



Filipino Nurse Recruits Are Finally Coming



Last February, our International Nurse Recruitment Team traveled to the Islands of the Philippines to recruit nurses to help fill many of our nursing vacancies. In the last twelve months, the International Nurse Recruitment team and Filipino nurses who were offered positions in the Medical Center have been busy fulfilling all the requirements for these nurses to finally travel to America. For both groups, the last twelve months has felt like an eternity. It seems at last that all these efforts are paying off as we prepare for the first group of nurses to arrive. We expect the first group to arrive in March.

Why Filipino Nurses?

The Medical Center Leadership's choice of the Philippines as the first country to recruit nurses was based on a number of considerations. First, most Filipinos are conversant in the English language since English and Filipino are their official languages, and Filipinos use English in the conduct of everyday business and government. As well, English is the medium of instruction in higher education and most high schools. Second, the curriculum followed in Philippine nursing schools is very similar to the curriculum used in American schools of nursing. And third, Western medicine is practiced in health care institutions in the Philippines although certain cultural practices are recognized and respected. These similarities provide a baseline by which we can predict the success of this initial foreign recruitment venture. They provide a common ground on which we can start the work of learning from each other's culture and partnering to provide the best care for our patients.

How Were These Nurses Selected?

The International Nurse Recruitment team applied rigorous criteria in the screening and interviewing of applicants for nursing positions in our facility. This review made it possible to identify predictors of successful nursing practice in America. Factors considered included the applicant's nursing school, National College Entrance Examination grade, Nursing school grades, Philippine Board Examination

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Foreign Nurses *(Continued from pg.1)*

grades and CGFNS (Commission on Graduates of Foreign Nursing School) grades. This review was prerequisite to a more stringent interview process that focused on the breadth and depth of the applicant's clinical experience and how similar their practice is to expectations at UMMC. Interview questions established the applicant's knowledge and experience about clinical procedures and technology. Applicants were quizzed about organization, priority setting and use of resources. They were also rated on important dimensions such as communication (spoken English), presentation, and potential.

The Next Hurdle

Only half of those who flocked to the Peninsula Hotel in the Philippines, where our recruitment team was based, were offered jobs in our Medical Center. But being offered a position was only the beginning of a long journey of "proving" that they are "deserving" of migration to this country. In order to be granted a visa to come to the United States, graduates of foreign nursing schools still have to pass the CGFNS examination. In addition, the Maryland State Board of Nursing requires foreign nurses to pass two English examinations – the TOEFL (Test of English as a Foreign Language) and the TSE (Test of Spoken English) and the NCLEX (the official name for the State Board RN examination).

The last hurdle is the immigration process. Immigration is ordinarily a very difficult and laborious process in the Philippines because systems are not as efficient as we have come to expect in America. This challenge became even more difficult after the terrorist attack on the World Trade Center on September 11, 2001. American Embassies everywhere are understandably more strict and apply more stringent criteria prior to granting even an interview to a visa applicant. Even measured by tropical time standards the business of coming to America as a nurse is a test of patience and endurance, if not talent, tenacity and resolve.


A Promise or a Threat?

It would seem logical to expect that Medical Center staff would be welcoming of individuals who are slated to fill staffing gaps in our patient care units. And yet, this "open arms" attitude may not be entirely true. There is much ambivalence about how much help foreign nurses can be expected to provide. Wherever we are in this range of feelings about international recruitment, our questions and concerns probably have merit and are largely based on information, exposure to foreigners as well as range of positive and negative experiences with individuals trained in foreign

lands. These factors usually shape our attitudes and fears. Our attitudes and fears in turn shape our behavior, which in turn can influence the success of this foreign recruitment venture.

The International Nurse Recruitment Team has been tasked with the challenge of developing and implementing a plan for the smooth transition of the Filipino nurses into our care delivery structure. This team has been listening to our current staff to acquaint themselves with what staff feel and what it will take to facilitate success. The questions staff asks vary from "Why were Filipino nurses offered the same pay structure as current staff"? In other words, "Shouldn't they be paid less?" to anxieties about Filipino nurses speaking a language our staff can't understand and fears about clinical competencies Filipino nurses may not have. While specific responses to these questions exist, those answers may not be satisfactory. The concrete answers may not respond to the real questions. The real questions may be "What are these foreign nurses like", "How different are they from me", and "How will these differences affect me?"

