConnection

Personal Health Records

Mary Fedor, BSN, RN, clinical informatics analyst

Personal health records (PHRs) are tools that allow people to "access and coordinate their lifelong health information and make appropriate parts of it available to those who need it" (Markle Foundation 2008). PHRs empower individuals to manage their health, health care, and health care costs. In an online survey conducted by Markle in 2008, 79 percent of Americans believe in the benefits of having an electronic PHR. Unfortunately, "Only 2.7 percent of adults have an electronic PHR today (representing about 6.1 million persons). Most (57.3 percent) do not keep any form of personal health records, and 40 percent keep some paper health records" (Markle Foundation 2008). PHRs are helpful when patients are unable to provide information in emergency situations or are incapable due to cognitive function. As our population ages, and natural disasters increase, an available and accurate health record is crucial to provide continuity of care. It can be used by family members to manage their loved ones medical history, allergies, medications, recent labs and diagnostic tests. This information can be shared with their physicians to enhance communication between caregivers, improve the quality of care, and improve patient safety. According to the Institute of Medicine report, Preventing Medication Errors 2007, states that "poor communication and exchange of medical information at transition points for patients from one provider to another are responsible for many medical errors and adverse drug events" (Institute of Medicine 2006).

PHRs contain information that is controlled by the individual. Each individual controls how their information is accessed, used, and disclosed. There are many free tools that can be accessed to get one started. One site, www.myphr.com, offers PHR forms available in English and Spanish, for adults and children. These forms can be printed, saved to a file on one's computer, or to a jump drive.

Another tool called Blue Button is a service available to veterans. Veterans can log on to My HealthVet at www.myhealth.va.gov, to save or print their health information. Patients who utilize Medicare have access to another version of the Blue Button service. This is free and available on the www.MyMedicare.gov site. Once registered, the patient has access to their health information, prescriptions, lab tests and other information. It can be accessed from anywhere. A printed version called "On the Go Report" is available and useful when traveling. "If you help make health care decisions for a loved one or take care of someone with Medicare, you do not automatically have a right to see or use their medical information, even though you may need it in order to make sure their care is coordinated. By law, only the patient has the right to their own health information, even if you are an immediate family member or if you help set up their PHR" (Medicare.gov).

There are many resources available to assist one to create their own PHR. The Illinois State Medical Society has a free printable PHR on their web site <http://www.isms.org/patients/Pages/PersonalHealthRecords.aspx>. It is available in English or Spanish. There are also free apps available for Apple, Blackberry, and Android phones, allowing the user to download their PHR to their smart phones.

Since PHRs are managed by the individuals, they must be reviewed and updated periodically. PHRs should be updated after routine physician visits, when new prescriptions are added or deleted, outpatient diagnostic tests and procedures, and inpatient stays. One of the Meaningful Use (MU) requirements states that patients who are admitted to the emergency room or an inpatient status can request an electronic copy of their medical records within three days of discharge. At Advocate Christ Medical Center, the patient completes an "Authorization for release of patient health information" form and sends it to Health Information Management (HIM). These forms (form # 005013) are available on every floor. The forms are available in English, Arabic, Polish, Russian, and Spanish. There is a small fee for this service.

PHRs can be used by individuals to manage their health, health care information, and costs. It can also be helpful for caregivers to communicate valuable information about their children and loved ones to physicians and nursing staff. Take a few minutes and create your own PHR or one for a family member.

References

American Health Information Management Association. (2012). Retrieved March 2012 from <http://myphr.com/>

Lober, WB, Zierler, B., Herbaugh, A., Shinstrom, SE., Stolyar, A., (2006) Barriers to the use of a Personal Health Record by the Elderly Populations. Retrieved March 2012 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1839577/?tool=pubmed>

Illinois State Medical Society. (2012) Retrieved from www.isms.org/patients/pages/PersonalHealthRecords.aspx

Markle Foundation (2008). Americans Overwhelmingly Believe Electronic Personal Healthcare could improve their Health. Retrieved March 2012 from www.markle.org

National Institute of Medicine. (2009). EHR/PHR Basics. Retrieved December 2011 from <http://www.nlm.nih.gov/medlineplus/magazine/issues/summer09/articles/summer09pg17.html>



New Knowledge, Innovations, and Improvements

Magnet Force: Quality of Care; Quality Improvement

Educational Events

ACLS Renewal Course

June 8, 7:30 to 11:30 a.m., 0614
June 8, noon to 4 p.m., 0614

ACMC Nursing Research Council Meeting

June 28, 11 a.m. to noon, 629AB
July 24, 11 a.m. to noon, 0629AB

APN/CPP Council Meeting

June, no meeting
July 18, 1 p.m. to 2:30 p.m., 0636 A&B

Basics of LEAN

June 5, 9 to 11 a.m., 0614
July 5, 9 to 11 a.m., 0614

Care Management Education

June 21, 1 to 3 p.m., 0636A&B
July 19, 1 to 3 p.m., 0636A&B

Clinical Coach Course

June 13, 8 a.m. to 12:30 p.m., CE classroom
June 27, 2 to 6:30 p.m., CE classroom
July 11, 8 a.m. to 12:30 p.m., CE classroom
July 25, 2 to 6:30 p.m., CE classroom

