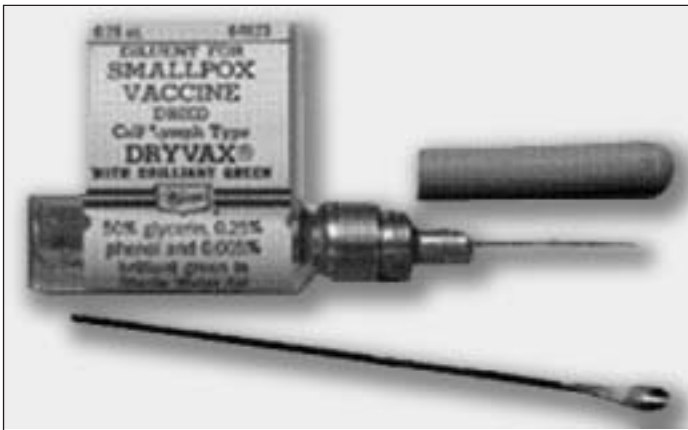




Smallpox Healthcare Worker Response Team Forming



The Medical Center is now accepting volunteers for our **Smallpox Healthcare Response Team** consisting of 250 medical center staff. Of these 250 volunteers, approximately 40 will be offered the smallpox vaccine; the remaining 210 will be educated and placed in a "ready reserve" group that can be contacted and vaccinated within 24 hours should a case of smallpox actually occur any place in the world. The 40 health care providers in the vaccinated group must be willing to provide direct care for smallpox patients. Some vaccinated staff will be trained to vaccinate others if there is an emergency. These volunteers will consist of nurses, physicians, radiology technicians, respiratory therapists, security, facility management and other critical personnel.

Volunteers for the vaccination group must have received the smallpox vaccination at a previous time, either as a child, during military service or as part of a research trial. Why? Revaccinated individuals are **much less likely to experience** an adverse reaction to the smallpox vaccine.

Staff in the "ready reserve group" may or may not have been vaccinated in the past.

What are Smallpox Health Care Teams?

Smallpox Health Care Teams are health care workers who have been vaccinated so they can be ready and willing to provide care for smallpox victims in case of an outbreak.

Requirements include:

- Must be voluntary;
- Vaccination is required for all team members;
- Preference is to revaccinate staff who have been **previously vaccinated** because they are less likely to have serious adverse reactions; and
- May require overtime or unscheduled shifts in the event of an outbreak.

The last case of smallpox in the U.S. was in 1949, and the last case in the world was in 1977. Although the disease was declared eradicated in 1980, some of the virus has been maintained by the Center for Disease Control (CDC) in Atlanta, some maintained in Russia and possibly elsewhere as a biological weapon, but no one knows for sure where.

Smallpox vaccine is actually made from cowpox virus (called vaccinia virus), which is a close "cousin" of the smallpox virus. **The smallpox vaccine does not contain smallpox virus so it cannot cause smallpox.** Once someone is vaccinated, the usual reactions to the smallpox vaccine proceed as:

(Continued on Page 2)

Smallpox *(continued from pg.1)*

Day	Description
0	vaccination occurs
3-4	a blister (papule) forms at the vaccination site
5-6	the blister fills with fluid (called a vesicle) with surrounding redness (this defines a 'take', or proof of successful vaccination)
8-9	a well-formed pustule or pus-filled blister develops
12+	scab forms on the pustule
17-21	scab falls off, and a permanent scar remains

Protecting Worker Safety

A person's response to the smallpox vaccination depends on any residual immunity they may still have from a previous smallpox vaccination. Experience with many people who have had smallpox vaccinations has shown that revaccinated individuals are much less likely to experience an adverse reaction to the vaccine. This observation that revaccinated persons are less likely to have an adverse response is why the Medical Center wants to be safe to only include in the vaccination group those staff who have **previously received smallpox vaccination**. Staff who do volunteer will be carefully screened to minimize their likelihood of experiencing serious or life-threatening adverse reactions.

Who CANNOT volunteer for vaccination?

Staff should not volunteer if either they or a member of their household have either:

- Immunodeficiency: HIV/AIDS, lymphoma, generalized malignancy, agammaglobulinemia, or history of therapy with alkylating agents, antimetabolites, radiation or large of steroids or immunomodulating drug (e.g. transplant/autoimmune disorder);
- Malignancy (except squamous cell or basal cell skin cancer);
- Use of immunosuppressive medication (for greater than two weeks); (Corticosteroid nasal sprays are permissible);
- Eczema (atopic dermatitis) of any degree (either current or have ever had);
- Current other skin disorder such as contact dermatitis, burns, impetigo, acne, varicella zoster (shingles), or sutures.

In addition, either staff or their household contacts who have any of the following should not volunteer:

- Pregnancy or planning pregnancy within four weeks following vaccination;
- Allergies to the antibiotics polymyxin B, streptomycin, tetracycline, or neomycin; or cidofovir, probenecid or Vaccine Immune Globulin;

- Known or suspected liver disease, kidney disease or diabetes; and
- Others who are:
 - Less than 18 years old or have an infant at home who is less than 1 year old;
 - Currently breast-feeding;
 - Have received chickenpox (varicella) vaccine within past four weeks

Protecting Patient Safety

The Medical Center wants to ensure that we take precautions to prevent smallpox vaccination transmission to our patients (nosocomial transmission). While covering the vaccination site with a dressing and not touching it are very important steps in preventing any transmission, the Medical Center wants to be even more safe by ensuring that vaccinated staff not work in direct contact with patients. They will be reassigned to other duties until the vaccination site fully scabs. In addition, staff who are vaccinated will be thoroughly educated on how transmission to others can be prevented.

