

A quarterly publication for United Hospital Nurses

# nursing notes



## United Hospital Magnet application status

**Sue Penque, RN, MSN, Vice President, Patient Care and Operations**

United Hospital embarked on a journey in 2003 to recognize the excellence of nurses and nursing practice at United Hospital. Goals included:

- Recognize and document examples of exceptional caring by United Hospital nurses
- Advance the profession of nursing
- Achieve a nationally recognized level of nursing care through applying for Magnet nursing status through the American Nursing Credentialing Center (ANCC)

Through the vision, insight and work of many nurses at United, we are well on our way to reaching the first two goals. United's application to be surveyed for Magnet nursing status has been denied due to an Allina unfair labor practices violation in

2003. United is eligible to resubmit its Magnet nursing application in 2007 and will continue to evaluate this option.

### **Benchmark Nursing Excellence**

The dedication United nursing staff members show toward providing care by partnering with physicians, colleagues and other caregivers goes beyond the walls of our hospital.

The ANCC Magnet accreditation program provides a framework to benchmark nursing excellence. United nurses have a rich history of caring and giving to the community. Gathering this information has not only validated the nursing excellence we have at United Hospital, it has strengthened professional nursing at every level in the organization.

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fall 2006



**UNITED  
HOSPITAL**

*Allina Hospitals & Clinics*

# Rapid Response Team

Nancy Roberts, RN, Day Surgery Center

As registered nurses we are trained to use our assessment skills. One of the senses we rely on the most is our power of observation. We process the majority of information about our patients by seeing what the monitors say, assessing the patient attached to those monitors and processing this information into our “nursing brains” and making an action plan. The Rapid Response Team, instituted in December 2005, puts observation, assessment and action into motion by a myriad of team players.

Sarah Gustafson, RN, ACM on 4940, talked about how she utilized the Rapid Response Team when a “patient just didn’t look right.” She can’t always put a finger on why, but her instincts tell her something about this patient is not right, and she does not hesitate to call the Rapid Response Team. Sarah and her coworkers receive a variety of postop patients on the evening shift, where they maintain a 4:1 patient care ratio. Most hospital admissions are on the 3 - 11 p.m. shift, which makes for an ever-changing environment for both nurses and patients. Sarah described situations that occur on her shift, where resources are more limited than on the day shift. She said, “It’s nice to have another pair of eyes,” when she calls the Rapid Response Team.

Sarah cares for patients who have hypotension, peaked T waves or blood sugars all over the map, making them prime candidates for developing serious cardiac issues. Sarah is an experienced ACM who knows that her staff looks to her as a valuable resource. She does not hesitate calling the Rapid Response Team, inviting the assessment capabilities of the Critical Care RN and Respiratory Therapist.

Sarah feels her nursing observations are validated by the Rapid Response Team. “They don’t take over the situation and are not intimidating to us,” she reports. She feels it is very important to learn from and work collaboratively with the Rapid Response Team.

Carol Lee, RN, works evenings on Orthopedics and describes situations when she has called the Rapid Response Team. Carol appreciates, their quick response, monitoring skills and ability to administer medications. “In the old days, we used to page a resident and that took precious time,” Carol says. She feels that in the four times she has called Rapid Response, they validated her instincts about patients. In her experience, calling the Rapid Response Team does not mean the patient automatically gets transferred to ICU. Often patients stay on the unit. Their vital signs are observed by the Rapid Response Team, and the bedside RN and Rapid Response Team collaboratively decide if the patient needs to be transferred to the ICU.

The powers of observation are validated and acted upon by the Rapid Response Team. Sarah and Carol are just two of the RNs who have been active participants in making the Rapid Response Team a successful tool. To make patient care as efficient and timely as possible, it takes a TEAM who:

Together  
Effectively puts  
Assessment into  
Motion

The Rapid Response and the nurses, who call them do just that.

# Stroke Certification

Kelly Gannon, RN Neurology Program Leader

Who: JCAHO  
What: Stroke Certification  
When: November 2006  
Where: United Hospital  
How: JCAHO tracer methodology

United Hospital’s application for stroke certification has been accepted. A representative from JCAHO will visit United Hospital for one day in November 2006 to evaluate our stroke program. The surveyor will use the tracer methodology to trace the path of a stroke survivor.

In preparation for the survey, posters will be distributed to all nursing units with stroke information pertaining to the visit. Additionally, mock tracers will be conducted in September and October to help prepare staff for the site visit. Please contact Gannon at ext. 17318 with any questions.