Nurses who are joining the Medical Center as a result of the international recruitment initiative have gone through the proverbial eye of the needle to prove that they are capable of practicing in America. They are licensed to practice nursing in the State of Maryland as a pre-requisite to their employment meeting the same standard as any American trained nurse. Their performance in our Medical Center hinges on their efforts to learn about our patient populations, and to learn and navigate our systems and our culture (American and corporate). Their success or failure in our facility will be a testimony to our advocacy and our support of their efforts. They are not just coming here, they are joining us. They have something to offer that we need. Given that by the time they arrive they have already proven that they are capable, how well they perform will reflect not only their capability but ours. Our capabilities to train, support, advocate and use their talent to meet our hospital's goal of providing the safest and highest quality patient care.

Foreigners can and do add a different perspective, a different world-view. They will have different routines, techniques, and habits. Different is not necessarily bad, just different! We both have to adjust. We probably share as many similarities as we have differences. We can try to discover these similarities early on to make it easier to bridge the differences. Who knows? In the end, we may learn something so different from each other that the differences forge a new and better us. 


New Blood Glucose Monitor Coming

The Medical Center began using the new Roche glucose monitor, the **Accu-Chek Inform**, in early February. The new monitor improves patient care management by offering:

- Accurate and reliable testing of capillary, venous, arterial, and neonate cord blood;
- Automatic download of information to our laboratory;
- Automated quality assurance
- Improved information management, and
- Safer lancets for our patients and staff

The monitor operates by touch screen and is fully customizable. It uses the same operating system found in the Palm Pilot line of Personal Digital Assistants (PDA). All Nurses, Nurse Extenders, Nursing Assistants, and other Patient Care Services staff who will be using this monitor need to be trained and successfully complete the Glucose Monitor Equipment Competency. Multiple inservices were held prior to deployment and activation of the monitors. For those areas requiring additional training, training for staff who could not attend the previous sessions, and/or those areas that want to use a "Train-the-Trainer" approach, please contact Laura Shockey, Laboratory Quality Assurance Specialist, at X8-0863.

If unit staff are interested in a "Train-the-Trainer" approach,

the person designated as the unit's Accu-Chek Inform trainer should request Train-the-Trainer information from Laura Shockey when they receive training. They will receive a packet with helpful information and tips, including the Roche glucose monitor competency to take back to their unit. 




The new Roche Accu-Chek Inform glucose monitor scheduled for Medical Center-wide deployment in early February.

Phlebotomy Course for Nursing Extenders

The Professional Development Committee has developed an eight-hour course to provide Nursing Extenders with the on-the-job training needed to demonstrate safe and effective phlebotomy technique. This course is offered to help staff develop phlebotomy competency as part of their job at this Medical Center. Phlebotomy is puncturing a vein with a needle for the purpose of drawing a blood specimen; it is **not** starting IVs. This course is not designed nor intended to provide staff with the comprehensive training required for American Society of Phlebotomy Technicians' Certification, and attendees at this course are not awarded this national certification. Class size is limited to 20 participants. Course dates are **March 14** and **March 28**, 2002 from 8:00 a.m. to 4:00 p.m.

Course Outline:

- Introduction to the Course
- History of Phlebotomy and Certification
- Vascular Access Theory
- Vein Anatomy
- Complications venipuncture
- Patient Considerations
 - Vein Assessment
 - Patient Safety Issues
- Infection Control Practices
- Venipuncture Technique
- Patient Identification

- Site Selection
- Site Preparation
- Puncturing the vein
- Obtaining blood specimen
- Order of draw for selected tests
- Specimen Labeling
- Dressing the puncture site
- Lab Practice and Demonstration on Manikin
- Venipuncture Competency validation with Hands-on Demonstration on Lab Partner
- Course Evaluation and Awarding of Certificate of Course Completion 

New Blood Safety Program Launched

The Medical Center is launching the Blood-Product Administration Safety (BPAS) Program to improve patient safety. This program is designed to enhance patient safety in general, using blood-product administration as a pilot application area. The central goal of the project is to establish an effective system for improving system-wide safety while building a safety culture.

The new approach emphasizes that caregivers are creating safety, even though they are vulnerable to making errors. To create a safe system for care delivery, an effective infrastructure of learning is necessary to develop an understanding of the system's vulnerability.

The specific focus of the BPAS program is to learn how to improve the process of blood-product handling. The learning objectives include:


- Discovering ways in which the process can be improved
- Identifying the factors that make it difficult for nurses and other care givers to complete the current set of procedures or protocols for handling blood products.
- what can be done to make the process easier.
- Examining adherence to protocols, i.e., which steps are the ones most often misunderstood or missed, and why.

The project's goal is not to find out who is "following the

rules" and who isn't. Everyone wants to carry out patient care in the safest way possible. The ultimate goal is to improve the whole care system. The project examines the system not the individual caregivers.

