

Tracer Pathways — Improving Service

Barb Knudtson, RN, Education Services

In 2002 JCAHO started a new initiative called “Shared Visions-New Pathways.” This initiative resulted in significant changes to the accreditation process that “sharpens the focus of the accreditation process on operational systems critical to the safety and quality of patient care.”

A key part of the changed survey process is the introduction of the tracer methodology — an evaluation method in which surveyors select a patient and use that individual’s record as a road map to move through the organization to assess and evaluate the organization’s compliance with selected standards.

In June 2005 United Hospital staff and leaders experienced the new tracer method during the mock survey visit with Helen Hoelsing. Staff and leaders who participated commented on the in-depth look at patient care, the significant involvement of the bedside nurse and the range of questions that resulted from looking at one record.

The mock survey started with a patient selected on 3400. Hoelsing, our surveyor, sat with the patient’s nurse and record. The nurse reviewed the patient’s current status with Hoelsing. Then the nurse and Hoelsing looked through the charts “tracing” the care of the patient through a variety of departments including

Emergency Department, Interventional Radiology, Cath Lab and Blood Bank. Once this review was complete, Hoelsing went to those identified areas with a set of questions related to practice in those areas and tied to the patient she had reviewed on 3400.

Key areas of focus in the tracer are:

- Patient safety goals
- Planning patient care
- Transitions and communication between areas and caregiver staff
- Pain management

To prepare United nursing staff for this change, a number of strategies have been implemented:

- Unit and department tracers will provide individual nurses with an opportunity to practice the new method. These will be carried out at first by leaders, then unit practice councils, and eventually ACMs.
- Messages of the Week are being provided to leaders to review with staff to be ready for the types of questions surveyors will ask.
- Key messages are provided for staff every week in *Update*.
- Pocket guides and brochures will be released sometime in October as a resource to staff.
- A patient safety goals badge has been provided to all staff.

PRACTICE CHANGE: PICC Flush after Blood Draw

The Nursing Research Council

The Nursing Research Council was recently asked by the IV Team to review clinical research evidence around the amount of flush solution to use after a PICC blood draw. Our past policy stated to flush the PICC with 10 cc of normal saline (NS). Community standards and recommendations from the IV Nurse’s Society are to adequately flush a PICC with 10-20 cc NS to prevent clot formation. This change is being made to our current “Intravascular Access and Therapy” policy. Another change you will see on the “Venous Access Device” addendum of this policy is to use a 10 cc syringe (rather than the previously stated 3 cc syringe) when drawing blood to prevent rupture or fracture of the PICC. When reviewing these practice changes, Nursing Practice Care Delivery (NPCD) also recommended and will follow-up on working with pharmacy to get these flushes on the MAR to facilitate documentation. Any questions about this practice change can be directed to any member of the Nursing Research Council or NPCD.

Policies

Linda Johnson,
Patient Care Support Services

Listed below are those documents in the United - Patient Care Policy/Procedure category on the Allina Knowledge Network (AKN) that have been updated since 6/2/05.

You can view these revised policies on the AKN.

Revised

- Breast Massage & Hand Expression
- Breast Milk Collection & Storage
- Chest Suction, Chest Drainage System
- Eclipsys SCD: Documentation and Printing
- Eclipsys SCD: Downtime
- Eclipsys SCD: Routine Hardware Maintenance and Problem Resolution
- Eclipsys SCD: User Access
- Emergency Patient Care
- Gastrostomy Tube Replacement
- Hypoglycemia, Treatment of
- Identification Bands — Patients
- Identification of Operative Site
- Med — Administration — Transdermal Route
- Med — Management of Extravasation of Peripheral Intravenous Solutions & Drugs
- Pain Management
- Declotting Central Venous Catheters Using Alteplase
- Apheresis, In-Patient
- Restraint or Seclusion Use: Behavioral Management
- Food/Drug Interactions

Deleted

- Autotransfusion
- Breast Pump — Medela® Classic
- Breast Pump — Medela® Lactina
- Breast Pump — Medela® Manual

Being an Excellian® Super-User at ANW

Lisa Waytulonis, RN, Clinical Documentation

Lisa Waytulonis, RN, Clinical Documentation, worked as a super-user for the Abbott Northwestern (ANW) Excellian® go-live this summer. As a member of United's Excellian® Core Team, Waytulonis gained valuable experience she plans to use in helping plan for United's go-live (scheduled for first quarter 2007).