Ethics for Lunch

8/24, noon to 1 p.m., 0629 AB

Magnet Advisory Council

June 26, 9 to 10 a.m., 0637
July 24, 9 to 10 a.m., 0614

Neurovascular Conference

June 21, 1 to 2 p.m., 0636

Nurse Forums

June 7, 7:30 to 8:30 a.m., 0629 A&B
June 7, noon to 1 p.m., 0629 A&B
June 7, 5 to 6 p.m., 0629 A&B

Nursing Grand Rounds - Adult

July 18, noon to 1 p.m., 0629 A&B

Nursing Grand Rounds - Pediatrics

June 21, 11 a.m. to noon, 0629 AB

Nursing Residency

August 2011 Cohort

■ June 12, 7:30 a.m. to 3:30 p.m., Clinical Ed. Dept.
■ July 24, 7:30 a.m. to 3:30 p.m., Clinical Ed. Dept.

October 2011 Cohort

■ June 29, 7:30 to 11:30 a.m., 0636
■ July 27, 7:30 to 11:30 a.m., 0636

January 2012 Cohort

■ June 14, 7:30 to 11:30 a.m., Clinical Ed. Dept.
■ July 12, 7:30 to 11:30 a.m., Clinical Ed. Dept.

March 2012 Cohort

■ June 26, 7 to 11 a.m., Clinical Ed. Dept.

May/June 2012 Cohort

■ June 15, 7 a.m. to 3:30 p.m., Clinical Ed. Dept.

September 2012 Cohort

■ TBA

Pediatric Advanced Life Support (PALS)

June 22, 8 a.m. to 5 p.m.
EMS Academy, 5220 W. 105th St., Oak Lawn, IL

Psychiatric Grand Rounds

June 13, TBA, 0613
July 11, Role of Neuropsychiatry at a Neuroscience Institute, 11 a.m. to noon, 0613

Professional Clinical Practice Council

July 19, 7:30 a.m. to 4 p.m., 0629 A&B

Preceptor Allied Health

July 16, 8 a.m. to noon, Clinical Ed. Dept.

Save the Date!

Med-Surg Division Conference
June 13 (all day) Drury Lane Oakbrook Terrace, IL

Steps Application Deadlines

September 1

Steps Nursing Forum

July 2, 8 to 10 a.m., 0614
July 9, 1:30 to 3:30 p.m., 0614
July 11, 9:30 a.m. to 1:30 p.m., Kensington



Structural Empowerment

Magnet Force: Professional Development

Share With Us!

Do you have a story to tell? Do you have an idea for a feature in NURSING NOW?

Write it down and send it via e-mail or fax to one of the editorial board members.

We want to hear from you!

E-MAIL: debbie.oconnell@advocatehealth.com
FAX: 41-5640

Spirituality

Emergency Department Staff Helping Those in Need

Joan Kelley, BSN, RN, TNS, nurse clinician III, emergency department

How would you feel if you did not know when or where you would receive your next meal? Fortunately most of us may not give this a second thought. However, this nagging thought is something that our community's indigent and homeless population deal with daily. Public Action to Deliver Shelter (PADS) southwest side homeless shelter at 71st St. and Kedzie Avenue is the answer to this question for a countless number of individuals. They have come to depend on the facility for hot hearty meals nightly and staff members of the Advocate Christ Medical Center emergency department (ED) are ready to help. This partnership was developed and implanted by an ED nurse named Ann Pratl. In an



Ann Pratl, RN, Darlene Hale, EKG, Stephanie Reid, ERT, Joan Kelley, RN, Nikki Nino, RN, and Katie Naegele RN.

effort to complete community service hours for her son, a St. Rita High School student, Ann accompanied her son and his class mates to provide assistance in the forms of meals and camaraderie to the individuals who frequent the PADS facility. Ann, an ED unit council member, brought the idea back to the council for exploration. The concept of helping to provide meals monthly was welcomed with open arms by the staff of the ED. The staff brainstormed and agreed to provide a hot meal on a monthly basis. A posting in the ED break room highlights the event and asks for volunteers to both prepare and serve meals. Donations to this cause have come in the form food, money and of course valuable time. To date more than 25

staff members have partnered together along with some more than willing local high school students to provide meals on the second Tuesday of every month. The PADS shelter not only provides meals, but a hot shower when needed along with toiletries such as soap, toothpaste and deodorant, and most importantly, a kind word. Additionally basic medical care has been arranged with the volunteer services of medical staff. I was fortunate to be a part of this endeavor and cannot express the gratitude that was received from this vulnerable population. The connection through food and fellowship is one of those unique lifetime experiences that highlight the concept that giving is so much better than receiving. Way to go ED staff!