As part of the project, a group of caregivers will be formed on each of the selected hospital units participating in the BPAS pilot program to internally collect and analyze data on blood safety. That group will discuss ways to improve the blood administration process on their unit, and ways to inform the other care providers in the unit effectively about blood safety. The approach of this project is to empower the care providers themselves with the ability to have a direct positive impact on patient safety.


Two phases are planned—a pilot program, and a hospital wide version. The pilot program was launched in December, and it will run for two months initially on a limited number of units. Following an evaluation of the effectiveness of the BPAS pilot program, a broader version of the program may be implemented throughout the Medical Center.

Questions or comments regarding the BPAS project can be directed to **Jacob Seagull**, telephone number 410-706-1859, or e-mail: jseag001@umaryland.edu, or Sherry Perkins at extension 81704, or e-mail: sparkins@umm.edu. 

UMMC Wins Three Awards

UMMC received three awards for work in improving patient satisfaction through Professional Research Consultants (PRC) in a ceremony on October 10. A Gold Achievement Award was given to 4 Shock Trauma Acute for their improvements in nurse responsiveness over the past year under the direction of manager, Julie Ray. During the past year, this unit had the largest point gain for nurse responsiveness. This unit was also recognized at a ceremony in February by the Nursing department in its first annual Patient Satisfaction Recognition Program. Two Silver Achievement Awards were also received for the hospital's You Were Noticed program and for the Patient Care Services department's ongoing work to improve nurse responsiveness throughout the hospital.

The awards were presented at PRC's annual Patient Satisfaction Conference on October 10 in San Antonio. **Angie Amig**, Manager of CCU, PCU, and 3D accepted the awards for the Medical Center.

The awards honor work from multiple areas of the hospital and many employees who have contributed their time and talents to improving patients' perceptions of our organization and making their hospital stays more pleasant. Congratulations and thanks to the winners! 




Angie Amig, Manager of CCU, PCU, and 3D accepted three awards the Medical Center earned for work in improving patient satisfaction through Professional Research Consultants (PRC) in a ceremony on October 10.

Special Topics in Clinical Practice Offered

Two offerings of the **Special Topics in Clinical Practice** conference have been scheduled for all Patient Care Services staff. This full day program will be offered twice; once on **March 21** and again on **April 4** in the auditorium in the School of Social Work.

The schedule begins with an overview of the Medical Center's new palliative care program followed by critical information on preparing for our forthcoming JCAHO visit. Patient safety care implications will be shown from a multidisciplinary approached in the following plenary. The remainder of the day offers staff the choice of five concurrent sessions on topics including:

- Dealing with people in crisis.
- Managing patient's behavior with restraints.
- Mock JCAHO survey questions and answers.
- Way of ensuring patient safety, and
- Conscious sedation.

To register for this program, call extension 86257 to fax your request to 88258 to get a copy of the brochure. 

Special Topics in Clinical Practice

7:30-8:00 am	Registration and Continental Breakfast
8:00-8:10 am	Welcome - Katherine McCullough , Senior Vice President for Patient Care Services
8:10-8:50 am	Palliative Supportive Care - Not Just for the Dying - Palliative Care Team
8:50-10:00 am	Preparing for JCAHO Site Visit: Where Are We At Risk and What Can We Do About It? - Fe Nieves-Khouw
10:00-10:15 am	Coffee Break
10:15-11:30 am	Real Life Issues in Patient Safety - Videotape of Real Case with Discussion Led by nancy Barczak & Fe Nieves-Khouw
11:45-12:45 pm	Concurrent Sessions in Tracks - Session I

Dealing with People in Crisis	Managing Patient's Behavior with Restraints	Mock JCAHO Surveys	Ensuring Patient Safety	Conscious Sedation 101
Workshop A	Workshop B	Workshop C	Workshop D	Workshop E
Families in Crisis and Customer Service Recovery Skills	Managing Patient's Behavior with Restraints	Typical JCAHO Survey Questions & How to Answer Them	What is "Blame-Free" Incident Reporting? Can We Make It Safer Here?	Review Course in Managing Conscious Sedation

12:45-1:45 pm Lunch (on your own)
 1:45-2:45 pm **Concurrent Sessions - Session II**

Workshop F	Workshop G	Workshop H	Workshop I	Workshop J
Families in Crisis and Customer Service Recovery Skills	Managing Patient's Behavior with Restraints	Typical JCAHO Survey Questions & How to Answer Them	What is "Blame-Free" Incident Reporting? Can We Make It Safer Here?	Review Course in Managing Conscious Sedation

2:45-3:00 pm Break
 3:00-4:00 pm **Concurrent Sessions - Session III**

Workshop K	Workshop L	Workshop M	Workshop N	Workshop O
Families in Crisis and Customer Service Recovery Skills	Managing Patient's Behavior with Restraints	Typical JCAHO Survey Questions & How to Answer Them	What is "Blame-Free" Incident Reporting? Can We Make It Safer Here?	Review Course in Managing Conscious Sedation

3:00-4:00 pm Program Evaluation and Distribution of CE Certificates

Correction

In the November-December, 2001 issue of *News & Views*, the definition of a sentinel event was incorrect. The sentence on page 7 of that issue should have read, "A sentinel event is an **unexpected** occurrence involving death or serious physical or psychological injury, or the risks of these events occurring," and not define sentinel as "expected occurrences" as printed. Sentinel events are not expected events, they are always **unexpected**.