Prior to the go-live, Waytulonis pre-loaded patient information and medications into Excellian®. After go-live, she worked five shifts as a super-user nurse across three cardiovascular telemetry units at ANW.

In her role, Waytulonis found that good communication was important to a successful go-live. For instance, she found that meetings between nursing shifts to review outstanding issues, problems and to hand-off the issues log were essential. Each charge nurse had a digital pager so that urgent information could be communicated housewide as necessary for leaders to share with employees, super users and Excellian® staff.

The super-user is essential to a successful Excellian® go-live. Super-users need to be highly motivated and interested in supporting their peers, physicians and others by being out of the count and working directly with them during implementation. They are involved in reviewing department work flows, acting as a teacher's assistant during training and directly communicating with staff on the units during go-live.

Members of United's Excellian® SWAT team participated in the ANW go-live and will be going to Mercy and Unity hospitals to assist them. Participating in these go-lives helps us plan for successful implementation at United. We also hope to benefit by having super-users from those sites come here to support us during our go-live. United will need many more super-users from all areas for our own go-live. Watch for more information on super-user recruitment at United.

Celebrations

Congratulations to the following nurses who recently achieved national nursing certification!

Medical-Surgical Nursing Certification:

- Brenda Larsen, RN, 2600
- Joyce Grosser, RN, 2600
- Monica McClelland, RN, 4400
- Katie Westman, RN, 4920/40
- Lisa Torres, RN, 4920/40
- Shannon McNamara, RN, 4920/40

Gerontological Nursing Certification:

- Barb Murray, RN, 4400

Oncology Nursing Certification:

- Leslie Foreman, RN, Breast Center Nurse Clinician

Rehab Nursing Certification:

- Maren Nelson, RN, 8940

Gastrointestinal Nursing Certification (CGRN):

- Lisa Haviland, RN, Endoscopy

Other News

Margo Halm, RN, CS, PhD, director of Nursing Research/CNS was recently appointed to the American Association of Critical-Care Nurses Research Grant Review Panel.

Diabetes Update

by Diabetes Resource Staff: Patti Long, RN, CDE; Marti Rud, RN, CDE; Lisa Schipp, RN, ES; and MJ Lee-Vanhoulton, RN, CDE

Latent Autoimmune Diabetes in Adults (LADA)

A growing number of adults have a form of diabetes that does not seem to fit initially into the broadly accepted categories of type 1 or type 2 diabetes. These patients have a form of diabetes called latent autoimmune diabetes in adults (LADA). They are often not overweight and have little or no resistance to insulin. It is not much different from type 1 diabetes that appears in children but strikes later in life and has a slow onset. An estimated 5 percent to 10 percent of all patients with diabetes may have it. Because insulin resistance is minimal or nonexistent, the standard medications designed to reduce insulin resistance tend not to be effective. Medications that are often effective in

controlling blood glucose for years are those that stimulate pancreatic production of insulin, slow digestion of carbohydrates or reduce excess glucose production.

Diagnosis of LADA includes measurement of C-peptide levels, which would be low to normal (C-peptide levels in type 2s is within normal or elevated). Depending on these results, a measurement of antibodies that attack beta cells (especially antiglutamic acid decarboxylase antibodies) may be performed and in the case of LADA would be elevated. The treatment of choice for these individuals would be insulin as with type 1s.

New Product Alert

- The Opticlick® Lantus® pen is now available to our patients through the diabetes resource staff. If you have a patient who you feel may benefit from this product, please initiate a diabetes consult.
- We have received many complaints about pain from the orange lancets

stocked in the glucometer kits. There is now an alternative. The purple lancets are much kinder to our patients as they have a smaller gauge needle. You can order these from materials management — Lawson number 154665. Lets make our patients as comfortable as possible. Give them a try!

Medication Update

A new medication has just been approved for the treatment of diabetes, called BYETTA™. It will be injected BID up to 60 minutes before meal time. It does not replace insulin but offers improved glucose control by increasing the production of insulin in response to food, suppressing postprandial glucagons

secretion and regulating gastric emptying. It may even encourage new beta cell formation, and it has been proven to cause weight loss in many patients. It is delivered by a pen in 5 to 10 mcg and must be kept in the refrigerator and discarded 30 days after the pen is initiated. LOOK FOR IT SOON!