Volunteers Carefully Screened

To prevent or limit any adverse reactions to staff, families, patients and public, the Medical Center's Pre-event Smallpox Vaccination Plan calls for a total of 250 health care workers from a variety of job descriptions be put into two groups; Vaccination Group (about 40 staff) and the "Ready Reserve" (about 210 staff).

The Vaccination Group will consist of front-line health care providers who will:

- Care for four to five patients for seven to 10 days;
- Vaccinate others quickly;
- Care for employees/patients with vaccine adverse reactions;
- Be deployed to other areas, if needed;
- Be reassigned (if necessary) to work with no patient contact; and

The actual timing of the vaccinations of staff in this group will be staggered over time so that about four to five staff are vaccinated per week.

The Ready Reserve Group of about 210 staff:

- Will not actually receive the vaccine BUT;
- Will be prepared to be vaccinated in 24 hours of a credible event (any place in the world);
- May or may not have received the vaccine previously but previous vaccines preferred;

(Continued on Page 3)

Smallpox *(continued from pg.2)*

- Be fully educated about the risks of the vaccine and sign preliminary informed consent;
- Be initially screened by questionnaire, but not by lab tests; and
- Have their contact and other information be maintained in a database.

What To Do If You Want To Volunteer To Be Vaccinated?

Staff who volunteer for smallpox vaccinations must consent to free, baseline and confidential HIV test and pregnancy test (if you are a female). The Medical Center requires this testing. This testing involves a 30-minute on-campus (but outside of the Medical Center) doctor visit for HIV consent, a blood sample draw and urine sample, then a 15-minute follow-up doctor visit one week later for results. If the tests are negative, a clearance will be faxed back to Employee Health. If a test is positive, the individual will be notified, but not Employee Health. If selected for vaccination, staff will sign a consent form at the time of off-site vaccination by State Dept. of Health. Vaccinations will not be given in the Medical Center. Instead, State Dept. of Health staff will perform the vaccinations.

Vaccinated staff will return to the off-site vaccination facility one week later to determine the 'take' of the vaccination, and to monitor the vaccination site. Then, vaccinated staff will visit UMMC Employee Health Office two to three times each week to monitor the vaccination site.

Also, vaccinated staff will be given information about how to identify potential adverse reactions, contacts for concerns and medical care, and information about how to receive compensation for medical expenses and any lost work time related to the vaccination. If a staff person becomes ill from the vaccination, they will receive administrative leave for time off work, and Workers' Compensation for medical care.

Steps for Volunteers

1. Staff who want to volunteer should complete the Smallpox Volunteer Information Sheet (available on the Intranet) or provided in the Pre-Event Smallpox Vaccination Employee Education sessions.
2. Employee Health Service/Infection Control will review and determine the staff selected for the vaccination group.
3. Those selected for the vaccination group will be called by the Employee Health Service for an appointment to fill out additional forms. Appointments will be made with a

physician for pre-screening tests (HIV, pregnancy), and follow-up for results.

4. Once cleared by a physician, the Employee Health Service will then arrange an appointment with the health department for the smallpox vaccination and follow-up visits.

To obtain more information about smallpox vaccination:

- Email: smallpox_vaccine@umm.edu (note: there is **one space** between smallpox and vaccine);
- Call the Employee Health Service at **328-0958** or fax 328-6319;
- CDC's excellent website at: <http://www.bt.cdc.gov/agent/smallpox/>

History of Smallpox Vaccination

History records that in 1796 Dr. Edward Jenner first vaccinated an 8-year-old boy with material removed from a cowpox lesion on the hand of a milkmaid. Proof that the inoculation gave protection against smallpox was obtained six weeks later when the boy was inoculated with pus from a smallpox victim and the boy did not develop the disease.

Jenner found that persons successfully inoculated developed a small scab at the site of the inoculation which dropped off after about two weeks leaving a small scar. Before making his report in 1798, he had successfully vaccinated 23 people. The material he used came from cows which in Latin are called *vacca*, hence the term **vaccination**.

Jenner never saw the causative agent of smallpox since his discovery and his application of it came more than half a century before the establishment of the germ theory of disease.

From **Microbiology** by Michael J. Pelczar, Jr., professor of microbiology at the University of Maryland, and Roger D. Reid, director of biological sciences division in the Office of Naval Research, and published in 1965 by the McGraw-Hill Book Company in New York.



Black Nurses – A Historical Perspective

By M. Elizabeth Carnegie, DPA, RN, FAAN, Editor Emerita of *Nursing Research*, and author of *The Path We Tread: Blacks in Nursing Worldwide, 1854-1994*.

Black women have nursed our nation during slavery, war and peace. While nurturing their own families and fellow slaves, they cared for the sick and breast-fed white babies within the families that owned them. Though the term "nurse" was not used, their activities were clearly within the scope of nursing. Prior to the Civil War, there were also nurses among free blacks. Mary Williams and Frances Rose were two such nurses whose names were listed in the city of Baltimore's 1840 directory.

