NEWS & VIEWS

UNIVERSITY OF MARYLAND MEDICAL CENTER
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Student Nurse Residency Class of 2010

By: Angela Sintes, MS, RN, CNL

The UMMC Student Nurse Residency program is designed to enhance and foster the professional growth of the student nurse throughout his or her senior year of nursing school. Each BSN student nurse works one-on-one with a unit preceptor for 36 hours a week for ten weeks. This relationship allows the student to experience bedside nursing and bridges the gap between their final year in nursing school and the intimidating novice year of professional nursing. Core areas of focus include enhancing clinical competence, providing opportunities for growth with communication between student nurse and fellow members of the health care team, assisting with the formation of realistic expectations of self and clinical staff, providing role clarity, and increasing the recruitment initiatives between the student nurse to new graduate nurse within the University of Maryland Medical Center.

The residency program has run each summer since 2007 with the concluding ceremony and celebration for 2010 held on July 30. In its fourth year, 45 student residents were placed on 26 inpatient units throughout the hospital and assigned to a bedside nurse preceptor. The student residents represent 11 different schools of nursing and will be graduating in December 2010 or May 2011. The application process began in January, when we received over 100 applications. Eighty student nurses were interviewed, and 45 outstanding applicants were selected from schools of nursing in Maryland, Virginia, Delaware, Pennsylvania and Florida.

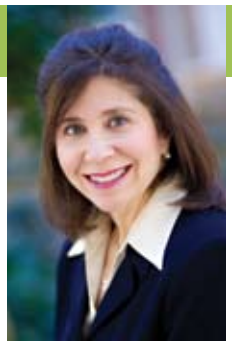
Each student has a preceptor on his or her unit and a mentor who advises and guides the student and supports his or her personal and professional growth. The nine mentors for this year's program were nurses from the Clinical Practice & Professional Development Department who were assigned four to eight student residents to support throughout the program.

In addition to working 36 hours per week doing bedside care with his/her preceptor, each student nurse resident attends biweekly education sessions where they are exposed to lecture topics such as Phlebotomy, Wound Care, Substance Abuse, Palliative Care, Working with Generations, and Dealing with Difficult People. Post lecture, the residents engage in a "Tales from the Bedside" open forum facilitated by the program coordinator where they share their experiences and learn from each other. Afterward, they break out into their groups with their mentors and discuss their experiences, concerns, issues, or whatever comes up in a "debriefing" of the previous two weeks.

The student nurse residents and their preceptors separately complete performance feedback forms about the student and then share their comments and ratings with one another. These forms are given to the mentors on a biweekly basis and discussed during mentor sessions. Residents also reflect on their practice, ways they are improving and areas they need to focus on, and give feedback to their preceptors in biweekly journals which are e-mailed to their preceptors and mentors. Preceptors are able to use the feedback

see **Class of 2010** on page 4

IN THIS ISSUE...



Lisa Rowen's Rounds

Culture of Safety

September 2010

The recent Johns Hopkins Hospital tragedy, where a patient's son shot a surgeon, the patient, and himself, sent shock waves rushing through the hallways and hearts of American hospitals and their health care providers. At our Medical Center, just a couple miles away and where so many of us know so many colleagues at Hopkins, the concern, fear, and desire to help was palpable. Immediately upon hearing the news, our Director of Security, Steve Moyer, was on the telephone offering help to the Security force across town. Our Chief Medical Officer (CMO), Jonathan Gottlieb, was also on the telephone with the Hopkins CMO, determining if they needed to evacuate any of their patients to the Medical Center. We held our collective breath, and many of us prayed there would be no further harm to the patients and families, staff, and physicians. We exhaled together when we learned that the incident had ended, but we continued to ache for our colleagues, our profession, our society, and ourselves.

We live in a violent world. Violence is everywhere, including schools, places of worship, and shopping malls. So why we are we shocked when we see or experience violence in hospitals? I think it's because most of us have chosen health care as a result of our internal desire to help others. We hope and expect our health care settings to be harm-free zones. We take care of everyone who comes through our doors, whether they have infectious diseases, have been victims or perpetrators of violent crimes, or have behavioral health issues that make them a risk to others, and this creates a challenge to sustain a culture of safety. When we constantly focus on the safety of patients and promoting best possible outcomes, frequently health care providers are placed at considerable risk. In fact, violence occurs in health care settings more frequently than many other industries. Fortunately, there are many strategies to improve safety in health care settings.