Reminder

When you admit a patient with an insulin pump, you **MUST** get orders for the basal rates and meal boluses, as well as for the correction boluses. These **MUST** be written on the MAR. If the physician orders “per patient,” you must ask the patient what his or her rate is and clear it with the physician. Patients need to bring all supplies as we do not have these. Site changes are to be charted same as any other site change. Patient must be completely independent in all areas related to the pump or it is not safe for that patient to wear the pump in the hospital. Run the insulin pump custom document as soon as possible as this outlines your responsibilities and lists the pump manufacturers’ resource numbers. This document is found by selecting #5 in the custom document screen, typing “insulin” and selecting insulin pump document. All insulin pump patient admissions **REQUIRE** a consult with diabetes resource as per the admission screening tool.

DID YOU KNOW?

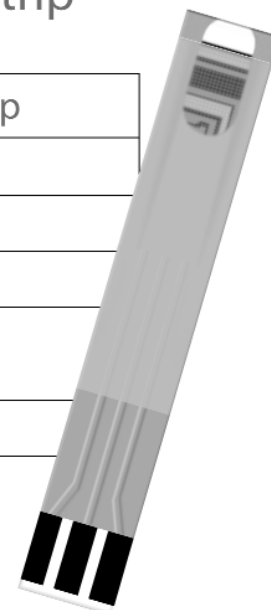
- About 8.6 million people over 60 have diabetes! That’s 18.3 percent of that age group, and the numbers are equal among men and women.
- We work with two home delivery companies: Byram Healthcare and CCS Medical. Both offer home delivery of diabetes and other supplies (i.e., stoma supplies). They both bill insurance companies, including Medicare, and only charge what Medicare allows (less co-pay for these patients). CCS also has prescription drug delivery, and they accept Medicaid and all other types of insurance. For more information about these companies, talk with one of the Diabetes Resource RNs.



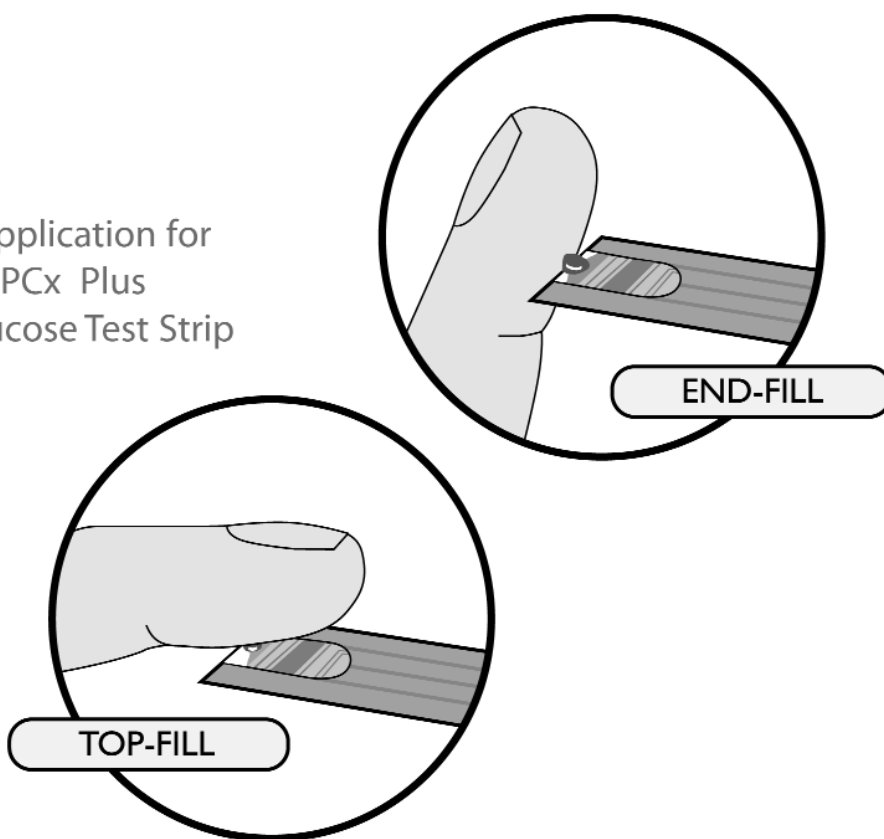
Precision PCxTM Plus

Blood Glucose
Test Strip

Feature	Precision PCx TM Plus Blood Glucose Test Strip
Sample Size	2.5µL
Test Time	20 seconds
Assay Range	20-500 mg/dL
Hematocrit	20-70% < 300 mg/dL 20-60% ≥ 300 mg/dL
Sample Application	Dual-Fill (End-Fill or Top-Fill)



Sample application for
Precision PCx Plus
Blood Glucose Test Strip



The features of the new PCx strip include:

- Gold wrap to easily distinguish it from the current silver wrapped version
- The test strip requires less blood
- The target area for the blood application on the new strip is at the end of the strip rather than the middle.
- The strip has a clear plastic coating that allows you to see blood wicking into the strip

Look for it this Fall.
Happy glucose testing.