# Aromatherapy Class

Clinical aromatherapy is the use of plant essential oils with clients for specific, measurable therapeutic outcomes. This two-day course Oct. 21 and 22 will help you understand the clinical use of plant essential oils, including their use in treating chronic and acute pain, insomnia, wound healing, skin rashes, headaches, migraines and stress.

The course will be held at United Hospital. To register or for more information, please contact Carol Nelson at ext. 18016 or [carol.nelson@allina.com](mailto:carol.nelson@allina.com).

# Ethics Case Study

Julie Sabo, RN, MN, CCRN, APRN-BC, CNS

A 58-year-old non-English speaking Hmong man was admitted for renal failure. The patient initially responded to dialysis and aggressive intervention but developed a nocardia bacterial infection. He was treated with antibiotics and placed on a ventilator, but developed abscesses in his brain. After two weeks on the ventilator, the patient showed neither progress nor further decline. The attending physician wanted to proceed with a tracheostomy, offering a 30 to 70 percent chance of recovery with continued aggressive treatment. The family was concerned that the treatment conflicted with their loved one's value system and asked if the patient could be "allowed to die."

What would your consultation be in this case and what procedural steps would you follow?

## Case Analysis

This case represents the principle of self-determination as represented by the patient's surrogates, together with an obligation for the physician to protect the patient's best interests and honor sanctity of life. The cultural issues heighten the care required to communicate clearly and reflect carefully. The family asks if the patient may "be allowed to die." The answer is yes if the family presents clear evidence that they are representing the patient's wishes. Since they seem instead to be wondering aloud, it becomes an opportunity for the physician

and treatment team to encourage patience and to collaboratively develop a plan with reasonable timelines. Since there is no reason to expect that the patient could not tolerate the tracheostomy, since it would bring a measure of comfort, and since the prognosis shows a reasonable hope for recovery, it would be appropriate to continue aggressive therapies and proceed with the tracheostomy. It would also be appropriate to utilize a time-limited trial, working with the family to discern progress or decline. Such a trial is a mutual agreement between physician and family to continue therapies for a set amount of time, after which therapies will be withdrawn if the patient declines or shows no progress toward recovery.

# Confusion/Delirium in Hospitalized Patients

Margo Halm, RN, PhD, APRN-BC, CCRN, Director of Nursing Research and Quality

Acute confusion/delirium occurs in as many as 40 percent of hospitalized patients. It is a transient state of cognitive impairment manifested by simultaneous disturbances of consciousness, attention, perception, memory, thinking, orientation and psychomotor behavior that develops abruptly and fluctuates diurnally. Studies have shown that acute confusion/delirium is largely preventable if nurses and other health care professionals identify risk factors and put preventive interventions in place. This bundle of nursing interventions include:

1. Identify and treat underlying physiologic problems such as hypoxia, infection, pain or alcohol withdrawal.

2. Substitute medications known to cause or contribute to confusion such as Ativan, Benadryl or Pepcid (see full list of medications on the Acute Confusion Supplemental Pathway).

3. Consistently use communication strategies such as speaking clearly, repeating thoughts and feelings for validation and frequently reorienting patients. Use these techniques in a manner that does not directly confront their reality.

4. Manipulate the environment by encouraging the use of hearing aids and glasses, removing tubes and catheters as soon as possible and integrating home routines. The Acute Confusion Supplemental Pathway has a new feature, the "Familiar Routines Questionnaire." Maintaining normal

routines and encouraging familiarity is exceedingly important in patients who have become confused after admission to the hospital. Please print the pathway and give the questionnaire to your patient's family member to complete. Then integrate these routines into the patient's plan of care as much as possible.

5. Promote active family involvement in the patient's care to maintain familiarity and assist with reorientation strategies. A revised brochure, "Acute Confusion Management: How to Care for a Family Member" will be available soon through Allina Press to help you educate patient's family members about acute confusion and delirium.

# Diabetes Update

Diabetes Resource Nurses and United Pharmacy

## Medication Update

**Exubera®** — In January 2006 the FDA approved Exubera® inhaled powdered insulin. Exubera®, a short acting analog insulin like NovoLog, is approved for type 1 and type 2 diabetes. There is no long-acting inhaled insulin at this time. The application for this product would most likely be the type 2 patient that needs extra insulin at meal time.