How to Use the New Pain Assessment Form

The new Pain Assessment and History Form (shown on the opposite page) is attached to the revised Intake and Triage Form, and it is designed to document pain assessment in one of two situations. The first instance where the Pain Assessment form is used occurs during the initial patient admission screening. If the patient answers "yes" to the pain assessment question on the first page of the Intake and Triage form:

Pain Screening: (If answer is Yes, complete full pain assessment)

Pain present now?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	per	<input type="checkbox"/> patient	<input type="checkbox"/> family	<input type="checkbox"/> tool	
Current history of pain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	per	<input type="checkbox"/> patient	<input type="checkbox"/> family	<input type="checkbox"/> tool	<input type="checkbox"/> unknown

Then, the admitting caregiver turns to the Pain Assessment form and completes it by documenting the patient's responses to questions asked in the same sequence as they appear on the form.

The second situation you should use the Pain Assessment tool is when the patients first complains of patient after admission or when you think the patient is in pain and they answer "yes" to your question "Are you having any pain?" In these instances, the pain form probably was left blank because the patient did not answer, "Yes" to the pain-screening question on admission. So, go back to the Intake and Triage Form, turn to the pain assessment part and complete the pain assessment dating the assessment at the bottom using the date you completed the pain assessment not the date the Intake and Triage form was completed.

Use the Patient's Words

One key aspect of pain assessment is to document the words the patient uses to describe their pain. You should not try to interpret what the patient is saying at this time. Instead, check off the boxes in front of the words patients use to describe their pain. If the patient uses a word not on the assessment tool, then check off "Other" and write in the word the patient used to describe their pain. The patient can fill out the middle section of this Pain Assessment History form beginning with the section that states "Please tell us about the pain...."

Why Are the Patient's Words So Important?

The words listed on the new Pain Assessment form were derived from the pain literature reporting typical words patients use to describe their pain. More importantly, some words, such as "burning" are considered a classic description of neuropathic pain. Neuropathic pain, such the phantom limb pain patients feel in their amputated limb, does not respond well to opioid pain drugs. So the words patient's use can help direct interventions that could be more effective sooner, than if patients were prescribed therapies not based on such qualifying information. So remember, do not attempt to interpret, abbreviate, or use your own words, instead check of the words the patient uses. Then, integrate the patient's pain descriptions into care planning in collaboration with the prescribing physician or nurse practitioner.

What About the Database in Trauma?

Staff in the Shock Trauma Center should document their pain assessment in the Patient's Database. This automated form will electronically date the form using the date the pain assessment part was actually completed. This electronic form of documentation in Trauma will gradually move into the other parts of the Medical Center as *Patient Plus* evolves in these areas. Trauma has the automated version first because the former Trauma computer system was not Y2K compliant, and it had to be replaced sooner than the rest of the Medical Center's computer system.

If you have any questions about this new Pain Assessment and History form or pain management in general, call Lynn Armstrong at 85921 (e-mail llarmstrong@umm.edu) or Karen Kaiser at extension 87690 (e-mail kkaiser@umm.edu).



PAIN ASSESSMENT/HISTORY FORM

Patient's Name JOHN SMITH (s/p Abd. Surg.) Medical Record # XXXXXXXX

Patient may complete except for where noted.
May Detach and Place with Flow Sheets

For Health Care Professional Use: ~~Complete if Intake/Tri~~

Pain Score = patient's score/total possible score (ie., 5/10).

Pain Score: Now 3/10 Worst in last 24 hours -

Tool: CHEOPS Checklist of Nonverbal Pain In
 Descriptor Scale Numerical Scale/VAS

Who is answering the following questions? Patient

Word child uses for pain: _____

Please Note: Can't make requested change to form... i.e., changing "Professional" to "Personnel." Form is an image (scan of original c/r/c provided by customer). Please advise.