Structural Empowerment
Magnet Force: Community and the Healthcare Organization

Pericardial Infusion

Continued from page 12

Nursing Diagnosis	Goals	Intervention	Evaluation
Alteration in hemodynamic status related to low cardiac output secondary to pericardial effusion	Maintain vital signs (VS) within baseline and/or acceptable values	<ul style="list-style-type: none">Monitor VS every 15 minutes and PRNAdminister medication as ordered:<ul style="list-style-type: none">a) infuse Normal Saline IVF bolus 250 ml every 15 minutes.b) titrate Dopamine starting at 5 mcg/kg/min and Neosynephrine 5 mcg/min drips according to BP and heart ratec) Give Protamine sulfate IV to decrease bleedingKeep patient informed of rationales for every interventionPrepare patient for emergency pericardiocentesis	<p>Return of patient's VS to within acceptable limits</p> <p>R.E.'s BP post pericardiocentesis was 119/75mmHg, HR 78</p>
Alteration in comfort level related to left shoulder pain	Prevention of bleeding, hematoma and infection to bilateral inguinal	<ul style="list-style-type: none">Application of warm compress to left shoulderRepositioning of patient.Relaxation by deep breathing techniqueVisual and auditory distraction.Documentation of pain: site, onset, duration, quality and effectiveness of interventions	<p>Patient can verbalize acceptable degree of pain relief using the NRS (numeric rating scale).</p> <p>R.E. pain level after pericardiocentesis is zero.</p>
Impaired skin integrity related to presence of bilateral inguinal sheaths	Prevention of bleeding, hematoma and infection to bilateral inguinal	<ul style="list-style-type: none">Monitor groin site every 15 minutes for presence of bleeding and hematomaAdminister Protamine Sulfate as orderedKeep patient on bed rest and HOB <30 degrees as ordered while sheath is in place.Assess abdominal and flank areas for pain and tendernessMonitor pedal pulses every 15 minutesKeep bilateral inguinal dressings clean, dry and intact at all times.	<p>Absence of bleeding, hematoma and infection to bilateral inguinal area</p> <p>R.E. bilateral groin area remains soft, no bleeding or hematoma</p>
Potential for ineffective coping of patient and family related to anxiety secondary to procedure complication	Patient and family will remain calm and will verbalize understanding of emergency treatment	<ul style="list-style-type: none">Frequent explanation of interventions to patient and familyAllow patient to verbalize thoughts and feelingsUtilize the nurse liaison to give periodic updates of patient's current condition to the familyReassure family that patient will be monitored closely and kept safe in her absence	<p>R.E and his family remained calm and cooperative and was able to understand the reason for the necessary emergency treatment</p>

Personal Critique and Reflection

This case was interesting to discuss for me because this is the first time I have personally seen a pericardial effusion develop after an ablation. The patient's condition can change from stable to critical in a matter of seconds. Every patient is unique, there is no such thing as a routine recovery in our department. Each case is different and needs frequent monitoring no matter how simple or routine their procedure may be. I am proud to say that my emergency room experience, and being a nurse for 18 years, made me

immediately recognize the signs and symptoms of an impending cardiac tamponade. I believed that my critical thinking skills made a huge difference on R.E's life. Identifying these symptoms was crucial in preventing a fatal complication to the patient and even a devastating one to his family. This case made me realize that if the 2Decho was done sooner, the pericardial effusion could have been diagnosed quicker and hence more definitive interventions could have already been done. Confirmation of pericardial effusion before the patient starts showing any signs of

cardiac tamponade will always have a better outcome. This case made me more aware of what signs and symptoms to look out for an evolving cardiac tamponade after RFCA. R.E's. vague complaint of shoulder stiffness was significant and contributory to his medical emergency. Any patient complaint should always be noted and the cause of such complaints investigated. I will share this experience with my co-workers as a learning tool. Any nurse who takes care of patients after RFCA should always be on the alert to watch for signs and symptoms of pericardial effusion. Our institution has a standing order after RFCA for the 2D echo to be performed the following morning after the procedure. It might be more beneficial if the order for 2D echo can be changed to STAT instead of routine to assess for any complications sooner. This case was a collaborative team effort from nurses, physician, technicians and ancillary associates to support and care for the patient and his family. As a team, we were able to work together to provide R.E. the necessary immediate treatment needed to solve his medical emergency resulting in a favorable outcome to this case. In procedure recovery, we handle different cases such as cardiac, pulmonary and gastroenterology patients. We also take care of patients as young as neonates up to geriatric in age. We can take care of our patients in our department for as little as an hour or for as long as they are assigned a bed in the hospital. Or even, an overnight stay for our cardiac patients that need closer monitoring before being discharged the next day. Our main goal is to make them comfortable and keep them safe after their procedure, while watching for any post-procedure complications, identifying it, and taking immediate action to prevent further complications to the patient. In conclusion, I enjoy and take pride in working at procedure recovery. It is very fast paced and deals with a wide variety of patients similar to the emergency room. I have the privilege to work with fellow nurses who have amazing critical care experience that I can rely on. I am confident that we can provide excellent care to our patients.

Reference

Bradbury-Golas, K., Campo, T., Chiccarine, A. (2010). Getting to the heart of back and shoulder pain. *Advanced Emergency Nursing Journal* 2010, 32(2), 127-134.

Humphreys, M. (2006). Pericardial conditions: Signs, symptoms and electrocardiogram changes. *Emergency Nurse* 2006, 14(1), 30-36.

Lee, G. (2007). A review of the literature on atrial fibrillation: Rate reversion or control? *Journal of Clinical Nursing* 2007, 16, 77-83.

Marchiondo, K. (2007). Transesophageal imaging and intervention: Nursing implications. *Critical Care Nurse* 2007, 27(2), 25-35.