At the Medical Center, we are dedicated to continuously advance our culture of safety for all who enter our doors. I am happy to report that data from our culture of safety surveys reveal sustained annual improvement on almost all measures over the past three years. However, we can always do better, and, in fact, this must be our imperative. There is a deep leadership commitment to re-assess our physical and cultural safety environment. Over the next several months, you will frequently hear about this initiative and the outcomes from our CEO, Jeffrey Rivest. As we perform an assessment of our safety culture, let's look inward and consider what each of us can do to positively contribute to the safety of our workplace environment.

Safety culture risks come in many forms, and in addition to a threat of or actual physical harm from others, we must also consider disruptive and uncivil behaviors that contribute to emotional or psychological harm. First and foremost, a safety culture is characterized by open and respectful communication among all members of the health care team. This is where safety begins and it is the foundational component for improving a culture of safety.

Uncivil behaviors include being rude, disrespectful, dismissive, threatening, demeaning, and inappropriate (Forni, 2002). In the nursing literature, uncivil behavior is also called lateral or horizontal violence.

Lateral violence is defined as "any inappropriate behavior, confrontation, or conflict that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual, through physical, verbal, and/or emotional abuse of an employee (Center for American Nurses, 2008; International Council of Nurses, 2004). Lateral violence can occur between any two or more colleagues or members of the health care team, and it is not role dependent. The occurrences of incivility are reported in most health care settings and involve nurses, nursing assistants or techs, attendings, residents, and all other team members.

Behaviors of lateral violence include (Rowe and Sherlock, 2005; Griffin, 2004):

- Non-verbal innuendo
- Verbal affront
- Undermining activities
- Withholding information
- Sabotage
- Infighting
- Scapegoating
- Backstabbing
- Failure to respect privacy
- Broken confidences
- Silence
- Backbiting
- Gossip
- Passive aggressive behavior

Do any of these sound familiar? Have any of us been on the receiving or giving end of these behaviors? In addition to laterally violent acts, which can occur once or more than once, if the pattern is repetitive it becomes workplace bullying. This is when repeated inappropriate behavior, direct and indirect, whether verbal, physical or otherwise, is conducted by one or more persons against another or others, in the workplace and/or in the course of employment, which could reasonably be regarded as undermining the individual's right to dignity at work (Task Force on the Prevention of Workplace Bullying, 2001).

Many of our nursing teams, including the Staff Nurse Council and the Research Council, have identified acts of lateral violence in our workplace as a reality and something we need to address. Learning more about and taking action to address lateral violence and incivility will be an area of focus for all of our nursing councils this year, as well as many Medical Center committees. If this is an area of interest to you, please let your manager know that you want to get involved.

Our culture of safety and its evolution is dependent on people in all roles and at every level to become active and engaged in the topic. We owe this to each other, and we owe this to our patients and families. Patient outcomes and safety will improve as we decrease uncivil behavior. We will benefit through the creation of a much more satisfying work environment for all.

News & Views is published bimonthly by the Department of Nursing & Patient Care Services of the University of Maryland Medical Center

Scope of Publication:

- Clinical and professional nursing practice in inpatient, procedural, and ambulatory areas that is **evidence-based, innovative, and outcomes driven** (clinical, quality, and customer service)
- Inclusive of unit, divisional, departmental, and/or organizational strategic goals
- Suggested content topics
  - Evidence based practice
  - Performance improvement with outcomes
  - Relationship based patient and family care
  - Relationship with UM School of Nursing
  - Professional development
  - Commitment to excellence
  - Patient & family education
  - Patient safety and quality
  - Research
  - Governance structure
  - Awards and recognition
  - Regulatory requirements
  - Community involvement

Guidelines for Article Submission

1. Times New Roman - 12 pt black font only.
2. Length - three double spaced, typed pages maximum.
3. Include name, position title, credentials, and practice area for all writers.
4. Credentials must be provided for anyone named in the article.
5. Proofread article for spelling, grammar, and punctuation before submitting.
6. Provide photos in .jpg format.
7. Send completed articles via e-mail to anaunton@umm.edu.