Marketing of this product, which was limited to endocrine physicians, is currently on hold as some problems have been identified. United Hospital Pharmacy & Therapeutics Committee has not yet reviewed Exubera®, but is expecting to do so this fall and will likely establish use criteria. There is no long-term data on the effects of this drug on the respiratory system. Absorption can vary by 40 percent from dose to dose (related to technique and illness such as the common cold), making hypoglycemia a risk. Cost may turn out to be the most significant obstacle due to lack of insurance coverage of this medication. The out-of-pocket price has not yet been announced.

**Levemir®** — A new insulin that is just out from Novo Nordisk is called Levemir® (insulin detemir). It is a long-acting insulin and is dosed and given similarly to Lantus®. It is available in vials or flex pens. This medication has not yet been reviewed for the formulary at United. A couple of updates on the old standbys:

**Actos, Avandia** — The major side effect for this medication is fluid retention, which can lead to heart failure. This can be especially

troublesome if the patient already has a history of heart failure.

**Metformin** — This medication is not recommended for patients who have elevated creatinine >1.4 in women and >1.5 in men. Should be used with caution in people with elevated liver enzymes or heavy alcohol use/abuse. If you see these situations arise please discuss with the primary physician.

## New Product Alert

Medtronic MiniMed has FDA approval for a new pump with real-time continuous glucose monitoring system. The Guardian RT continuous monitoring system, also from MiniMed, has been available in limited release since September 2005. One of the advantages over the Guardian RT is the software that offers 24-hour graphs that track how blood glucose is changing and what's going on while the person is asleep, when many people have hypoglycemia.

**Stevia®** — Stevia® is a new sweetener derived from a bush native to South America that has been used for centuries by natives of Paraguay as a sweetener and for medicinal purposes. It is 200 to 300 times sweeter than sugar. Stevia® has its own flavor, like maple syrup or molasses, and may be used in cooking or any other way sugar or other sweeteners are used. Claims of medical benefits include lowering blood sugar, lowering blood pressure and decreasing dental plaque. It is available in white powder, green powder, liquid drops, powdered leaf and more. This product has not been approved by the FDA and the many forms have no regulatory controls.

## Updates/Reminders

Watch for new and improved insulin protocols.

**DKA** — The DKA protocol has been revised (thank you Dr. Shank!) and will be presented to the United Pharmacy & Therapeutics committee in September 2006. The new insulin flow sheets will fit well with this protocol, so there will be only one flow sheet for all IV insulin drips.

**IV Insulin Drips** — There has been some confusion about which IV insulin drip protocols to use in different situations. We recently had a DKA patient who was placed on the Medicine IV insulin protocol. This could potentially be very dangerous, as DKA patients have very different needs and medical issues that are not addressed or could be made worse by using the wrong protocol.

Please don't hesitate to clarify any order or call the Diabetes Resource staff if you have any questions or concerns.

**Insulin Pump Orders** — We will soon have a packet that will be generated when a patient using an insulin pump is admitted to the hospital. The packet will include the insulin pump order set, patient consent form and a worksheet for the patient to document the day's insulin doses, which the RN will review and sign off on the MAR each shift. The education for these documents will be available in the fourth quarter nurse learning packets.

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# Diabetes Update

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## Upcoming Events

Diabetes Expo — Saturday, Oct. 14, from 9 a.m. to 3 p.m. at the Minneapolis Convention Center. This annual event attracts hundreds of people to learn more about diabetes. Exhibits feature some of the latest products, free health screenings, ask the experts, cooking demos and exciting speakers. There are 281,000 Minnesotans who have diabetes, so please help get the word out.

**Monthly Inservice Sessions** — The monthly inservice sessions resume in September.

Tuesday, Sept. 26, 1:30 - 2:30 p.m. and 4 - 5 p.m. in the Bentson Family Conference Room (United lobby). Dr. Doyle will present information on diabetes and renal failure

Wednesday Oct. 25, 1:30 - 2:30 p.m. and 4 - 5 p.m. in Room 3610.

Dr. George Miller will speak about diabetic retinopathy.

Monday, Nov. 27, 1:30 - 2:30 p.m. and 4 - 5 p.m. in the 9<sup>th</sup> floor Conference Room. Dr. Benadict (endocrinologist) will speak about new treatment options and review case studies.

Please join us for these informative events. CEU are available and snacks are provided at monthly inservices.

# Reduce Patient Falls: Rounding for Outcomes

**Pam Howard, RN, Patient Fall Reduction Project Lead**

The Alliance for Health Care Research has studied call light use and the effectiveness of rounding for clinical outcomes. The goals are to better understand how proactive nursing behaviors can reduce call lights, assess how well these behaviors correlate to gains in patient safety and quality care and determine the impact on patient satisfaction.