PrecisionTM

Always true to you

United Hospital Nursing Shines during Magnet Mock Survey

Julia Au Coin, PhD, a consultant from the American Nurses Association Credentialing Center (ANCC) and a professor at the University of North Carolina's School of Nursing, conducted a mock survey of the nursing department of United Hospital on Aug. 8-9, 2005. A mock survey is part of the process to attain ANCC's Magnet Hospital award for Nursing Excellence. A committee of United nurses has been working for more than a year to earn this prestigious award. Currently, only 3 percent of American hospitals have met the stringent requirements to be designated a "Magnet Hospital."

During her two days at United, Au Coin met with staff nurses, nursing leaders, pharmacists, respiratory therapists, administrators and physicians. She asked probing questions about nurses' accomplishments, perception of nursing by other departments and nursing collaborate for excellent patient care.

Au Coin focused mainly on staff nurses, touring many of the nursing areas and interviewing individual staff nurses. She asked them why they choose to practice at United, if they were certified in their nursing specialty and how United helps them attain/maintain certification. She also was interested in staff nurses' community involvement, including types of volunteer activities, and how we achieve balance between our personal and professional lives.

Au Coin spoke with members of United's nursing committees about how information on research and quality initiatives is communicated to other nursing colleagues. Au Coin was impressed with something that most of us take for granted — the view from and the design of many of the patient rooms.

by Naomi English, RN, Patient Care Float

As we accompanied Au Coin around the campus and heard her speak during the informal wrap-up session, we all realized just how special and valuable nursing is at United and how our daily efforts impact the excellent delivery of patient care. This mock survey gave our magnet process a big boost as it served to build momentum and validate what we as nurses have already accomplished.

Those of us on the Magnet Steering Committee feel that the designation is well within our grasp. We continue to make progress toward this achievement. United has submitted an application, and work has begun on the extensive amount of written documentation that is part of the process.

I am very happy to be a part of this endeavor and represent the staff nurse perspective. Feel free to contact me at naomi.english@allina.com, or you can contact Julie Sabo (1-8378) or any of the other committee members.

Magnet Steering Committee

Ruth Darvell, RN	1-8335
Julia Endres-Spray, RN	1-8095
Naomi English, RN	1-8030
Kathy Forbes, RN	1-8525
Margo Halm, RN, PhD	1-8536
Barb Knudtson, RN	1-8775
Susan Loushin, RN	1-8240
Ginny Oskey, RN	1-8666
Sue Penque, RN	1-8815
Laurie Post, RN	1-8450
Pat Ryan, RN	1-8369
Julie Sabo, RN	1-8378
Debbie Sapp	1-8585
Karla Sohl, RN	1-2375
Marie Stuewe, RN	1-6335
Rose West, RN	1-8031

Words from staff:

Why I Returned to United Hospital

Jessie Schwab, RN, is a critical care nurse on 3940. She started at United in 1999 as a nurse's assistant, but left in 2004 to go to a home care agency. She returned six months later. This is an interview with her on her perspective of returning to United.

Q: *What were you looking for when you left United?*

JS: I wanted to expand my role as professional registered nurse and increase my clinical expertise. At the time there were no open positions at United, so I looked elsewhere.

Q: *What persuaded you to return?*

JS: I started at United as an NA and progressed to an RN. I felt very comfortable with the environment here and with my nursing colleagues. I came back to United in the Float Pool knowing that I would find a good environment in which to practice and opportunities to expand my role as an RN. I felt that the educational offerings were excellent and wanted to take advantage of them.

Q: *What keeps you at United now?*

JS: I feel I am a valuable member of the health care team; it is a respectful and learning environment. I foresee opportunities for me in the future as I continue to grow professionally. I took the critical care course, and it was great. I also am supported by my leaders and peers.

Q: *What advice do you have for others seeking nursing opportunities here at United?*

JS: Check everything out; there are so many opportunities for RNs here. You may not think one position is what you are interested in, but check it out anyhow. I networked with lots of people here, so they all knew I was looking for more opportunities and kept me informed when such opportunities arose.