1 pain occurs, whichever is first.
int of the scale, report/intervene.
 Worst/best score unknown
 PIPPS Poker Chip Tool

/family report unavailable

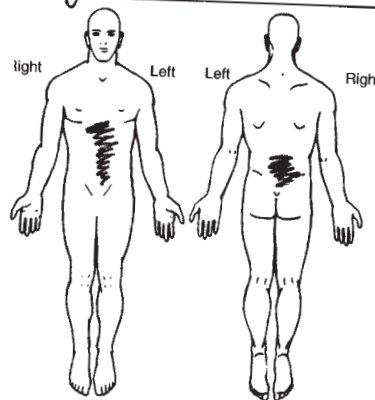
Nancy, RN

Please tell us about the pain you have now and any re
When possible, put a "X" in the box () that descr
more than one box. When possible, the patient should

1. Where is the pain? Shade all area(s) on the body map where there is pain.

2. What words describe the pain(s)?

- | | | |
|--|--|---|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Gnawing | <input type="checkbox"/> Shock-like* |
| <input checked="" type="checkbox"/> Burning* | <input type="checkbox"/> Knife-like | <input checked="" type="checkbox"/> Shooting* |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Pain with touch* | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Crushing | <input type="checkbox"/> Piercing* | <input checked="" type="checkbox"/> Tender |
| <input type="checkbox"/> Dull | <input checked="" type="checkbox"/> Pressure | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Heaviness | <input type="checkbox"/> Pulling | <input type="checkbox"/> Unable to determine |
| <input type="checkbox"/> Hot* | <input checked="" type="checkbox"/> Sharp | Other: _____ |



3. When does it hurt? All day Morning Afternoon Night Anytime Unknown

4. How often does it hurt? All the time Most of the time Some of the time Once in a while Unknown

5. How long does it hurt? The pain lasts for _____ hours. Unknown

6. What makes the pain better? Cold Distraction (TV/music/read/talk/work, etc.) Heat Limit movement
 Medicine Move, change position Rest Sitting Sucking Unknown Other: _____

Medicine	Dose	How often used
MORPHINE SULFATE	2-4 mg IV	q 2°

7. What causes pain or makes it worse? Cough MD/RN Physical Exam Lying Down Moving Nothing
 Rest Standing Staying in one position Sitting Turning Other: _____

8. What other problems are there because of the pain? Appetite loss Change in activity Depressed
 Difficulty thinking Loss of sleep Irritable Nausea/vomiting None Unknown
Other: _____

THANK YOU! Please give this to your doctor or nurse.

Comments: pt requests MSO4 for pain based on d/prior admission in 1994 w/pain relief during Myocardial Infarction.

To be completed by the Doctor/Nurse

Comments: _____

Signature/ Title: Nurse Nancy RN Date 10/01/01 Time: 01:01

Signature/ Title: _____ Date ____/____/____ Time: _____


*If pt. describes pain using a starred word/complains of uncontrolled chronic pain, consider an APMS Consult (requires a MD order).

Working in a Blame-Free Place

The Quality Fair held last October 2001 included one room dedicated to patient safety. The Education and Communication Subcommittee of the Patient Safety Team filled this room with a variety of storyboards on patient safety. The last storyboard in the room asked staff what they thought it would like to work in a "blame-free" environment.

The intent here was to get staff feedback on how they felt about working at a place where errors or incidents in patient care were viewed as objectively as possible. That is, instead of focusing blame on the individuals involved, the emphasis would be on how we could learn about system errors or gaps in care delivery processes that contributed to the error. In

doing so we could learn about what cause the incident and if there are possible broader applications of what we learned to reduce the likelihood or prevent the error from occurring again.

Listed below are the responses staff wrote on large "Post-It" notes that filled the wall under the question "How would it feel to work in a blame-free learning environment?" These comments are unedited, and none were omitted. These comments are interesting, and they seem to show how staff favorably view working in blame free environment around patient safety. The real work that remains is creating it. 

How would it feel to work in a blame-free learning environment?

“ Strange, but great.

You mean, someone would really listen?

The first step to improve self-reporting is the blame-free environment.

To communicate with employee's, just don't keep it all in the manager's room.

Everyone works together for one purpose, no one blaming someone else.

No Name, No Blame. FAIR management to ALL.

No one should be blamed. SAFE.

Let employees know their good points as well as their bad points.

That would be a progressive and encouraging environment.

Work in a team, make it easier and blameless.

Enjoyable and encouraging. *Team work works.*

It would be great for everyone

Would it be difficult to manage blame-free with accountability and the need for discipline?

Start at the educational level for nurses, i.e. schools of nursing; often use incident sheets as tools included in evaluation and grades.

Fun to come to work XOXO. Clean work, even safe.

Improving process and decreasing the finger pointing.

Try again and again. *Encourage reporting "near misses".*

Have a unit/hospital process where we reward this reporting along with suggestions on how to improve or prevent the "near miss" situation.

I would feel more at ease working in a blame free environment, we are all human and make mistakes.