2010 Publication Schedule

ISSUE DATE	ARTICLE DUE DATE
January/February	February 1
March/April	April 5
May/June	June 7
July/August	August 2
September/October	October 4
November/December	December 6

UMMC Great Catch Award

UMMC has consistently encouraged staff to report concerns that affect safety and quality. The "Great Catch Award" is an extension of this commitment and rewards staff for "catching" an error before it can affect the patient. The Medical Center instituted the "Great Catch" award to increase the focus on early recognition, intervention, and reporting of safety and quality issues to protect patients from potential harm.

UMMC employees can nominate themselves or another employee for a "Great Catch Award" by submitting a story describing an occurrence where harm or potential harm to a patient was prevented or averted. Use the "Great Catch" form posted on the UMM intranet. Please fax the completed forms to #8-8258 to the attention of Fe Nieves-Khouw or e-mail to fnieves@umm.edu. Selected "Great Catch" awardees will be presented and recognized at the UMMC manager's meeting.

June 2010 Winners

Yaquara Vanterpool (Lab)
Great Catch: **Prevented a Potential Adverse Event**

Yaquara (Que) was accessioning STAT lab specimens and noticed that labels on two different patients were included in the same bag intended for one patient's blood. Upon further investigation, Que found that one of the tubes in the bag had the wrong label. One sample belonged to another patient. Que called the unit and notified three different individuals. If Que had not noticed the mislabeling, the patient could have received the wrong treatment. Que prevented a potential adverse event related to a wrongly identified blood specimen.

Cynthia Merida (Medical IMC)
Great Catch: **Potentially Averting a Medication Error**

Cynthia was caring for a patient on an alcohol withdrawal protocol listed on the intranet. While preparing to administer the medication as indicated on the protocol, she noticed a discrepancy between the protocol and the eMAR. She noted that the dose on the protocol was double the dose on the eMAR. Cynthia notified the physician on call who instructed her to follow the eMAR. Upon further investigation, it was determined that the dose on the intranet was the revised version of the protocol, and the eMAR reflected an old order set. Information Services & Technology was notified to make the appropriate change to the order set, and a revision was added to the protocol on the intranet.

July 2010 Winners

Meredith Klepper (Pediatrics)
Great Catch: **Prevention of a Medication Error**

Meredith noted that TPN and IL rates ordered for Sunday night were vastly different from what was ordered on Saturday night. She questioned the order with the pediatric surgery intern, Dr. Omar Velasco, who stated that the orders were incorrect. Meredith called the pharmacy and new orders were faxed. Meredith demonstrated the importance of continuity of the care plan, vigilance, and assertiveness.

Monica Chiduza (SICU)
Great Catch: **Prevention of a Medication Error**

Monica had a pancreas/kidney transplant patient who had an abnormal potassium level of about seven. The SICU resident ordered dextrose, insulin, and calcium to reduce the potassium level. Monica explained to the resident that this medication therapy may not be appropriate for the patient. The transplant physician agreed with Monica. The SICU resident thanked Monica for her suggestion. This turned out to be a teaching moment for the nurse and resident.

Class of 2010 from page 1

found in student journals to improve their own mentoring skills and to understand the experience from the resident's perspective. The mentors provide formal feedback and elicit discussion.

Throughout the program, mentors, preceptors and unit leadership assist the residents in choosing a topic of interest for which they will create a poster and prepare a presentation. Topics include process improvement initiatives, pathophysiological processes, and equipment and therapies specific to their unit of hire. The Student Nurse Residency Poster Summit was held in the Weinberg Atrium on the second to last day of the program. Topics displayed included "The Neutropenic Diet: Not An Evidence Based Practice" by Gabriella Cantalupo working on the Blood and Marrow Transplant unit, "Are You Ready? Mock Codes Prepare Nurses for Initial Response to Code Blue Calls" by Johnny Raynor of the Cardiac Surgical ICU, "Caring for a New Patient Population: Medication Management for Pulmonary Arterial Hypertension" by Samantha Albrecht of 3D-Telemetry, "Patient Safety: Verbal Orders" by Jennifer Landis of the Pediatric ICU, and "Phantom Limb Pain: A Nursing Perspective" by Kristen Carroll of Shock Trauma Acute Care. Each student presented his or her topic in the UMMC auditorium in front of co-residents, mentors, preceptors, managers and unit leadership, and they fielded questions.