Black men also worked as nurses. In 1783, James Derham, a black nurse from New Orleans, saved enough money to buy his freedom from slavery. He later became a prominent physician in Philadelphia, where he practiced medicine and won the highest respect from his medical colleagues. Derham is credited with becoming the first black physician in America.

Educating Black Nurses

In 1879 Mary Eliza Mahoney became the first black graduate from an American school of nursing -- the New England Hospital for Women and Children in Boston -- thereby becoming the first professional black nurse in the United States.

Formal education exclusively for black nurses started in 1886 with the establishment of a nursing program at Spelman Seminary (now Spelman College) in Atlanta. In 1891 the first hospital school of nursing for black women was established at Provident Hospital in Chicago by pioneer black surgeon Dr. Daniel Hale Williams. Subsequently, many more schools for blacks were founded out of the sheer necessity to train black nurses to take care of black patients.

The first baccalaureate program at a black school was established in 1936 at Florida A&M University in Tallahassee. Associate degree programs emerged in the early fifties, with the first to be offered at a black institution -- Norfolk State University in Virginia -- in 1955. Today, historically black colleges and universities continue to play a major role in training blacks for the nursing profession. Twenty-four of these universities offer nursing programs leading to baccalaureate degrees, 12 offer master's degrees and two offer doctoral degrees.

Black nursing students have also made inroads at some of the nation's most prestigious nursing schools, including the University of Maryland at Baltimore School of Nursing,

which has the highest percentage of black students and faculty, and Johns Hopkins University.

Banding Together

In 1908 black nurses banded together to form their own organization, the National Association of Colored Graduate Nurses (NACGN), to fight discrimination in education, employment and within the American Nurses Association (ANA). After fighting for equal rights and gaining ANA's assurance that black nurses would be accepted as members on an equal basis, the NACGN disbanded in 1951. Since then, two black nurses have served as two-term ANA presidents.

Twenty years after integrating the ANA, black nurses identified the need to focus on the health of the black community and its access to the health care system. As a result, in 1971 the National Black Nurses Association (NBNA) was formed. While the ANA is still considered the premier professional nursing organization, the NBNA pays close attention to minority concerns and serves as a national resource of black nurse recruitment, retention and education.

Nurses in the Military

Beginning with the Revolutionary War, black nurses have served in every conflict in which our nation has been involved. Harriet Tubman, Sojourner Truth and Susie King Taylor played significant roles as nurses in the Civil War. Black nurses also served honorably in the Spanish-American War.

During World War I and World War II, black nurses fought for the right to participate as nurses. They were finally accepted into the Army Nurse Corps after the armistice was signed signaling the end of World War I, and hundreds of black nurses served during World War II, although assigned mostly to segregated units.

Four black nurses were finally accepted into the Navy Nurse Corps during the last months of World War II; and by the time the Air Force Medical Service was established in 1949, with the Air Force Nurse Corps an integral part of it, integration was policy. Black nurses distinguished themselves in the Korean War, the Vietnam War and the Persian Gulf War. They are now serving in all branches of the armed services, being assigned without discrimination.

Abridged and reprinted from Aetna, Inc. Color copies of the beautifully illustrated African American Nurses History 2003 Calendar, from which this text and timeline are reprinted, can be downloaded or ordered from Aetna's history Web site at: www.aetna.com/diversity/aahcalendar/index.html.

(Continued on Page 5)