Accountability without blame.

Safe. Unbelievable. Relaxing and enjoyable.”

Are you Getting J-Mail?

J-Mail is our name for brief messages on important topics that clinical staff are expected to know and speak to during the actual JCAHO site survey in April or May 2002. Staff can get J-Mail as an attachment through our GroupWise e-mail system. Staff must have an e-mail address to get J-Mail.

Once you get J-Mail messages, you should open, read, print and post them in your work areas for staff who do not get e-mail at work, and think and talk about how they apply to your job and work. A resource person and their telephone number are provided in each J-Mail if you have any questions.

If you know anyone with an e-mail address who does not get J-Mail, but should, please send their e-mail address to rwelton@umm.edu and put "J-Mail" in the subject area. Copies of past J-Mail messages are archived in and available from the **JCAHO Site Review Preparation** link on the Medical Center's Intranet Home Page. 

J-Mail on What You Should and Do Know About the Plan of Care

What is the Plan of Care?

The plan of care (POC) is a method of **interdisciplinary communication** that tracks our desired outcomes for the patient. A POC can take many forms but always has these common elements:

- Developed from the **initial screening and assessment**.
- Defines **measurable goals** addressing problems identified during assessment.
- Lists interventions for each goal.

Documentation of goals and plan of care by individual services for each patient is important because it:

- Coordinates the care efforts of all disciplines.
- Helps us **communicate** with other services.
- Is required by regulatory agencies (JCAHO).

When used effectively, plans of care can enhance the combine care effect not otherwise possible.

Writing Goals

All disciplines **write goals** which must be:

- **Objective**.
- **Measurable**.
- **Time limited**.

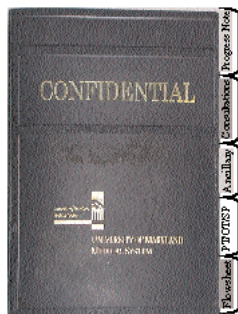
Integrating Care

We integrate care by:

- Reading **other disciplines** notes regularly.
- **Participating** in multidisciplinary rounds
- **Communicating** one-on-one with other disciplines.

Where Do We Document the Plan of Care?

- Individual disciplines document their plans of care in **specific locations** in the chart.
- Nursing uses a new POC form located in the Progress Notes section of the chart.



← MDs, Nurse Practitioners, Physician Assistants, Nutrition, Social Work, Pastoral Care & Substance Abuse Counselors.

← Nursing's plans of care and their progress notes.

← Consulting Physicians.

← Respiratory Therapy use Respiratory Care Progress Note.

← Occupational Therapy, Physical Therapy and Speech Language Pathology use own forms.

← Nursing's Intake/Triage form and physical assessments on the *ICU Flow Sheet* or the *Daily Patient Profile* (current forms at bedside).

Staff must be able to:

- Describe how care is planned and provided in an **interdisciplinary** and **collaborative** manner.
- Describe how assessments & plans of care of other disciplines are **integrated** in the care provided to patients.
- **Document, evaluate and revise** measurable goals based on patient needs.
- Document why some patient needs **will not be addressed** during this hospital stay, such as substance abuse in a patient admitted for gall bladder surgery.

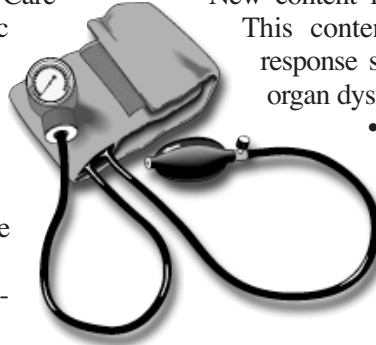
If you have any questions about POC, call Mike Harrington at 8-7385.

Basic ICU Course Revised

The Medical Center has revised the Basic Critical Care Nursing course, sometimes referred to as "Basic ICU", based on feedback from past course participants and their managers. The newly revised course, shown below, includes:

- focus on basic principles that are critical to safe and effective practice;
- new content relevant to practice in critical care settings; and
- an additional day for selected hands-on competency assessment.


Managing hemodynamic monitoring is one of many critical roles for ICU nurses, so the hemodynamic monitoring lecture has been revised to help new nurses grasp this complicated content. This section and other sections were revised to help facilitate staff learning safe and effective practice by including some hands on application.



New content includes a section on Multisystem Failure. This content covers shock, systemic inflammatory response syndrome/septic shock and multiple system organ dysfunctions. Other added lectures include:

- Death, Dying and Palliative Care
- Managing Conscious Sedation and
- Pain Assessment and Management.

The course was lengthened by one day to accommodate a Competency Assessment Day. This 8-hour section of the course includes hands-on application and demonstration of such competencies as Venipuncture, Airway Protection, Infection Control, and Mock Codes.