In addition to the potential to recruit these residents as graduate nurses, another outcome of this program was the employment of 36 student nurse residents as student nurse technicians. Other feedback from this program will be captured from the responses of the SNRs in the online survey they completed after completing the program. One student conveyed her appreciation and growth through the words written in her final journal *(reprinted with permission).*

Journal: July 23, 2010

For my journal this week I wanted to do something a little different then the given format. Hope that's ok! I wanted something that could sum up what I've learned over the entire residency.

While I have learned many skills and had encountered a vast number of interesting clinical situations, I do not believe that the concrete experiences I've had over the past two months are the most important lessons I've learned. The best gift this residency has given me is a wonderful new confidence in myself.

Working on the unit these last two weeks, I have felt independent. I have not hesitated to respond to changes in patients' conditions. I have implemented my own interventions where they fall with in my scope of practice. With the combined guidance of my preceptor, mentor, unit manager, and the staff of 11E, I have reached a point where I can finely see the bigger picture that a nurse needs to understand to care for his or her patients. I feel at ease keeping track of medications and orders, responding to changes in condition, communicating with staff and family, and working patient education into my daily routine. At the beginning of this residency completing even one of these tasks for one patient felt overwhelming. Now I perform them confidently with four to five patients.

I would like to thank everyone who has facilitated my ability to be in this program. It has worked several wonderful changes in my life and I am very grateful to you all.

Wynnona Engle-Pratt
Student Nurse Resident, UMSON

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Honorable Mention

Brian Burke, BSN, RN, CPN, SCNI, General Pediatrics

Congratulations to Brian Burke who was featured in the Baltimore Sunday Sun, July 16, 2010. Brian appeared in the Career Focus section on health care in an article titled "Transitioning From Office To Health Care Career". The article describes Brian's career transition from a commercial banker for five years to a nurse in general pediatrics. Brian left the financial world in 2003 to attend nursing school, and he graduated in 2007 with his BSN. "Despite the fact that it's been challenging with the hours, I've found great happiness with the career change and what it brought me," says Burke.

Great Stories

Dear Dr. Rowen,

"Today" I was truly inspired by a newly hired PCT. I encouraged her to write to you and let you know about her initial impressions of UMMC's nursing department. She comes to UMMC with great work experience and educational preparation. She has worked at several area hospitals in Baltimore (St. Joseph's and Northwest) and New York Presbyterian. During the course of the day, she could not stop talking about the positive energy of all of the nursing staff that she has worked with in her short time at UMMC.

Tiffany is currently enrolled at Howard Community College in the pre nursing program and is considering an application to UMSON.

I hope you enjoy reading her letter!

Judith H. Hill, BSN, RN, ACRN
Senior Clinical Nurse II
Correctional Health Facility, 11SD

Dear Dr. Lisa Rowen,

My name is Tiffany Steele, and I am a PCT with Supplemental Staffing. I wanted to share with you my feelings and experience here at UMMC. I started on June 28, 2010, and after my three days of orientation of gathering information about UMMC and listening to other employee's experience, I became very excited to work here. Compared to the other hospitals that I worked, they did not take as much pride in their organization and have other employees come to share their stories or explain why this is the best place to work. I can appreciate the time each presenter took to explain their story or to give the many reasons why UMMC is the best place to work. Over the years, I have never felt that I would stay with a company longer than 1 to 2 years because they tell you they are the best, when later you find out that's not true or there were no career advancements. For the first time in my life, I can honestly say and see that I could retire from UMMC. I plan to continue my education and receive my AA in nursing and also my BSN. Who knows I may go further, but the sky is the limit. If it wasn't for the move to applying and receiving this job at UMMC, I would never feel as excited as I do now. I look forward to meeting you, but I wanted to take this time and let you know of the wonderful experience and the commitment to longevity with this organization. I am glad to be part of this team.