Nurses Through History: A Timeline

- | | | | |
|------------|---|------|--|
| 1783 | James Derham, a slave from New Orleans, bought his freedom while working as a nurse. He later became the first black physician in America. | 1941 | Lt. Della Raney Jackson became the first black nurse to enter military service during WWII. |
| 1820 | Jensy Snow of Petersburg, Virginia, opened a hospital and continued for 30 years to provide health care services for the community. | 1951 | Mabel K. Staupers received Spingarn Medal for leadership in the movement to integrate black nurses as equals in the nursing profession. |
| 1854 | Mary Grant Seacole nursed alongside Florence Nightingale as a volunteer saving the lives of countless soldiers during the Crimean War. | 1952 | National League for Nursing, the leading professional association for nursing education, formed. |
| 1861-1865 | Harriet Tubman served as an unpaid nurse to wounded civilians and soldiers in the Sea Islands off the coast of South Carolina during the Civil War. | 1955 | Elizabeth Lipford Kent became the first black nurse to earn a Ph.D. |
| 1865 | Sojourner Truth served as a nurse for the Freedman's Relief Association during Reconstruction in Washington, D.C. She was recognized by President Abraham Lincoln for her work. | 1961 | Mabel K. Stauper's book <i>No Time for Prejudice: A Story of the Integration of Negroes in Nursing in the United States</i> published. |
| 1879 | Mary Eliza Mahoney became the first black to graduate from an American nursing school. She is known as the first professional black nurse in America. | 1967 | Lawrence Washington became the first male, black or white, to receive a regular commission in the U.S. Army Nurse Corps. |
| 1886 | Spelman Seminary (renamed Spelman College) in Atlanta, Georgia, established the first nursing program for African Americans. | 1971 | Dr. Lauranne Sams, former dean and professor of nursing at Tuskegee University, became a founder and first president of the National Black Nurses Association. |
| 1892 | Nursing schools were established on the campuses of Tuskegee Institute in Alabama and Hampton Institute in Virginia. | 1976 | Mary Eliza Mahoney, Martha Minerva Franklin and Adah B. Thoms inducted into the American Nurses Association Hall of Fame. |
| 1890-1920s | African Americans established a network of approximately 200 black hospitals and nurse training schools. | 1978 | Estelle Massey Osborne became the first black nurse to be inducted as honorary fellow in the American Academy of Nursing. Barbara Nichols became the first black nurse to be elected president of the American Nurses Association. She was reelected in 1980. M. Elizabeth Carnegie became the first black to be elected president of the American Academy of Nursing. |
| 1893 | Howard University, Washington, D.C., established nursing program leading to a diploma. | 1979 | Brig. Gen. Hazel W. Johnson-Brown became the first black woman in the Department of Defense to become a brigadier general and the first black to be chief of the Army Nurse Corps. |
| 1896 | American Nurses Association founded. | 1982 | Fostine Riddick became the first black nurse appointed to the board of trustees of a major academic institution, Tuskegee University, Alabama. |
| 1900 | Jessie Sleet Scales became the first black public health nurse in U.S. | 1991 | Brig. Gen. Clara Adams-Ender became the first black woman and nurse to be appointed commander general of an Army post. As the highest-ranking woman in the Army, she commanded more than 20,000 nurses serving in the Persian Gulf War. 1992 State Senator Eddie Bernice Johnson (D-Texas) elected to the U.S. House of Representatives -- the first nurse, black or white, elected to Congress. |
| 1908 | Martha Minerva Franklin founded and became the first president of the National Association of Colored Graduate Nurses. | 1999 | Elnora Daniel became the first black nurse elected president of a major university, Chicago State University. |
| 1918 | Eighteen black nurses admitted to the Army Nurse Corps after the armistice of WWI and assigned to Camp Sherman, Ohio, and Camp Grant, Illinois. Frances Reed Elliott Davis became the first black nurse accepted in the American Red Cross nursing service. | | |
| 1931 | Estelle Massey Osborne became the first black nurse in the U.S. to earn a master's degree. She also was the first black nurse to be elected to the board of directors of the American Nurses Association in 1948. | | |
| 1936 | The National Association of Colored Graduate Nurses created the Mary Eliza Mahoney Award. The first recipient was Adah B. Thoms, who devoted her time and energies to gaining admittance for black nurses to the American Red Cross. | | |



Bariatric Conference Scheduled for April 25



Course Description: This four-hour conference provides the nurses, therapists and support staff with valuable information to meet the needs of bariatric patients

Purpose: To introduce “Bariatrics” as a unique patient population requiring

unique interventions. Identify transfer and mobility challenges for obese and functionally impaired patients while providing effective techniques and equipment use for safe patient management.

Course Objectives: Upon completion the course participant should be able to:

- Define obesity and identify high risk individuals based upon body type.
- Identify patient functional needs and mobility challenges.
- Identify transfer devices and/or techniques for use in the work place.
- And resolve safety issues in bathroom environments.

About the Presenter

Michael Dionne, a graduate of Marquette University was a lead therapist for acute care at the Milwaukee County Hospital, a state designated priority level one trauma center in Milwaukee, WI. Mr. Dionne developed many of the techniques you will learn in this course from his experience in spinal cord injury, heart and lung transplant clients, brain injury, trauma, vascular and orthopedically involved patients.

Mr. Dionne was honored to be an invited speaker for both the 1999 & 2000 APTA—Multiple Sections Conference. Also, he has presented to the American Society of Bariatric Surgery and Trauma Nursing Symposium in Philadelphia. More information can be obtained utilizing the following information:

Choice Physical Therapy, Inc.
5233 Indian Circle
Gainesville, GA
770-532-4327
www.BariatricRehab.com

Accreditation

The University of Maryland Medical Center has approved this program for 4.5 contact hours. The University of

Maryland Medical Center is an approved provider of nursing continuing education in nursing by the American Association of critical Care Nurses.

Accommodations for Disabled Persons

Accommodations for disabled persons may be requested by calling 410-328-6257 two weeks prior to the program.

Session times and locations

Two Sessions

April 25, 2003
8:00 AM – 12:00 PM
12:45 – 5:00 PM

Held in Shock Trauma center Auditorium

Registration Fee

- No Charge for UMMC staff
- No Charge for UMB students with photocopy of student ID
- \$35.00 for UMB Faculty Associates
- \$35.00 for staff from other UMMS sites (Kernan, University Specialty, North Arundel, Maryland General, Mt. Wash. Ped. Hosp and the Carter Center.)
- \$35.00 for students from other schools other than UMB
- \$50.00 for outside registrants

Paid registration includes parking, refreshment breaks, all conference handout materials, and continuing education certificate. If you are unable to attend, you must cancel your registration before April 18, 2003 to receive a refund or transfer your registration to another person. You must contact the Office of Clinical Practice and Professional Development to complete the transfer. No refunds will be made after April 18, 2003.