If you're interested in becoming a course faculty member, please contact **Deborah L. Peterson, BSN, RN**, Clinical Transition Coordinator, at extension 8-1628 Fax (410) 328-8258, pager #7451. 

Revised Basic Critical Care Nursing Course 2002

Tuesday, February 12th, 2002 (6.25hrs)

8:00 - 8:15	Introduction	
8:15 - 9:15	Pulmonary Anatomy	1.00HR
9:15 - 9:30	Break	
9:30 - 10:45	Pulmonary Assess/Interventions	1.25HRS
10:45 - 11:00	Break	
11:00 - 12:15	Pulmonary Disease	1.25HRS
12:15 - 1:15	Lunch	
1:15 - 2:30	ABG'S→Ventilator Management	1.25HRS
2:30 - 2:45	Break	
2:45 - 4:15	Vent Management→Weaning	1.50HRS

Wednesday, February 13th, 2002 (6.75hrs)

8:00 - 9:30	Cardiovascular A&P/Assessment	1.50HRS
9:30 - 9:45	Break	
9:45 - 11:00	CAD & CHF	1.25HRS
11:00 - 11:15	Break	
11:15 - 12:30	Angina, AMI, Pacing	1.25HRS
12:30 - 1:30	Lunch	
1:30 - 2:45	Hemodynamic Monitoring	1.25HRS
2:45 - 3:00	Break	
3:00 - 4:30	Hemodynamic Monitoring	1.50HRS

Thursday, February 14th, 2002 (6.50hrs)

8:00 - 9:00	Neuro A & P	1.00HR
9:00 - 9:15	Break	
9:15 - 10:45	Neuro Assessment→Studies	1.50HR
10:45 - 11:00	Break	
11:00 - 12:15	Head Trauma→ICP	1.25HRS
12:15 - 1:15	Lunch	

1:15 - 2:45	Stroke (Aneurysms, Hemorrhage)	1.50HRS
2:45 - 3:00	Break	
3:00 - 4:15	Seizures	1.25HRS

Tuesday, February 19th, 2002 (6.75hrs)

8:00 - 9:30	Gastrointestinal	1.50HRS
9:30 - 9:45	Break	
9:45 - 11:00	Nutrition in the Critically Ill	1.25HRS
11:00 - 11:15	Break	
11:15 - 12:30	Substance Abuse	1.25HRS
12:30 - 1:30	Lunch	
1:30 - 2:45	Renal	1.25HRS
2:45 - 3:00	Break	
3:00 - 4:30	Shock/Multisystem Failure	1.50HRS

Wednesday, February 20th, 2002 (6.00hrs or 7.25hrs)

8:00 - 9:00	PACU	1.00HRS
9:00 - 9:15	Break	
9:15 - 10:30	Families/Staff in Crisis	1.25HRS
10:30 - 10:45	Break	
10:45 - 12:00	Death, Dying/Palliative Care	1.25HRS
12:00 - 1:00	Lunch	
1:00 - 2:30	Risk Management in the ICU	1.50HRS
2:30 - 2:45	Break	
2:45 - 3:45	Conscious Sedation	1.50HRS
3:45 - 5:00	Pain Management	1.25HRS
Total Course Hours		33.25HRS

Key: **BOLD** = New Lecture Content

HS/HL Provides PDA Website

PDAs, or personal digital assistants, are among the latest tools professionals use to stay organized. In response to their popularity, in the medical and health fields, and the growing resources available for handheld computers, the Health Sciences and Human Services Library (HS/HSL) has developed "**Personal Digital Assistants – Going Mobile.**" This selected list of web sites is useful in learning more about handheld technology in general, useful applications, pricing and feature information. The web site contains three sections: Hardware, Evaluation Resources and User Resources. These resources are available through the HS/HSL web site at <<http://www.hshsl.umaryland.edu>> under the "Electronic Resources" category and then the "PDAs" link under "Web sites by Subject." For additional information, please contact the Reference Desk at (410) 706-7996. To suggest additional sites, please e-mail the HS/HSL Web Design Team at webteam@hshsl.umaryland.edu.

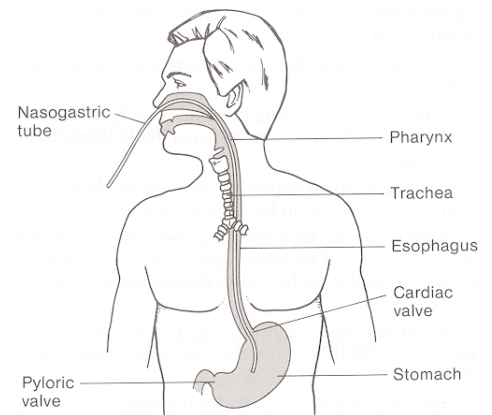


Preventing Aspiration Pneumonia

The Technology Task Force, a sub-committee of the Clinical Practice Committee, has developed a project to decrease the incidence of aspiration pneumonia within UMMC. Data shows that over 42 cases of aspiration pneumonia could be prevented annually, and by doing so we could significantly improve care, shorten length of stay and achieve a cost savings of \$215,880 per year.