McDonough, M. (2009). Mission control: Managing atrial fibrillation. *Nursing* 2009, 39(11), 58-63.

Stanley, J. (2011). Pharmacological treatment of persistent atrial fibrillation in the older adult: evidence-based practice. *Journal of the American Academy of Nurse Practitioners* 2011, 23(3), 120-126.

Zak, J. (2010). Ablation to treat atrial fibrillation: Beyond rhythm control. *Critical Care Nurse* 2010, 30(6), 68-78.



Exemplary Professional Practice
Magnet Force: Quality of Care

CONTACT HOUR EDUCATION

Polypharmacy and the Elderly

Mary Hormese, Pharm.D., Advocate Christ Medical Center

Based upon a previous article written by Zwphameh L.G. Stein, RPh.

Read the Contact Hour article and take the test at the end of the article.

1. Complete the entire answer form. (Answer forms may be photo copied.) **DEADLINE:** Answer sheets must be received in the Clinical Education Department no later than September 28, 2012.
2. Return the answer forms through in-house mail or fax
MAIL: Clinical Education, Room 1030
FAX: ext. 41-5640

SCORES: To earn 1 contact hour of continuing education, you must achieve a score of 80% (8 of 10 correct). Certificates indicating successful completion will bear the publication date of *NURSING NOW*. If you do not pass the test, your answer sheet will be returned for you to correct and resubmit prior to deadline.

ACCREDITED: *NURSING NOW* Contact Hours presentations are accredited as a provider of continuing education in nursing through the American Nurses Credentialing Center's Commission on Accreditation (ANCC); State of Illinois Board of Nursing, Advocate Health Care.

CONTACT HOURS: This CNE activity is being offered for 1.0 contact hour. The provider of the activity has disclosed in writing or verbally there is no conflict of interest declared by the planners and presenters/content specialists.

QUESTIONS: Contact Sue Barry at ext. 41-4409 or e-mail her at: Sue.Barry@advocatehealth.com

Answers to the 2012 Volume 11, Issue 1 Contact Hour Quiz: "Informed Consent in Clinical Research"

1. Research related informed consent is complete once the consent form is signed by the patient?
a. True
b. **False**
2. Which of the following are the 3 basic characteristics of informed consent?
a. Information, benefits of the research protocol, liability statement
b. Information, documented cognitive assessment, ability to write
c. **Information, voluntary participation, decisional capacity**
d. Information, compensation for participation, voluntary participation
3. There are 8 elements required by law to be included in the informed consent document.
a. **True**
b. False
4. Who is responsible for ensuring that informed consent documents and processes adhere to required guidelines?
a. Federal and Drug Administration (FDA)
b. **Institutional Review Board (IRB)**
c. Principal Investigator
d. Department of Health and Human Services (DHHS)
5. Who is responsible for ensuring that the informed consent process is adequate and provides potential subjects with sufficient opportunity to have questions answered?
a. Federal and Drug Administration (FDA)
b. Institutional Review Board (IRB)
c. **Principal Investigator**
d. Department of Health and Human Services (DHHS)
6. What is required of those persons who will obtain informed consent from potential study subjects?
a. Provide evidence of research ethics training
b. Be listed on the study IRB application
c. Receive proper training about the study
d. **All of the above**
7. A HIPAA authorization document is required to be signed independent of the informed consent document.
a. **True**
b. False
8. Children assent is generally recommended for the following age group?
a. 5 years or older
b. **7 years or older**
c. 9 years or older
d. 10 years or older
9. What method should be used to verify the subject's understanding of the research study and its risks and benefits?
a. Document the interaction of informed consent
b. Answer the subject's questions
c. Ask the subject questions about the protocol
d. **All of the above**
10. Special requirements are needed to enroll Non-English speaking subjects into the study?
a. **True**
b. False