Checks **must** be made payable to **UMBF, Inc.** Send completed registration form and payment to: Programs Office of Clinical Practice and Professional Development, Room S10B02
University of Maryland Medical Center
22 South Greene Street
Baltimore, MD 21201

Registration Brochures may be picked up in the Office of Professional Development, (S10B02) or by calling (410) 328-6257

For additional information contact **Judy Seltzer (410) 328-0699**, Office of Professional Development.



Crash Cart Improved



The Medical Center's Resuscitation Committee, composed of clinicians, nurses, and representatives from many support services, reviewed and updated the drugs and supplies in the adult crash carts and made a series of changes. Supplies on all adult crash carts in the University Hospital, Shock Trauma, and off-site locations (such as the Redwood

Professional Building) **have been or soon will be** changed.

Airway supplies on adult crash carts have changed and now include the following:

Laryngeal Mask Airways (LMAs) sizes #4 and #5 are now available, and they can be used when a patient is difficult to both ventilate and intubate. They are a standby measure until an anesthesia provider, with additional skills and equipment, can secure the airway. An anesthesiologist should always be stat paged as part of the planned response to any airway emergency.

A **cricothyrotomy kit** can be used to secure a surgical airway in the event of swelling in the upper airway. The kit supports the Seldinger insertion technique, and it complies with the Maryland Board of Nursing requirement that a cricothyrotomy kit be available at all sites where a nurse is administering moderate sedation.

Two **colorimetric carbon dioxide detectors** are available to confirm placement of an endotracheal or tracheostomy tube. These devices should be used after **every** intubation or whenever there is a question about the location of the airway. They measure the amount of carbon dioxide in the exhaled air by a color change in the detector.

An **esophageal detector device** is also available to confirm endotracheal tube placement when carbon dioxide production is low.

A **#2 Miller blade, surgical lubricant, and face shields with eye protection** are now carried in the intubation tray. In addition to airway supplies, the following other supplies changes have been made:

Intravenous safety catheters are now available to decrease the risk of needle stick injuries. Regular intravenous catheters will continue to be carried. The Intracaths have been deleted.

A **Cordis introducer** is now available for rapid fluid replacement.

Blunt fill needles allow for medication administration using the needleless IV system and **filter needles** should be used when aspirating medication from a glass ampule.

Non-sterile gloves will now be immediately available on each crash cart.

A **sharps container** and **plastic bag for airway equipment** should be used to minimize the biohazard risk as many crash carts were returned with exposed needles or glass ampules in the drawers and/or contaminated airway equipment lying in a drawer.

Also, **Medication Drip Charts** have been updated, and the current **ACLS algorithms** are available with the cardiac arrest paperwork.

Inside each crash cart will have a **charge ticket**, which should be stamped with the patient's plate and returned with the cart when it is exchanged.

The Committee made these changes to improve patient care and staff safety. Future articles from the Resuscitation Committee will look at our cardiac arrest record and data analysis. An update on the changes in the crash cart drugs will be covered in a future article.



Hello DJ



Dennis Vidal and Genevieve Borja were newlyweds when they arrived in March 2002 with the first group of Filipino nurses recruited by our International Recruitment team. Coming from a very different culture where there is much extended family

support, Genevieve and Dennis braved this new world with determination to be good nurses as well as good parents. This is because Genevieve was pregnant and the couple not only had to get clinically oriented to their units but also to the different issues that they would encounter as parents in America.

Derek James (DJ) Vidal was born in June of 2002. By then, Dennis had finished orientation in the Neuro ICU, and Genevieve had survived morning sickness while orienting in the SICU stepdown unit.



Although this transition was far from simple, Dennis, Genevieve, and Derek have built a family of friends who provide loving support to all of them.

Derek became a Christian when he was four months old, being baptized at St. Jude's Shrine and Cathedral on Paca Street. **Marianne Salao**, a colleague in the SICU step down unit, but more importantly, a friend who arrived with the first group of



Filipino nurses became DJ's godmother. **Kish Cabunoc** who arrived with the second group of Filipino nurses and lives in the same apartment building is also a godmother. In the Philippine tradition, there's usually two sets of godparents or at least two godmothers or godfathers. Kish is also a nurse and she works on Gudelsky 5.

Derek James is the first baby born to the Filipino Nurse Recruitment effort. Other newlyweds have arrived since Dennis and Genevieve and another couple is expecting their firstborn. These children will be first generation Americans as the cycle continues in the land of immigrants.



HIPAA Is Here

All UMMC Employees Will Need to Complete HIPAA Training by April 14, 2003

What is HIPAA?

HIPAA refers to federal legislation known as the **H** **e** **a** **l** **t** **h** **I** **n** **s** **u** **r** **a** **n** **c** **e** **P** **o** **r** **t** **a** **b** **i** **l** **i** **t** **y** **A** **c** **t** of 1996. Although maintaining patient confidentiality has always been a priority at UMMC, HIPAA outlines specific standards for health care providers to follow in order to protect the privacy of patient information. HIPAA also establishes civil and criminal penalties for non-compliance.

What Will UMMC Employees Need to Do?

UMMC must comply with all HIPAA privacy standards by April 14, 2003; those standards include all-employee training in HIPAA. The HIPAA training program should be available by early March, 2003. Managers will be notified of the specific start date. UMMC employees will access the program through the Intranet or Internet, following the same steps to access Annual Safety Training (via

HealthStream). Please note that even though annual safety training courses can be completed on or anytime before an employee's annual performance review date, this basic HIPAA training course must be completed by all employees by April 14, 2003.