Our data shows that teaching unlicensed staff (Nursing Assistant and Nursing Extenders) about aspiration pneumonia and how to help prevent it would address one of the root causes. This Task Force has planned training on the following topics and competencies:

- Giving Tube Feedings Safely.
- What is Aspiration Pneumonia and How Do I Prevent It?
- Giving Tube Feedings to Patients at Risk for Aspiration.
- Performing Effective Mouth Care.
- Feeding Patients Food with Different Consistencies.



Competency assessment skill verification is included in this training, so staff will come away from this training with signed-off competencies. Staff from Speech, Nutrition and Nursing will be faculty.

Session is scheduled in **four-hour blocks** beginning at **7:00 am** and run to **11:00 pm** on Tuesday, **February 19, 2002** in the **10W Solarium**. Schedule your staff for one of these four-hour sessions shown below by calling and registering via the Office of Professional Development and Clinical Practice at **86257** as soon as possible.

In-Service Times:

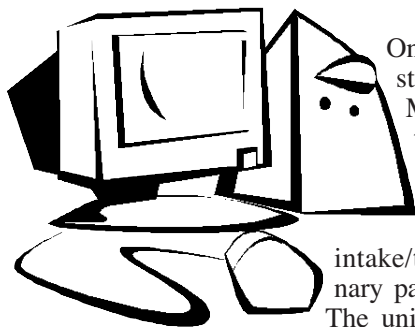
- 7:00 am – 11:00 am
- 1:00 am – 3:00 pm
- 3:00 pm – 7:00 pm
- 7:00 pm – 11:00 pm

Added Training for All Staff on the New Blood Glucose Monitor

Trainers from Roche, the vendor for our new blood glucose monitor, also will be available on these dates and at these times to train **all clinical staff** who will use the new glucose monitor. Again, staff will leave this Roche session with a signed blood glucose monitor competency. This training is open to all staff, including nurses, it will occur at a separate station from the above training, and take about 45 minute to complete. Staff do not need to register for this training; instead they can just "show up" at the 10 West Solarium and the Roche trainers will teach and watch a return demonstration.

Patient +...It's All About Your Patient and You!!

By Anne Naunton, MS, RN
ITG Clinical Leader



On February 27th, a milestone will be met in the Medical Center world of the electronic medical record. The cardiology pilot units will implement the automated intake/triage and multidisciplinary patient education processes. The units involved are the PCU, CCU, and the Cardiac Catheterization Lab.

entry, wireless devices will also be piloted in the cardiology areas. These devices will allow users to enter and view clinical information on a portable device that is not fixed on a stationary desktop.

A clinical information system relies heavily on the input from the users for a successful design, and builds of an end product. In this case, ownership and involvement of the cardiology clinical staff, leadership, physicians, essential care disciplines, and the ITG project team was key to developing of this new technology.

This deployment is not a replication of the form that already exists. Instead, the automated form is an updated version of intake/triage information, including risk assessments. When a risk is identified, an electronic message is sent to the ancillary service involved. These services include social work, rehab, case management, infectious disease, pastoral care, palliative care, drug/alcohol counseling, food and nutrition, and wound-ostomy-contenance. In addition, the information triggers pain and falls assessments to appear on the screen when key responses are selected.

The assessment and referral process changes associated with automation will lead to significant improvements. Such as:

- Increased productivity due to reduction in manual interventions.
- Timely communication of identified risks to relevant disciplines.
- Elimination of paper forms.
- Improved compliance with UMMC and JCAHO standards
- A standardized multidisciplinary process for documentation.


In an effort to provide clinicians with flexibility during data

Quotes from pilot area staff:

"I am very excited about this. The automation of the intake/triage process will improve patient outcomes because I believe that risks will be identified and addressed in a more timely fashion".

"I have been waiting for this technology for 10 years".

"I will look forward to when I can run reports that will help me monitor and analyze patient data that will lead to improved outcomes".

Our next steps include further automation of documentation and developing online physician orders. The opportunities an automated medical record offers in promoting and providing safe patient care is endless. This project will place UMMC on the leading edge of clinical information technology. The continued partnership of the health care team and the information technology group will support the Medical Center's values of quality of care and excellence in service. 



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