Polypharmacy and the Elderly

Volume 11, Issue 2 Contact Hour Quiz

- Polypharmacy has no official definition, but can be considered as:
 - Any number of drugs over seven
 - Any number of drugs over three
 - Involving only prescription drugs and not OTCs
 - Any combination or number of drugs that can be unnecessary or redundant and defeats the attempt to render the best patient care
- The nurse must be cognizant of a patient's potential polypharmacy because:
 - It may be the reason for the patient's admission to the unit or can potentially lead to future adverse events
 - It is difficult to give so many medications
 - Polypharmacy prevents the RN from spending more time with the patients
 - The RN is worried about the cost of so many drugs
- Polypharmacy can result in the following:
 - One drug (or more) increasing the effect of another drug(s)
 - One drug (or more) decreasing the effect of another drug(s)
 - Decreased compliance due to increased number of medications
 - Toxicity and adverse events leading to hospital admissions and increased length of stay
 - All of the above
- As patients age, which of the following is false?
 - Increase in number of chronic health conditions
 - Decrease in medication consumption
 - Increase in medication consumption
 - Increased incidence of polypharmacy
- When a physician, RPh, or RN perform a review of medications, which of the following must be considered?
 - All prescription drugs
 - All OTCs
 - All vitamins and alternative medications
 - All of the above
- An RN is preparing a patient newly started on amiodarone for discharge. The RN should:
 - Only talk about side effects of amiodarone
 - Only talk about the drug interactions
 - Discuss the side-effects and potential for drug interactions associated with amiodarone and remind patient to inform his/her other health care professionals about the addition
 - Do not discuss amiodarone at all since it is a benign drug
- An RN must suspect a medication-related problem in a patient if one of the following develops:
 - The patient begins to ask too many drug-related questions
 - The patient refuses his meds
 - The patient's current complaint started with an addition or change in prior therapy
 - The patient complains about a change in bowel status
- Nurse Myrna Byrd looks at the new admit's drug list and notices that the patient is on acid suppression therapy, ferrous sulfate, calcium carbonate, and vitamin B12 tabs. She knows stomach acid is necessary for iron, calcium, and B12 oral absorption. When Dr. Healum Quick arrives on the unit, Nurse Byrd should
 - Ask Dr. Quick about the acid suppression therapy
 - Say nothing unless the pharmacist says ok
 - Suggest a dose increase on the iron, calcium, and B12
 - Break into song
- Nurse Helda Hare admits a patient with a lower gastrointestinal bleed. Patient is on clopidogrel (Plavix), and aspirin for a recent cardiac stent placement. Patient is also on escitalopram (Lexapro), and Warfarin (Coumadin). He is also on some alternative medicine drugs — superman tabs for strong bones, lead-the-charge tabs for increased visibility, and Siberian eel tabs to increase his charm. Nurse Hare should:
 - Only tell the physician about the aspirin and the clopidogrel (Plavix™)
 - Include only the prescription medications when she calls the physician
 - Ask the physician if she should hold all of the prescription drugs, but not the alternative medications, since they are not considered "real medications"
 - Call the pharmacy and see if the ingredients in the alternative medications can be identified, since they may interact with the patient's warfarin (Coumadin)
- Nurse Great-one on 3 South calls a meeting to discuss the implications of polypharmacy on the patients. They all decide which of the following?
 - Polypharmacy makes cost-control difficult
 - Polypharmacy is especially dangerous on their unit because of the possible interactions with chemo drugs
 - When a sudden problem develops in a chemo patient, polypharmacy makes identifying the cause more difficult
 - All of the above.

Your Answers

Please submit to Clinical Education

INA CE #:

Polypharmacy and the Elderly

- | | | | | |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 2. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 3. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 4. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 5. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 6. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 7. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 8. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 9. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |
| 10. | a. <input type="radio"/> | b. <input type="radio"/> | c. <input type="radio"/> | d. <input type="radio"/> |

(Please print clearly)

Time to read and answer questions: _____

Name _____ Credentials _____

Unit/Department _____

Address _____

City _____

State _____ Zip _____

Phone # _____

E-mail _____

Social Security No. _____

Cost Center _____

Evaluation:

At the end of this article the participant is able to:

- | | | |
|--|---------------------------|--------------------------|
| 1. Define polypharmacy. | yes <input type="radio"/> | no <input type="radio"/> |
| 2. Describe three methods to reduce the patient's medication errors. | yes <input type="radio"/> | no <input type="radio"/> |
| 3. Were the objectives relevant to the goal of this program? | yes <input type="radio"/> | no <input type="radio"/> |
| 4. Was the teaching method effective? | yes <input type="radio"/> | no <input type="radio"/> |
| 5. Did this offering meet your objectives? | yes <input type="radio"/> | no <input type="radio"/> |
| 6. Content was presented without bias of any commercial product or drug. | yes <input type="radio"/> | no <input type="radio"/> |
| 7. Additional comments/suggested future topics: | _____ | |

Polypharmacy and the Elderly

Mary Hormese, Pharm.D., Advocate Christ Medical Center

Based upon a previous article written by Zwphameh L.G. Stein, RPh.

Introduction

Polypharmacy is a major health care concern faced by today's world. Polypharmacy can be defined as "the concurrent use of multiple medications." Since patients may have multiple chronic conditions requiring treatment, the above definition may not be an accurate description of polypharmacy. Another definition that would be more applicable to the current health care situation would be "the unnecessary use of multiple and/or redundant medications in management of the same condition."

The Etiology of Polypharmacy

There are several factors that play a role in the development of polypharmacy. One huge factor that leads to polypharmacy is our aging population. As patients age, the number of chronic health conditions increases. A number of different medications may be used to treat these health conditions, and although all prescribed medications may be clinically justified, many patients take more drugs than they should. It has been found that patients over the age of 65 years are responsible for over 30 percent of medication consumption in our country. An average geriatric patient takes anywhere between two to six prescription medications and one to three non-prescription medications simultaneously. It is estimated that these numbers will continue to increase as the number of elderly patients in the population increases. In one study, predictive factors for the development of polypharmacy included the number of medications at baseline (i.e., at the time of initial contact with a given health care provider), patient age, presence of diabetes, coronary ischemic disease, heart failure, hypertension, atrial fibrillation, diseases of the esophagus and stomach, and drug use without an indication.

Nowadays, patients often have more than one medical care provider treating their conditions with a variety of prescription and non-prescription medications. This could be due to lack of knowledge and lack of coordination of care from both the prescriber and the patient. Patients may get medications prescribed to them both by the primary physician and other consultants. If there is no effort taken to coordinate care and thus prevent duplication, that patient may end up on similar medications without anyone noticing it. Another part of the same problem is doctor-shopping. This involves those patients who purposely go to multiple physicians to get the medications they want or are addicted to. Even though pharmacists at retail pharmacies may be able to prevent polypharmacy, it can be difficult to completely overcome this situation since patients can get their medications filled at different pharmacies.