Sincerely,
Tiffany Steele
PCT
Supplemental Staffing

UMMC Grant to Support Nursing Education

By: Trisha Fronczek, MS, RN-BC, CCRN
Professional Development Coordinator, CPPD

In the Fall of 2006, UMMC and the UMSON, together with MedStar Health System, received a five year grant from the Health Services Cost Review Commission, the state of Maryland's rate-setting commission. The purpose of this grant is to use shared resources to increase the pool of nurses available as clinical instructors, and to develop a pipeline for additional graduate educated nurses to serve as student nurse preceptors in the state of Maryland. This effort also seeks to impact the shortage of nursing faculty members, which will result in increasing the number of qualified applicants admitted to the entry-level baccalaureate programs.

The grant covers educational expenses, once UMMC nurses are enrolled in UMSON's Health Service Leadership and Management Master's Degree Program. The curriculum includes instruction in leadership, management, systems theory, education and curriculum development, specialty clinical courses, and information management. Sixty five UMMC nurses were enrolled in the program in three cohort groups.

As of May 21, 2010, twelve nurses in the UMMC Cohort Grant program graduated with their Master's Degree from the Health Service Leadership and Management Program at UMSON.

December 2009 Graduates

- Patricia Dix, MS, RN, CCRN, Maryland Express Care
- Jackie Williams, MS, RN, CNII, 10 East
- Suzan Lewis, MS, RN, CPN, SCNI, Pediatrics
- Beth Sherfy, MS, RN, CCRN, SCNII, PICU
- Michele Zimmer, MS, RN, CCRN-CMC, SCNII, PCU

May 2010 Graduates

- Cynthia Bauer, MS, RN, CCRN, SCNI, CCU
- Mary Ann Bautista, MS, RN, CNRN, SCNII, Neuro ICU
- Karen Cossentino, MS, RN, CCRN, SCNI, CCU
- Kyanni Fleming, MS, RNC-OB, CNI, Labor and Delivery
- Jenny Merenda, MS, RN, SCNII, Multi-trauma Critical Care
- Maria San Juan, MS, RN, CNII, SICU
- Lori Tanguay, MS, RN, OCN, SCNI, Stoler Pavilion

The History of Men in Nursing

By: Todd Milliron, RN, Senior Clinical Nurse I

Surrounding all the controversy and stereotypes of nursing that exist in modern day medicine, I thought it would be interesting to take a historical look at the history of men in nursing to separate fact from fiction. I could not believe how much information there is out there about men in nursing that I was never taught in nursing school. My education in nursing school was centered on Florence Nightingale or Clara Barton. There was no mention of nurses such as James Derham or Juan Ciudad.

Men were actually the first nurses, long before women were permitted to enter the profession. In fact, the first nursing school, which opened in India in 250 B.C., only considered men as "pure" enough to be nurses.

Throughout history, there have been several male nurses that have stood out. Brother Gerard was one of those nurses. Gerard was the founder of the Hospitallers, also known as the Knights of Malta. Gerard developed the eight pointed cross in honor of the eight beatitudes. The Knights of Malta is the only original nursing order still in existence with almost 1000 years of treating the sick and wounded.

Juan Ciudad, also know as "St John of God", organized a second order of the Hospitaller brothers that still exists in over 250 hospitals today.

James Derham was the first African-American to formally practice medicine in the United States. Derham was born into slavery and was owned by several doctors. One of his owners recognized Derham's passion for medicine and encouraged him to pursue his interest. Derham started working as a nurse and purchased his freedom by 1783. Derham went on to practice medicine and specialized in throat disorders.

These are just a few male nurses who have had a significant impact on nursing. There are many more, such as Walt Whitman, who is better known as a poet but actually served as a nurse during the American Civil War. Edward L.T. Lyon was the first male nurse to join the U.S. Army on October 6, 1955. Prior to that, the U.S. military stood firm on their objection to men in military nursing roles.

Unfortunately, everything for men in nursing was not perfect. During the Byzantine Empire, a group of male nurses known as the Nosocomi spread infection to all their patients. The term nosocomial infection began.

Florence Nightingale also played a significant role in male nursing. Her vision of nursing was to be practiced by women only. She is actually quoted as saying, "Patient care must be removed from the hands of men." As Nightingale's passion for nursing grew, so did her influence. Men were not allowed into her schools and were highly discouraged from nursing altogether. Men in nursing began to drop precipitously and were down to 1% of the total workforce by 1930.