Nurses in the study were educated to:

- Complete scheduled tasks during regular hourly rounds
- Address the three “Ps” (potty, position, pain)
- Conduct an environmental assessment (i.e., can the patient reach the telephone, tissue and TV controls?)
- Ensure each patient is comfortable and has enough bed covers
- Explain rounding to the patient so he or she understands comfort levels are being checked continuously
- Ask the patient if there is anything else you can do for them prior to leaving the room
- Tell the patient that a member of the nursing staff will be back again in one hour.

Key words were used with the patients to set expectations about when the nurse would return. “Is there anything else I can do for you? I have the time while I am in the room.”

Organizations are anecdotally reporting dramatic reduction in patient use of call lights and commenting about how quiet the units are as a result. And nurses are reporting that they really do have more time.

The complete study is expected to be published in the *American Journal of Nursing* in September 2006.

A hospital in Wisconsin has implemented hourly rounding and has found much the same results:

- Nurses are picking up on patient concerns and needs before they become urgent.
- An open dialogue is created with patients and allows nurses to “reconnect” at the bedside.
- Rounds give patients a consistent message from all staff members who come into their room

- Patients feel comforted to know caregivers are communicating.
- Rounding improves communications among all caregivers. The message board in patient rooms became an important communication tool for caregivers.

Information about rounding for clinical outcomes has been presented at many United Hospital RN Practice Councils. RN Practice Councils are asked to work toward implementing rounding on their unit. The suggested process is for nurses to round on even hours (i.e., 0800) and nursing assistants/patient care associates to round on odd hours (i.e., 1300). This process will provide consistency throughout the hospital.

Insights and efforts for effective rounding for clinical outcomes from other health care organizations will be shared with RN Practice Councils and nursing leaders. Please contact Howard at ext. 18228, for additional discussion, training requests and to share your successes in rounding for clinical outcomes.

# Policy Updates: Nursing Research Council

Margo Halm, RN, PhD, APRN-BC, CCRN, Director of Nursing Research & Quality

## Lidocaine & Coude Catheters

The Urinary Catheter policy was recently updated after our review of current nursing literature. Our new policy recommends the use of lidocaine jelly prior to Foley insertion to maximize patient comfort. It is important to note that it is necessary to obtain an order for both 2 percent Lidocaine or the UroJet as we have learned that it is not within our scope of RN practice to write “Lidocaine per policy” since RNs cannot prescribe medications. Physicians

must order individual drugs for each patient by law. Please obtain the Lidocaine order when you receive the Foley insertion order.

Our policy also states that RNs may now insert Coude catheters on male patients over 40 due to the prevalence of benign prostatic hypertrophy. Coude catheters have a curved tip that conforms more closely to the natural curve of the male urethra allowing easier passage into the bladder. Remember

the curved tip must be facing the direction of the urethral curve (most Coude catheters are manufactured with a dark line that extends along the top surface of the catheter to show the direction the curved tip is pointing once it passes into the urethra).

RNs may select a Coude catheter for male patients without a physician's order.

# Current Evidence of Trendelenburg Position

Margo Halm, RN, PhD, APRN-BC, CCRN, Director of Nursing Research & Quality

Did you know that the Trendelenburg position dates back to the 1870s with the pioneering German surgeon Friederich Trendelenburg? He recognized that by raising the hips of a supine patient the bulk of abdominal viscera slide downward toward the diaphragm providing a less cluttered operative field for lower abdomen and pelvis procedures. Later, other physicians popularized its use in the treatment of hemorrhagic shock because they believed it diverted blood from the lower extremities to the central circulation, thereby augmenting cardiac filling by increasing right and left ventricular preloads, stroke volume and cardiac output. Despite leading physicians later questioning the efficacy of this position in the 1950s, Trendelenburg continued as a mainstay of resuscitation.

The Nursing Research Council began reviewing the scientific evidence on the use of the Trendelenburg position in hypotensive patients last year. We found several studies that measured the effects of Trendelenburg on hemodynamic parameters in healthy

and acute/critical care populations. Although limitations exist in the 15 available studies, several conclusions may be reached.

Only 20 percent of these studies showed a statistically significant increase in BP and CO/CI in these populations, and the changes appeared to be transient lasting only one to seven minutes. Furthermore, research has shown that only 1.8 percent of peripheral blood is displaced to the central circulation attesting to the limited autotransfusion effects of Trendelenburg in the setting of shock and hypotension.