Direct-to-consumer advertising, growth in non-prescription drugs, and Internet pharmacies also have a huge impact on polypharmacy. Patients are often misled to believe in these alternative options and use these drugs without informing their health care providers. Majority of these patients are unaware of the dangers of these drugs such as counterfeit drugs, serious side effects and drug interactions.

The Costs of Polypharmacy

The most important reason why polypharmacy is a concern is due to the increased incidence of adverse drug events that stems from it. It has been shown that medication-related errors (MRE) and improper medication utilization causes more deaths than some other major causes such as breast cancer or HIV-related complications. An average estimate of deaths due to medication-related errors is anywhere between 44,000 and 98,000 fatalities per year. These numbers are continuing to rise every year and even though there are lot of initiatives to prevent this, polypharmacy still remains a significant problem in our current health care. Apart from the mortality concern, there is also morbidity associated with polypharmacy which can lead to increased length of stay in the hospital and readmissions. Below is a list of some of the adverse patient outcomes associated with polypharmacy. (Adapted from reference: 1)

Polypharmacy: Association With Adverse Patient Outcomes

Adverse drug reactions

- Arrhythmia
- Balance/gait disturbances (resulting in falls/injuries)
- Cognitive changes/confusion
- Constipation
- Cutaneous reaction/rash
- Gastric ulcers/bleeding
- Hypotension or hypertension
- Neurologic dysfunction (i.e. pseudoparkinsonism)
- Pyschiatric side effects (depression, suicidal ideation, etc.)
- Unexpected treatment failure

Drug interactions (often very complex)

Increased costs of medication and/or treatment

Increased risk of hospitalization

Patient nonadherence (increased with complex regimens)

Various medication errors

The following examples illustrate these points and highlight potential problems with polypharmacy:

Example 1: Assume that a patient sees an endocrinologist, who prescribes levothyroxine (Synthroid) tablets for the management of his/her hypothyroidism. Let us then assume that they visit their primary care physician with complaints of heartburn and this physician recommends an acid suppression medication, such as Calcium carbonate (Tums). This combination could result in a medication-related problem, due to a drug interaction. Specifically, the concomitant use of acid suppressors and levothyroxine (Synthroid) may lead to a decrease in absorption of the levothyroxine (Synthroid). This could be avoided if the prescriber educates the patient to separate these medications by at least 4 hours.

Example 2: Many long-term patients with diabetes have concomitant gastroparesis. Therefore, the prescribing of metoclopramide (Reglan) often ensues, but this drug is a dopamine antagonist and since many elderly patients may also have mild Parkinson's disease (which involves dopamine depletion), the use of metoclopramide (Reglan) in these patients could aggravate the patient's Parkinson's disease.

These examples are just a few of the complications that can ensue from polypharmacy. Specific concerns for disease states normally associated with polypharmacy and/or the elderly will be addressed in the sections to follow.

Polypharmacy and Phenytoin (Dilantin)

The number of patients experiencing seizures increases as our population ages, usually as a result of stroke or traumatic brain injury. In one subpopulation, seizures are alcoholic related and in another, the result of head injury due to falls. Phenytoin is a medication approved to manage patients with seizure disorders. It has a very narrow therapeutic "window," meaning that the difference between a toxic dose and a therapeutic dose is very small. Because of this, response to phenytoin is often assessed by drawing serum levels. However, phenytoin can be very problematic, since small increases in dose may result in large increases in drug levels due to enzyme saturation metabolism. Therefore, dose adjustments need to be done carefully based on the patient's age, liver and renal function, albumin level, and other interacting medications. Otherwise, the physician, who is prescribing phenytoin to an elderly patient with multiple pathological conditions, may then find his patient with a toxic blood level, which may be worsened by low albumin level or poor renal function. Toxicity can be manifested in several ways depending on the severity and it can go anywhere from vision changes and altered mentation to cardiovascular collapse and death. On the other hand, certain other medications or improper dose

adjustments may lead to decreased phenytoin levels, which can cause seizures. Phenytoin can also cause issues by interacting with other drugs leading to increased/decreased levels of other drugs.

Polypharmacy and phenytoin are not a good combination! Care should be taken with any patient on phenytoin therapy, due to its adverse effect profile as well as the potential for numerous drug interactions. Drugs that have major effects on phenytoin levels are listed below.

*Drugs that **increase** phenytoin serum levels:*

Some medications commonly prescribed for elderly patients can interact with phenytoin and cause increases in drug levels, leading to toxicity. These drugs include:

- Amiodarone (Cordarone)
- Benzodiazepines such as alprazolam (Xanax), midazolam (Versed), clonazepam (Klonopin) etc
- Allopurinol (Zyloprim)
- Clarithromycin (Biaxin), erythromycin (Ery-tab)
- Diltiazem (Cardizem)
- Omeprazole (Prilosec)
- Fluconazole (Diflucan)

*Drug that **decrease** phenytoin serum levels:*

In addition, phenytoin can decrease the levels of many anticonvulsants used concurrently with phenytoin, by increasing their metabolism. This list includes:

- Carbamazepine (Tegretol)
- Lamotrigine (Lamictal)
- Topiramate (Topamax)
- Valproic acid (Depakote)
- Ciprofloxacin (Cipro)

Phenytoin may also decrease the levels/effects of amiodarone (Cordarone), carbamazepine (Tegretol), clarithromycin (Biaxin), cyclosporine (Neoral/Gengraf), tacrolimus (Prograf), voriconazole (Vfend), warfarin (Coumadin), and many other drugs.