In 1971, the American Assembly of Men in Nursing was founded. The purpose of the AAMN is to provide a framework for nurses to meet, discuss, and influence factors which affect men.

Todd Milliron RN, Senior Clinical Nurse I
University of Maryland Medical Center
Marlene and Stewart Greenebaum Cancer Center

As recent as 1979, men have faced discrimination while trying to enter the profession of nursing. Joe Hogan applied to the Mississippi University for Women and was denied admission to their nursing program based solely upon his gender. Hogan sued MUW and his case went to the Supreme Court, where Sandra Day O'Connor wrote the landmark opinion that MUW's single sex admission policy violated the Fourteenth Amendment. Due to this decision, no publicly funded nursing programs could exclude men from their programs.

Looking at the history of men in nursing will hopefully enable us to see better into the future of nursing. Men share an important role with women in caring for patients but account for only 7% of the total workforce. Hopefully articles such as this, as well as the many others that exist, will reinvigorate men to enter the profession of nursing as they once did hundreds of years ago.

Presenting this information at nursing grand rounds, as well as writing this article, has inspired me to do more as a man in nursing. I have joined the AAMN and have already connected with other men in nursing outside of UMMC. I would also like to start a "Men in Nursing" focused committee here at UMMC that looks at ways to promote men becoming nurses. Please understand, this would not be a male only committee. We would need insight from women as well. I am not looking to separate men from women, but simply want to create a way to reach out to the community to help empower men to become nurses. I have personally always had a passion to help others and satisfy that passion by being a nurse.

How Can We Help Our Patients Quit Smoking?

By: Dale Rose, RN, MSN, Director of Ambulatory Nursing

A 34 year old woman comes into the clinic for a physical. In your initial assessment, you find out that she is a smoker. She is interested in quitting, and has tried to quit, but was unsuccessful in previous attempts. How can you help this patient?

Many people feel that quitting smoking is the hardest thing they've ever done. Helping patients quit has significant immediate and long-term health benefits. Patients start healing very quickly after quitting. Almost immediately, they will breathe easier and cough less. Soon they will feel more energetic, physically fit, and be able to concentrate better. Their family and friends will no longer be exposed to the health risks of second hand smoke. In the long term, patients will lower their risk of cancer, heart attack, stroke, emphysema, chronic bronchitis, and cataracts. Women of childbearing age will reduce their risk of fertility problems, premature births, and lower birth weight babies. Patients may even have whiter teeth and healthier gums after they quit!

Nearly one in five people in Maryland still smoke. Many patients are assessed for smoking, but less receive advice to quit. In Ambulatory Services, this was a quality improvement focus for the last year. We measured screening rates and advice to quit given through monthly chart audits of assessment forms, initial visit notes and most recent visit notes. We worked with Anne Williams, MS, RN in the Patient Resource Center to develop patient education materials to give to patients. As a result of this quality improvement project, screening rates increased from 34% to 95% of patients, and advice given increased from 49% to 73%. Advice given continues to be a focus for further improvement. This is important for all of our patients.

Here are some main points to remember when helping patients quit:

The Five A's of behavioral counseling for smoking are:

1. **Ask** about tobacco use
2. **Advise** to quit with clear, personalized messages
3. **Assess** the person's willingness to quit
4. **Assist** to quit
5. **Arrange** follow-up and support

We know that simple messages are best, and that it often takes repeated advice from multiple providers to help patients quit. Patients are often not successful in quitting the first time they try, and it helps if nurses and other providers follow-up and encourage them to keep trying to quit. In addition, there are some tips to consider in helping them be successful in quitting:

- When a patient is ready to quit, find out if other members of the household smoke. When other people living with the patient smoke, especially a spouse or significant other, the patient is less likely to be successful in quitting. One strategy to consider is having them quit together to increase their likelihood of success.
- Patients will find it easier to quit if they realize when they are most likely to smoke and find other ways of dealing with that situation.
- Getting rid of things that remind the person of smoking is helpful. This means throwing away all tobacco supplies, including cigarettes, lighters, matches, and ash trays.
- Eliminating smoking odors by cleaning curtains, carpets, clothes, and the car also removes the reminders of smoking.
- Many people associate drinking alcohol with smoking, so substituting nonalcoholic drinks may also help.
- Other tips for avoiding triggers includes keeping hands busy by writing, holding a pen or a coin, putting something in their mouths such as a sugar free gum, keeping busy by reading or another hobby, and going places where smoking is not allowed, such as a library or nonsmoking restaurant. It helps to know that cravings usually only last a few minutes, so these activities can help the patient get past the cravings.
- Medications, such as nicotine replacement therapy, Chantrix, Zyban, or Wellbutrin may be prescribed by a physician or nurse practitioner to assist the patient in quitting.