Where do Employees go for HIPAA training?

Because it is linked to the UMMC Intranet, the HIPAA training course can be taken from any personal or departmental computer at UMMC including the computers on N13W71 and N13W72. The HIPAA course can also be taken on personal computers outside UMMC that have internet access.

Who Can Employees Contact If They Have Questions?

If you have any questions, please contact UMMC HIPAA Work Group leaders, Lisa Keefe Snow (8-3788) or Jeff Huddleston (8-7506). You can also contact our Privacy Officer, Nicki Humphries at nhumphries@umm.edu or 8-5478.

Look for More Information about HIPAA in *Check it Out*.



Medical Center Holds First International Staff Reception

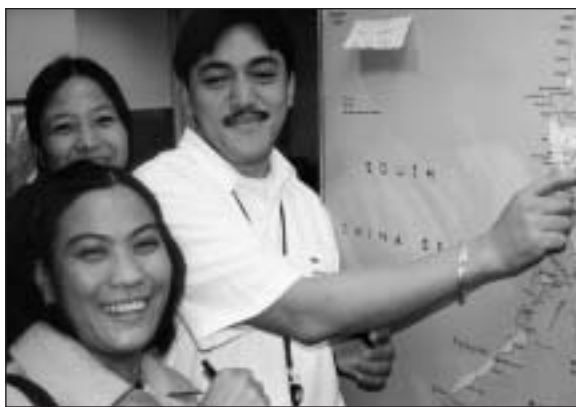
The Medical Center's First International Staff Reception was held on January 30, 2003 in the MIEMSS building. Nurses and Medical Technologists from the Philippines were joined by Senior Management, Patient Care Service Managers, preceptors and various staff who have played an important role in the success of the International Recruitment Program. Guests had a chance to get to know more about each other through a fun "Get to Know you" game while enjoying delicious food and refreshments. Maps of the US, Philippines and the world were displayed for everyone to pin a flag indicating where they grew up. This reception was a way to thank everyone for their hard work and a chance to get to know a little bit more about the similarities and differences of each other's cultures.



Left to right: **Jill Ramirez**, **Jesse Lopez**, SR Partner 10West, **Rona Quevada**, **Regina Tumang**, **Sharon Pasamba**



Patricia "PJ" Wilson, Acting Clinical Transition Coordinator **Cindy Kiamko**, and **Visitacion "Bing" Casal**.



Medical Technologists **Liza Dela Rosa**, **Marcelino "Gabby" Gabriel** and **Claire Uy** showing where they are from on the Philippine map.



Kish Cabunoc relating her experience leaving the Philippines and arriving in the US to work at UMMC.

NE/NA Skills Day Scheduled for March 11th

The first Nursing Extender (NE) and Nursing Assistant (NA) skills day will be held March 11th in the skills lab on the second floor of the School of Nursing, Lombard Street. There will be two sessions with the same information presented at each session. One session is from 8:30 a.m. to 12:30 p.m. and the other is 1:00 p.m. to 5:00 p.m.

The topics for the March skills day are:

- Tracheostomy Care;**
- Restraints/Restraint Alternatives;**
- EKG;**
- Documentation.**

This skills program is designed to enhance the knowledge and skills of current NE and NA's, as well as those just entering the job field. The most current information that relates to practice issues and competency assessment will be presented. Please call the Office of Clinical Practice and Professional Development to register at extension **8-6257**.

NEW Central Line Care Kit

Our new central vascular line care kit has arrived. It is currently labeled as the **ChloraPrep Kit**, but will be renamed the **Central Line Care Kit** once the first supply is depleted. The kit contains all the supplies needed to assist the bedside clinician in providing consistent and standard line care. The kit now provides “one-stop-shopping” for line care. They will be stocked on the supply carts and available for use at the end of February.

The contents include:

- Powder Free Nitrile Gloves
- ChloraPrep applicator
- 3M Medipore Island Dressing
- Label

The **ChloraPrep** applicator is a *One-Step process* and it replaces Betadine solution. The applicator, containing 1.5ml of Chlorhexidine Gluconate 2% and Isopropyl Alcohol 70%, provides a broad spectrum and immediate bactericidal activity, continued activity in the presence of organic matter, and a non-irritating and low allergic and toxic response rate.

To use the applicator:

Pinch the wings on the applicator to break the ampule and release the antiseptic.

Gently, use repeated back-and-forth strokes of the sponge for approximately **30 seconds**. The circular method is no longer necessary because Chlorhexidine kills on contact.

Allow area to dry for **30 seconds**.

The site is now ready for the Medipore Dressing and label.

In addition, the Medical Center also has new **Triple Lumen Catheter Insertion Kits** that contain the ChloraPrep, and a full-body sterile drape. Again, the ChloraPrep solution replaces the Betadine that was used to prep the skin.

If you or anyone on your unit has questions or concerns regarding the use of the kits or the practice standards for Central Line care, please call Deb Peterson, Clinical Practice and Professional Development, **8-1628**.