Phenytoin: Other Drug Interactions

- Warfarin: The combination of phenytoin and warfarin (Coumadin) is also problematic. Initially, phenytoin may increase the response to warfarin, leading to an increase in the INR and a subsequent dose reduction. Later on, a rapid reversal of warfarin's effect may occur, resulting in a decrease in the INR and a potential thrombus. Therefore, it is critical that the patient's INR be monitored carefully for patients on concomitant therapy with phenytoin and warfarin. On the other hand, warfarin may increase the concentration of phenytoin and can potentially lead to toxicity. Therefore, phenytoin levels need to be monitored.

Warfarin and Polypharmacy

Warfarin is one of the most common as well as most dangerous drugs. Patients taking warfarin together with several other medications require careful monitoring, since most drugs given with warfarin (Coumadin) tend to interact with it. Interacting drugs can either increase the effect (toxicity) or decrease warfarin's therapeutic effect.

Background:

Warfarin is an anti-coagulant that interferes with the hepatic synthesis of the vitamin K-dependent coagulation factors II, VII, IX, and X. The onset of action is 36 to 80 hours, depending on many factors, including other medications the patient is taking. Warfarin is used in the prophylaxis and treatment of venous thrombosis, pulmonary embolism, hypercoagulable disorders, and atrial fibrillation with a risk of embolism. The effect of warfarin in the body is measured by a lab test called INR (International normalized ratio). High INR means too much warfarin in the body, potentially leading to bleeding. Bleeding can be life threatening and includes intracranial, gastrointestinal, retroperitoneal bleeding etc. Low INR means lesser than preferred effect of warfarin predisposing the patient to clot formation.

What Influences Warfarin's Effect?

In addition to several drug interactions, alcohol, and genetic predisposition, the patient's diet can influence warfarin's effects. For example, patients who eat plenty of greens may have trouble obtaining the therapeutic effect of warfarin. This is because of the significant amount of vitamin K that is present in green vegetables. Vitamin K antagonizes the effect of warfarin and inconsistent intake of green vegetables can make it difficult to stabilize INR in the therapeutic range. Therefore, a patient's diet (which nurses must consider) should have constant vitamin K content. Patients should also be counseled to avoid alcohol and to notify physicians about any new medications or changes in medications so as to assess the need to re-evaluate the dose of warfarin. Over-the-counter medications and herbals may affect warfarin's effect and should be started only after consulting with a health care professional. Frequently patients may have to be on an interacting medication along with warfarin depending on the other health conditions the patient has. Therefore, close monitoring and dose adjustments are important.

So what is the big picture concerning warfarin? It is this — warfarin is a dangerous drug and the elderly are more susceptible to its adverse effects. It has a host of drug interactions, contraindications, warnings, and dietary interactions, as summarized below.

Drug Interactions

A summary of warfarin's drug interactions are listed below.

Drugs that Increase Warfarin's Effects: Warfarin's effect or toxicity may be increased by many drugs. These include, but are not limited to the following:

- Acetaminophen (greater than 1.3 grams for greater than 1 week)
- Amiodarone (Cordarone)
- Allopurinol (Zyloprim)
- Many antibiotics including antifungals (azithromycin (Zithromax), clarithromycin (Biaxin), ciprofloxacin (Cipro), trimethoprim-sulfamethoxazole (Bactrim), metronidazole (Flagyl), fluconazole (Diflucan), itraconazole (Sporanox), etc.)
- Many anticonvulsant/seizure medications (phenytoin (Dilantin), valproic acid (Depakote), carbamazepine (Tegretol) etc)
- Proton pump inhibitors (e.g. omeprazole (Prilosec))
- Tricyclic antidepressants (e.g. amitriptyline (Elavil))
- Statins (simvastatin (Zocor), lovastatin (Mevacor))
- anti-cancer drugs can also potentiate warfarin. Such anti-cancer drugs are 5-fluorouracil, gefitinib (Iressa™), and etoposide. This list is not exhaustive.
- Any other anticoagulants or antithrombotic agents (including aspirin and ibuprofen) may increase the likelihood of the patient bleeding without increasing the INR (clopidogrel (Plavix), prasugrel (Effient))

Drug that Decrease Warfarin's Effects: The list of drugs that decrease warfarin's effect is less numerous but by no means less important. This list includes:

- Barbiturates
- Bile acid sequestrants
- Carbamazepine (Tegretol)
- Bosentan (Tracleer)
- Rifamycin derivatives, such as Rifampin
- Certain chemotherapy medications
- Contraceptive agents or hormone replacement therapies

Herbal Drug Interactions with Warfarin: Almost all of the available herbal agents interact with warfarin. Some of the agents have not been tested for any interaction with warfarin and should not be taken due to the possibility of an interaction leading to an adverse effect. Common interacting herbals are: cranberry juice, ginkgo biloba, glucosamine, American ginseng, coenzyme Q10, St. John's wort, American, Panax, and Siberian Ginseng. In addition, green tea, red clover, licorice, feverfew, celery, and dong quai should be avoided.