Smoking cessation classes are available for patients through the Patient Resource Center. The classes are on Tuesday evenings weekly for 8 week sessions. For more information and scheduling, please call ext. 8-9355. In addition, the Patient Resource Center has information on other available classes around the state, and a smoking cessation video is available on video-on-demand (channel #156).

Most importantly, ask patients if they smoke during every clinic visit or hospitalization. If they do smoke, use a clear, strong, personalized message, such as "Quitting smoking is the most important thing you can do to protect your health."

UMMC Nurses in Haiti

By: Anne Naunton, MS, RN, CPPD

On January 12, 2010 at 4:53 p.m., an earthquake with a magnitude of 7.0 struck Porte-au-Prince, Haiti. This catastrophic event caused massive destruction and a death toll that reportedly exceeded 250,000 people. Haiti is about the size of the state of Maryland, with a population of over nine million people. It is the poorest country in the western hemisphere, and eighty percent of Haitians live below the poverty level.

Remains of a nursing unit.

In response to this tragedy, the University of Maryland Medical Center with the Shock Trauma Center, implemented a sustained program to save lives and alleviate suffering among the survivors of the disastrous earthquake in Haiti. This initiative complemented the Medical Center's mission to provide excellent, state-of-the-art care for the people of Maryland and beyond.

The largest hospital in Port-au-Prince, St. Francois de Sales hospital, was 70 percent destroyed by the earthquake. On January 28, 2010, the first Medical Center team was deployed to Haiti, just 17 days after the earthquake. This team, as well as those that followed, worked in the remains of that hospital, along with Haitian doctors and nurses who survived the disaster.

It is difficult to fathom the personal, physical, and professional sacrifices that individuals make when committing to a mission of this proportion as representatives of UMMC. It also goes without saying that the entire UMMC community is grateful and proud of our colleagues that embarked on this journey and provided care and comfort to the Haitians that withstood this enormous tragedy. Here are a few reflections from Medical Center nurses about their experience in Haiti.

Tom Crusse

"The Haiti mission was a life changing mission. I met wonderful Haitians who were resilient in the face of what appeared as chaos and destruction all around them. I met Haitian nursing and medical students who were willing to help and eager to learn from us and give us their perspective on patient care. The team from UMMC was great and made the mission the success it was. I will always remember the fascinating aid workers I met form around the world, the school that served as my home for two weeks, AppleJack the kitten that lived at the school, and, of course, the resilient people I met in Haiti who inspire me to not worry so much at what I don't have but appreciate all I have".

Tom Crusse RN,BSN,CEN, SCN II, Adult ED

One UMMC Team

"As an administrator and a nurse, there was no question that this was "the right thing to do". But, sending a team to Haiti, during the initial phase of the disaster was more than frightening. I was afraid because of uncertainties - the fear of the unknown. I was the person that stayed home to be the connection to the industrial world, and this was an awesome responsibility. I wanted so desperately to make sure my team had everything they needed to be safe. I remain impressed with the team's humanitarian courage. The joy and satisfaction of participating in this relief effort is worth more than all of the energy and effort that was put into this initiative. On a weekly basis, I continue to receive thank you notes from people in our institution and all over the country for allowing them to be part of the team. Can you imagine - them thanking me. My heartfelt thanks goes to each and every individual that participated in this effort - both in Haiti and at home. A special thank you goes to our Senior Leadership for allowing us to make this happen. And, I can't forget our friends and colleagues in the Dept. of Human Virology at the SOM and Catholic Relief Services".

Karen Doyle, MBA, MS, RN, CNAA-BC
Vice President of Operations & Nursing in STC

Linda Goetz (far right)

"I was a member of the 1st team that deployed to Haiti just 17 days after the earthquake. I have never participated on a medical mission and had no idea of what I was about to encounter, especially after such a disaster. The city of Port-au-Prince was devastated. Almost every building had collapsed. People were homeless and living outside. It felt like I was in a bad dream.