Evidence also exists on the harmful effects from physiological changes associated with this position. The sequence of symptoms have been documented as follows:

- Anxiety and restlessness
- Onset of pounding vascular headache
- Nasal congestion that may force mouth breathing
- Progressive dyspnea
- Loss of cooperation/hostility

- Struggling efforts to sit upright

Most of these symptoms were observed in patients in  $\leq 20$  degree Trendelenburg position. Given many RNs report typically using a 25 to 30 degree head tilt, it is arguable that steeper angulation ( $\geq 20^\circ$ ) could produce greater physiological abnormalities. And the longer the head down tilt is continued the more pronounced the abnormalities might be for patients.

Overall, the evidence supporting the hemodynamic effects of Trendelenburg in treating hypotension and/or shock is small and does not reveal significant, beneficial or sustained changes in BP or CO/CI in the hypotensive patient. Since Trendelenburg may also be associated with distressing symptoms and harmful effects to the respiratory, neurological and vascular systems (especially in the presence of pathology) this position should be used with caution until additional high-quality studies document the risks and benefits of Trendelenburg position for hypotensive patients.

# Celebrations

## Master's Degree in Nursing

- Kelly Gannon, RN, MSN, Nasseff Neuroscience Center (NNC) Neurology program leader, from Indiana University and Purdue University, Indianapolis.
- Annie Retter, RN, MA, Nasseff Heart Center (NHC) 3500, from Augsburg College, Minneapolis

## Bachelor of Science in Nursing

- Therese Demay, RN, BSN, 3500 NHC
- Rita Klym, RN, BSN, 3300 NHC
- Shannon Lacktorin, RN, BSN, 3900/3920/3940
- Kim Terrell, RN, BSN, Pain Clinic
- Lynn Schuman, RN, BSN, CV Lab clinical educator, magna cum laude

## Oncology RN Certification

- Audrey Robert, RN, OCN, 4500

## Neuroscience RN Certification

- Ann Caliguire, RN, 7900/7920
- Deb Donndelinger, RN, ACM 7900/7920
- Kelly Gannon, RN, MSN, Neurology program leader

## Pain Management RN Certification

- Kathy Enderlein, RNC, Pain Clinic
- Sue Dzubay, RNC, Pain Clinic
- Kathy Russell, RNC, Pain Clinic
- Wendy Wimmer, RNC, Pain Clinic
- Deborah Hauser, RNC, MSN, C-NP, Nurse Practitioner, Pain Clinic

## Research Grant Awarded

Congratulations to Jan Christison, RN, Pat Milbrett, RN, and Christine Larson, RN, Emergency Department staff nurses who received a clinical practice grant from the Minnesota

Nurses Association Foundation for their nursing research study "Frequent Utilizers of Emergency Department Services." Margo Halm, director of Nursing Research & Quality is mentoring the staff in conduction of this nursing study.

## Professional Appointments

Margo Halm, RN, PhD, APRN-BC, CCRN, director of Nursing Research & Quality, was recently selected for the national 2006-2007 Research/Evidence-Based Practice committee of the American Association of Critical Care Nurses.

## Correction

Lynn Zak's last name was incorrectly spelled in the last edition.

# United Nurses on AKN

## Rose West, RN, Patient Care Support Services Director

A new category has been added to United's AKN home page, "Nursing Practices, Information and Resources." It contains United-specific documents as well as links to the nursing page on [www.unitedhospital.com](http://www.unitedhospital.com) and the Allina Nursing site on the AKN. Among the United-specific documents are Nursing Evidence-Based Practice Guidelines and specific MNA/United documents, including the mutually agreed upon MNA/United decision logs and guidelines (i.e., vacation guidelines).

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**Publisher:** Margo Halm, RN, PhD, 651-241-8536, [margo.a.halm@allina.com](mailto:margo.a.halm@allina.com)

**Editor:** Colleen Kingsbury, senior communications consultant, 651-241-8518, [colleen.kingsbury@allina.com](mailto:colleen.kingsbury@allina.com)

**Editorial Board:** Sue Penque, RN, MSN, Margo Halm, RN, PhD, APRN-BC, CCRN, Glenda Cartney, RN, ACM, Nancy Roberts, RN, Julie Sabo, RN, MN, CCRN, APRN-BC, CNS, Colleen Kingsbury, United Hospital, 333 N. Smith Ave., St. Paul, MN 55102

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