Free Stop Smoking Training Offered for Staff and Faculty

This training provides state-of-the-art techniques for assessing and intervening with patients using tobacco products. This **one-hour** training is:

- Designed for social workers, pharmacists, dentists, dental hygienists, respiratory therapists, nurses and physicians practicing in all settings.
- Approved for **continuing education credit** for nurses, pharmacists, dentists and dental hygienists.
- **Free of charge** to all UMB and UMMC staff.

Staff can choose one session from the two sessions scheduled on April 30, 2003 and pre-registration is **required**. Call **8-6257 to pre-register** for one of the two sessions below.

Two sessions on April 30, 2003 are from:

- 12:00 noon to 1:00 pm
- or
- 1:30 to 2:30 pm

Faculty: **Jacquelyn Fried**, RDH, MS, Associate Professor, Dental School, UMB
Nalini Jairath, RN, PhD, Associate Professor, School of Nursing, UMB

Workshop Topics

1. Epidemiological facts of tobacco use in Baltimore.
2. Risk associations for tobacco use in Baltimore.
3. Present AHRQ “5 As” Ask, Advise, Assess, Assist and Arrange.
4. Wrap up, post-test, and program evaluation.

Weight Watchers...Is HUGE Success

Our "Weight Watchers at Work" sessions started on January 7, 2003. These one-hour sessions are held once a week for a total of ten weeks on Tuesdays. Each session begins at 11:00 am. in Room 537 of the 29 South Greene Street Building. The cost for **all ten** sessions is **\$119.50** or \$11.95 per session. The week of February 10th was week 5 of our current program, and at this half-way point the group has lost a total of **175 pounds!**

What's Behind Weight Watchers' Success?

Weight Watchers' started 40 years ago by a hefty New York housewife and it continues to grow in membership each year. One reason for its success is that it uses a popular "daily point system" which lets dieters eat anything, provided they stay within a given point range for their body weight such as 28 to 33 points per day. "It allows you to go out to dinner with friends and be a normal person," says Marion Nestle, who heads nutrition and food studies at NYU.¹ The idea behind the points is to give dieters flexibility to eat what they want while not pigging out. But the points can be tricky as a Café on the Square Smoked Turkey Sandwich Express with pasta salad and a blondie can have as many as 18 points depending on how much pasta salad and dessert you eat.

Second, the plan is affordable compared to other commercial weight reduction programs. It costs **\$12 to lose a pound on *Weight Watchers'***, compared with **\$45 for Nutri/System** and **\$50 for Jenny Craig.**¹ Almost 70% of *Weight Watchers'* \$624 million in revenues comes from member fees, like those mention above, and the other 30% comes from a mix of snack foods, cookbooks and diet calculators. With more than a million dieters meeting each week and attendance growing in double digits each quarter, Merrill Lynch stock analyst Carol Wilke says, "They are a large and growing target market - no pun intended".¹

Finally, the company's lean organizational structure makes for fat profit margins, which are currently 19%. And, 98% of their more than 34,000 staff work part-time which also helps cut costs. The stock market price of *Weight Watchers International*, the diet industry leader, has nearly doubled since it went public a year ago.²



Jean Nidetch is the New York homemaker who starred *Weight Watchers'* 40 years ago.

Too Many Women?

Women make up 95% of *Weight Watchers'* clients. The company is now test-marketing an Internet strategy aimed at men to increase their market share. But for now, they rely on repeat business as the average member returns **four times** over the course of his or her life.¹

Next Ten Week Session Begins in April

The **next 10-week session** will begin on **April 1st** and continue on **Tuesdays at 11am** in **Room 537** of the 29 South Greene Street Building. So, be one of them and get slim for spring by contacting **Carrie Yi** at extension **8-7696**.



Reference:

Florian E. When it comes to fat, they're huge. *Fortune*, Vol. 146, No. 7, October 14, 2002, pg. 54.

Passy C. Cranky consumers goes on a diet. *The Wall Street Journal*, December 31, 2002, D1-2.



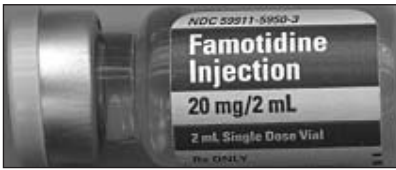
Type 1s Lifted!

Thanks to the hard work of many staff, the Medical Center has received a letter from the JCAHO indicating that our remaining Type I's in Medication Use and Medical Staff standards have been lifted and our scores will be changed to 1 (full compliance).

For the detail oriented reader, the JCAHO general public web site area reads for UMMC: accreditation with full standards compliance.

UMMC Pharmacy News RX:

Therapeutic Interchange of H2-Antagonists



Famotidine (Pepcid,) IV and Ranitidine (Zantac,) granules/tablets/liquid are the new H2-

Antagonists on the UMMC Formulary. The Therapeutics Committee has approved these H2-Antagonists for automatic therapeutic interchange as the most cost-effective therapies. Nizatidine (Axid,) and IV Ranitidine (Zantac,) have been removed from the formulary. Information about the therapeutic interchange can be found on the dispensing label and the MAR (Medication Administration Record).

Frequently Asked Questions:

What is meant by automatic therapeutic substitution?

Therapeutic substitution means to replace with a product of the same or similar clinical response. If the physician orders an IV H2-Antagonist that is non-formulary, famotidine will be substituted and sent to the nurse. Similarly, if a non-formulary oral (PO) H2-Antagonist is ordered, oral ranitidine will be substituted. *No* phone calls to the physician are necessary with automatic substitution.