Gerontological Nurse Certification

Becoming a Future Oriented RN

By Anna Gryczman RN, MSN, PHN, AHN-BC, United Hospital Staff RN

Did you ever wonder what the future will bring regarding your nursing career?

The future can be predicted by looking at demographics, technology and other societal forces. Demographic trends in the United States clearly point to an increasing number of elderly people needing health care services and not enough nurses prepared in geriatric nursing to manage their care.

But what does it mean for YOU? Will you be prepared to provide the best care for your older patients?

To become confident and competent in your ability to care for geriatric patients, you will need specialized knowledge, including an understanding of normal aging and familiarity with the different ways an older patient may present with subtle clinical manifestations.

Census Bureau (2000) population projections indicate that the number of elderly defined as the “age 65 and

older,” will grow by more than 50 percent in the next fifteen years. The most rapidly growing demographic group among age categories is the “oldest elderly” — the population age 75 and over.

Because of this you may want to consider Gerontological Nurse Certification today . . . invest in your personal and professional growth as a registered nurse.

The American Nurses Credentialing Center (ANCC) offers a gerontological certification exam for entry-level RNs. To prepare for the ANCC Gerontological Nursing Certification exam, the John A. Hartford Foundation Institute for Geriatric Nursing offers a FREE online review course. Visit www.hartfordign.org for more information and www.geronurseonline.org.

Because the majority of patients in most nursing specialties are over age 65, you will need geriatric nursing knowledge in almost every specialty. For example, if

you are considering a career in oncology nursing, you know that the majority of cancer patients are older adults. Or look at how many older patients have chronic health care needs requiring general medical-surgical hospitalization. The same is true for emergency nursing. According to Hutchins (1999) and O’Neill & Barry (2003), older adults make up 60 percent of visits to cardiologists and 53 percent of visits to urologists.

So consider Gerontological Nurse Certification today . . . your expert knowledge will positively impact patient outcomes in more than one way. Be proactive.

For information about gerontological nurse examination, including the eligibility requirements, fees, exam content outline, study references and a sample of practice examination questions, visit www.nursingworld.org.

Our Journey to Magnet Status: Focus on Force 1

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

Force 1 of the 14 forces of Magnetism speaks to the quality of nursing leadership. Leaders are not defined just as those in traditional leadership roles, such as nurse managers, directors or CNSs, but also the formal and informal nursing leaders we have in direct patient care roles. Nurse leaders are described as knowledgeable, strong risk takers. They are the wise nurses who we go to for nursing consultation when faced with a difficult patient situation, ethical dilemma or management issue.

Magnet Force 1 is exemplified in Magnet hospitals by a variety of characteristics. First, competency, skill and educational advancement are valued, role modeled and supported by the institution. The mission, vision, values and strategic plan of nursing are congruent with those aspects of the organization. The Chief Nurse Officer (CNO) represents all nurses within the institution at the highest governing body. The CNO and other nurse administrators secure adequate financial and human resources to support nursing practice throughout the hospital. Nursing input is valued, and decision making and nursing satisfaction are measured. Nurses from many roles are included in decisions and are involved in governing bodies. Nurses at all levels lead and participate in professional nursing organizations at all levels.

Whew! Those are big statements. So how do we at United exemplify this force? Sue Penque RN, MSN, APRN-BC, is our CNO; she is part of the Senior Management Team, which is the highest governing body at United. Her role is integral to all issues affecting nursing, and she actively advocates for nursing practice. The CNO and our Minnesota Nursing Association (MNA) leader, Linda Slattengren, co-chair our highest nursing governing

board, the Nursing Practice Care Delivery Board. Together they lead staff RN leaders and nurses in other roles from all areas in reviewing and approving variable staffing plans, nursing policies, nursing outcomes (patient falls, pressure ulcers, nursing satisfaction, etc.) and a multitude of other issues impacting nursing practice.

Our Low Lift Committee is another great example of how nurses have impacted patient care thorough the hospital. The nurses involved were leaders in obtaining, training and championing safety equipment to move patients.