In summary, when on warfarin, the best advice for the patient is to avoid alcohol and herbal drugs, keep a stable diet once the desired INR is reached, and discuss the drug

profile with the physician. The patient should be on as few drugs as possible and their INR must be monitored with any additions or subtractions.

Amiodarone and Polypharmacy

Amiodarone (Cordarone) is approved by the Food and Drug Administration (FDA) for life-threatening ventricular fibrillation or hemodynamically unstable ventricular tachycardia. Amiodarone also has many unapproved uses such as conversion of atrial fibrillation to normal sinus rhythm and in paroxysmal supraventricular tachycardia.

Amiodarone is an important medication for patients with the above heart conditions and protects the patient from a fatal arrhythmia. Therefore, many patients are started on oral amiodarone for long-term control of their heart rhythm. At the same time, amiodarone can be dangerous because of the significant drug interactions associated with it. For that reason, it is a good idea to have a systematic and thorough review of the medication profile for all patients taking amiodarone.

Similar to warfarin every aspect of amiodarone therapy cannot be thoroughly discussed in this article, but many relevant points regarding potential drug interactions will be reviewed.

Drug Interactions: Increased Effect/Toxicity

Even though amiodarone is used to prevent arrhythmia, one of the greatest risks associated with its use is the potential to cause arrhythmias when used in conjunction with other drugs that prolong the QTc interval. This can then lead to a fatal arrhythmia. Some of the more common drugs that may do this are below. Note that this includes some of the commonly used antibiotics. Consequently, prescribers should carefully monitor patients who are started on antibiotics and adjust therapy appropriately to prevent a fatal outcome.

- Amitriptyline (Elavil)
- Azole antifungals (i.e., fluconazole)
- Clarithromycin (Biaxin), erythromycin (Ery-tab), azithromycin (Zithromax)
- Haloperidol (Haldol)
- Ciprofloxacin (Cipro), levofloxacin (Levaquin), and moxifloxacin (Avelox)
- Concurrent use of other antiarrhythmics
- Theophylline (Theo-Dur)

In addition, amiodarone can increase the levels of many other drugs such as:

- Digoxin (give 50 percent of digoxin dose)
- Flecainide (reduce flecainide dose by 50 percent)
- Colchicine
- Statins
- Lidocaine
- Phenytoin
- Warfarin (Coumadin)

Drug Interactions: Decreased Effect

There are a number of commonly used drugs that can reduce amiodarone's effect, at times with serious sequelae. Some of the more commonly used drugs are phenytoin (Dilantin), phenobarbital, rifampin, and carbamazepine (Tegretol).

What can we do about Polypharmacy?

Medication reconciliation is an important part of the current health care system aimed at reducing medication-related adverse drug events and any forms of inappropriate medication use. One study utilizing medication reconciliation at admission found that 54 percent of patients had medication discrepancies, of which nearly 60 percent could result in potential harm if not discovered. This highlights the huge role accurate medication reconciliation has in preventing adverse events, reducing length of stay, and even readmissions.

If possible, the patient/nurse/caregiver can do the following things to help reduce his or her drug burden and thus prevent polypharmacy:

1. Maintaining an active and healthy life style will help prevent and help control several chronic conditions and thus reduce the number of medications needed.
2. Keep running lists of all medications including brand names, dose, frequency, and the duration of therapy. The list should include all over-the-counter (OTC's) drugs, vitamins, and alternative medications.
3. The patient should be advised to tell his/her health care provider at all medical appointments, how they feel since any new drugs have been prescribed or changed.
4. Educate patients that medication non-adherence may lead to unnecessary medication changes. If compliance is a problem, inquire about "once-a-day" alternatives.
5. Encourage patients to read all labels carefully. Patients need to be aware of possible drug interactions and side effects that may occur from therapy.
6. Patients should ideally use the same pharmacy for all prescriptions. This will help the pharmacist evaluate all of the patient's medications for appropriateness and to catch any potential drug-related problems. Ask pharmacist about interactions with OTC's, vitamins, duplicate medications, and alternative medications.
7. Some patients view the deletion of a medication as loss; assure them that the deletion is an improvement.

References

1. Stawicki, S.P and Gerlach, A.T. Polypharmacy and medication errors: Stop, Listen, Look, and Analyze. *OPUS 12 Scientist* 2009 Vol. 3, No. 1
2. Zagaria, M.A. (2006). Polypharmacy and potentially inappropriate medication in the elderly. *U.S. Pharmacist*. 31(10).
3. *Annals of Long Term Care Online* (2009). Possible polypharmacy awaits the elderly."
4. The Merck Manual of Geriatrics 21. Clinical Pharmacology. Accessed April 30, 2009.
5. Beers, M.H. Explicit criteria for determining potentially inappropriate medication use by the elderly: An update. *Arch Intern Med* 1197 (157): 1531-1536.
6. Bergman-Evans B. (2006). Improving medication management for older adult clients. *J. Gerontological Nursing* 32, 6-14.