What are the approved indications for Famotidine and Ranitidine?

Indication	Famotidine	Ranitidine
Duodenal ulcer treatment and maintenance	U	U
GERD	U	U
Gastric ulcer treatment and maintenance	U	U
Hypersecretory conditions	U	U
Heartburn / acid indigestion	U	U
Erosive esophagitis/maintenance	U	U
Prevent UGI bleed	L	L
Peptic ulcer	L	L
Stress ulcer prophylaxis	L	L

Note: U= unlabeled use ; L= Labeled (FDA approved) use

What is the recommended dose for these H2-Antagonists?

*Adult dosing:

	IV	PO
Famotidine (Pepcid,)	20mg IV q12h	Non-formulary
Ranitidine (Zantac,)	Non-formulary	150mg PO bid

***Requires dose adjustments in renal insufficiency**

Will famotidine be dispensed in minibags?

No. Famotidine can be safely given **IV Push over 2 minutes** and will be delivered in vials.

What adverse effects are common with IV famotidine (Pepcid,)?

The following adverse effects have been associated with famotidine: Headache (4.7%), dizziness (1.3%), diarrhea (1.7%), constipation (1.2%). Famotidine IV push has not been shown to produce any adverse hemodynamic effects.

Are there significant drug interactions with Ranitidine or Famotidine?

Ranitidine: This drug is a weak inhibitor of the enzyme system cytochrome P450. Its influence on the elimination of other drugs is not significant.

Famotidine: This drug does not inhibit the enzyme system cytochrome P450.



Taking Care of Business During a Record Snowfall



Vice President and Director of the Shock Trauma Center **John Spearman**, after three long and grueling days.

The time that it started to snow may vary depending on where you were on Saturday, February 15, 2003. But, it really started snowing very early on the following Sunday morning, and it continued to snow all day Sunday and into Monday. It snowed so hard you couldn't see drive or even walk at times. Snow shovels and plows couldn't keep up. And, according to State Highway Administration spokesman **David Buck**, "Up to 4 inches an hour fell during the thickest part of Sunday's storm."



Mark Paige, Facilities Manager for the Shock Trauma Building, was the "Go-To-Guy" for absolutely everything the Command Center needed done.

Gov. Robert Ehrlich issued a driving ban on Sunday to get people off the roads so road crews could concentrate their efforts on cleaning snow off the roads and not rescuing cars stuck in the snow. Ehrlich's declaration of a statewide emergency activated the National Guard to help local governments maintain safety, security and other services threatened by the storm. Maryland was still in a state of emergency on the following Tuesday.

Staff efforts to work together as teams, regardless of discipline or rank, were impressive. Some staff worked over their regularly scheduled times, others worked entire extra shifts. Many staff arrived at all hours of the day and not just at regular shift start times. Patients who were scheduled for discharge could not be discharged so staff supported them and their families who also could not leave. Many staff chose to spend their time-off sleeping at the hospital. The Medical Center is extremely grateful for the staff who stayed and came in during these three days of record snowfall.



At 9:00 a.m. on **Sunday**, February 16, View of one of the snow piles that dotted every street in downtown Baltimore. This pile is in front of the Penn Restaurant looking east towards the Health Science Library and downtown.

(Continued on Page 15)

Snowfall *(continued from pg.14)*



Reverend Alexandra Mattern-Rogglin, per diem Chaplain, handing out lunch coupons.

their major job was recruiting drivers of four-wheel drive vehicles, and coordinating them with the staff requests for pick up and transport to and from the Medical Center. Despite the 800 staff transported, this volume of transports is far less than the number of actual requests the Center

our Administrator-on-Call and Administrative Director of the Cancer Center, **Mark Kochevar**, activated our Command Center to deal with the problems of transporting essential staff to and from work. Staffed by a variety of management staff, the Command Center stayed open for three days, and assumed over-all management of the hospital's response to the biggest snowstorm in Maryland history.

The Command Center did a lot of things but

received. In fact, a few staff members had made every effort to come to work in this bad weather or be picked up, but a few of our volunteer drivers could not physically get to these staff to bring them in to work.



Kathy McCullough, Senior Vice President for Patient Care Services, **Mark Kochevar**, Administrative Director of the Cancer Center, and **Mary Beth Esposito-Herr**, Vice President of Patient Care Services, after three long days in the Command Center.



Carl the Compliance Crab

The Compliance Office is excited to introduce our new mascot — **Carl the Compliance Crab**. Carl was selected in a contest at the October 22, 2002 quality fair. **Michael Harrington** in Clinical Effectiveness, and **Cheryl Hancock** in Clinical Reimbursement gave him his name. Carl will be on all future UMMC compliance publicity.



Opps, We Goofed!

In the January/February 2003 issue of *News & Views*, the abbreviation in the table on page 9 should have read **MRSA** not **MRS**, and the sentence below the table should have read "Survival can be even longer when there is protein such as dried blood or nasal secretions in the microenvironment". And, all of the environmental culture results should be singular, not plural; e.g. VRE was found on only one diaper scale, not on multiple scales.

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News & Views is published bimonthly by and for the staff
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