How are United RNs taking a lead in the profession of nursing? Look at the number of United RNs running for MNA office, delegate or board of directors — pretty impressive. Other examples of leadership are:

- Bunny Engeldorf (Behavioral Health Service) — Commission for MNA Economic and General Welfare Program
- Linda White (Medicine) and Julia Endres-Spray (Oncology) — Both directors for MNA
- Anna Grcyzman (Float Pool) — Commission for Education
- Larry Himebaugh, Bette Sisler, Dan Halbakken, Denise Elling, among others (ED) — All are members of the Emergency Nurses Association
- Polly Groshens (ED) — Past president of Minnesota Emergency Nurses Association
- Diane Lemay (3300) — A member of the MNA Foundation
- Rosanne Ferguson (Sister Kenny Rehabilitation Institute) — Board member for the Minnesota Stroke Association
- Mary Goering (Birth Center) — Secretary for MN Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

- Linda Gfrerer and Susan Loushin (Education Services) — Members of Minnesota Organization of Leaders in Nursing
- Sue Penque (Administration) — Past president of American Association of Critical Care Nurses
- Julie Sabo (John Nasseff Heart Hospital) — Past president of local National Association of Clinical Nurse Specialists(NACNS) affiliate
- Kelly Gannon (Neuro Program Leader) — Member of American Neuroscience Nurses
- Margo Halm (CNS) — NACNS Nominating Committee member and fellow of the American Heart Association's Council on Cardiovascular Nursing
- Linda Christinsen-Rengel (Perinatal Outreach Coordinator) — Membership coordinator for Minnesota section AWHONN and on Planning Committee for Minnesota Perinatal Organization
- Cheryl Kirchner (Birth Center) — Member of the Education Committee for Minnesota Section AWHONN.

This list is by no means complete and it could go on and on!

What examples can you think of on your unit or in your life that exemplify and amplify the leadership that nursing takes on at United and in the nursing community each day? It is there every day and the results of that leadership are evident at the patient's side.

Correction:

In the summer 2005 issue of *Nursing Notes*, the author of "Staff Nurses Attend Magnet Conference in St. Cloud," was listed incorrectly. The author is Naomi English, RN, Patient Care Float.

Practice Change: Foley Catheter Care

The Nursing Research Council

The Nursing Research Council recently recommended practice changes related to Foley catheter management as based on evidence in the current research literature. These changes are discussed in the fourth quarter self-study packet.

Highlights include:

1. Use alternatives whenever possible, such as condom catheters, in men when short-term catheterization is necessary.
2. For insertion, a single-use packet of lubricant and/or 2 percent lidocaine jelly is recommended for comfort. In men, the lubricant should be gently injected directly into urethra. If using lidocaine jelly, wait 2-5 minutes before continuing.
3. Use the smallest catheter (14-18 Fr) and balloon size (5 cc) possible. Inflate the balloon with 5-10 cc sterile water. **NEVER** use more than 10 cc.

4. Pre-testing of silicone catheter balloons is not recommended since the silicone can form a crease at the balloon area, causing trauma to the urethra during insertion.

5. Secure catheters or tubing to the thigh in both males and females to prevent movement and traction. If using tape to secure, remove any sticky biofilm that accumulates on the catheter since microbes can ascend into the bladder from this residue, setting the patient up for a catheter-associated urinary tract infection (UTI). A nonadhesive catheter holder, such as the elastic Cath-Mate™ or multipurpose tube holder, should be considered to eliminate the presence of biofilm, especially if longer-term catheterization is anticipated.

6. Empty collecting bag every 4-6 hours to prevent bacteria from migrating up the catheter lumen.

7. Collection bags should always be kept below the level of the bladder and dependent loops in the tubing

should be avoided to prevent back-flow of urine into bladder.

8. Catheters may leak from a variety of causes, including kinked catheters or drainage tubing, constipation or fecal impaction, bladder spasms, infection, occluded lumens or encrustation. Refer to the self-study packet for an evidence-based protocol for managing each of these problems.

9. Irrigation of catheters should be avoided unless obstruction is suspected. Remember a physician's order is needed for intermittent irrigation.

10. Cleaning urinary equipment is no longer recommended during hospital stays to ensure a closed system is maintained to prevent catheter-associated UTIs. Therefore, leg bags should not be changed to night bags while patients are hospitalized.

11. There remains no definitive guideline on when Foley catheters should be changed. As a general rule, catheters should be removed as soon as possible.

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Submissions for *Nursing Notes* are preferred in writing (electronic) and can be sent to: Margo Halm, RN, newsletter coordinator, margo.halm@allina.com or United Hospital, 333 No. Smith Ave., Mail Route 60231, St. Paul, MN 55102, 651-241-8536. Please include your name, department and phone number.