The work kept us focused and very busy. We spent a lot of time organizing supplies, setting up ORs and a PACU. We collaborated with the surgeons to organize an OR schedule to get things moving. Being a nurse anesthetist, my job was to provide anesthesia care. The teamwork was incredible; everyone helped in any way possible. There was no down time; everyone kept moving all day.

This was an incredible and rewarding experience. The Haitians were very gracious and welcoming of our care. It was truly an honor to care for them in their greatest hour of need. I would definitely do it again".

Linda Goetz, MHS, CRNA
Director, Nurse Anesthetists

"My time in Haiti was one of the most rewarding experiences I have ever had. Each day we would go to the hospital and there would be anywhere from 30-60 people waiting for our help. They were always patient, never demanding and never complaining about having to wait to be seen. They didn't seem to mind that we didn't speak their language.

The devastation

We treated a variety of wounds and illnesses in our primitive outpatient clinic. We used index cards to record their medication and wound management, and would have them bring them back on each visit to provide consistency of care. If they needed medications we counted out pills and put them in a Ziploc baggy, and with the help of our interpreters, we wrote instructions in Creole on how to take the medications. The people were always kind and thankful for whatever care they received, even if it was only a band-aid they needed.

The Haitian medical staff and ancillary staff were always available and willing to help with whatever we needed. Even with the language barrier, we were able to reach out to each other and work well together. They taught us a few helpful Creole words for taking care of patients, such as how to say pain and relax. They were always around to help us with interpretation. We helped them care for patients, and they taught us the value of helping people in need that had no means to repay us.

We became known to the Haitians as the "people in pink", and that we would help them even if they didn't have money. The Haitian people were thankful for our help, our support, and our willingness to show up every day. We were thankful for the chance to make a difference for them after such a tragedy".

Patti Jones, BSN, RN, CCRN, SICU Charge Nurse and Staff Nurse

Cindy Swanson, CRNA in the operating room

Collapsed building behind the hospital

Heather Martin

"The end of February, 2010, I was fortunate enough to be a part of one of the many teams from University of Maryland to go to Haiti for the relief effort. During my two weeks there, I functioned as the Triage Nurse. Two RNs in Triage would see and treat up to sixty patients (74 one day) each day. My first week was working with June from the TRU in STC. My second week was with Karen from UMMC's ED. They were remarkable to work with. Each day we would comment on the growing numbers of people we were seeing.

At that point, we were seeing people who were following up with injuries from the earthquake and people getting on with their lives that needed care for pre-existing conditions and life's everyday issues. The most amazing part was their spirit. Every single person we met and treated had been through unspeakable chaos and tragedy. But they met you with a smile, a hug, a warm welcome, and never got angry for having to wait (sometimes all day) to see you. Triage saw many patients several times for follow up care, and they became old friends. Many would stop by on their way to the waiting area to hug you or chat for a minute. If you had an empy spot in your heart any morning, it was filled by noon! Their spirit and determination were inspiring, and I often wondered how I would weather the same situation. There is no way to imagine it.

Before arriving in Haiti, I had heard the news and seen the pictures. Somehow, I knew I was still not prepared for what I was about to experience. The absolute devastation throughout the city, the tent cities, and the collapsed hospital still took my breath away. Then to meet the survivors was heart wrenching. So many of them homeless, living in tents with no running water or effective waste management, orphans caring for themselves, people with no money for food. As an American nurse used to having a social worker with a huge bag of resources just a phone call away, I was lost to help much past my medical skills. It never felt like enough. So, to watch your patients walk away each day to a life that I still can't begin to imagine was very painful.

There were good times, too. The people I joined from the hospital will hold a fond place in my heart, many new friends to be enjoyed for a lifetime. The work they did was extraordinary, much like themselves. One of our drivers took us to the market to buy paintings and other artwork one evening. Discovering the art in Haiti was exciting. My second week there was with an anesthesiologist that has collected Haitian art for the last two decades. There were very happy to see her at market!

It is all burned into my memory, the faces, the sounds, the smells, the wreckage, the friends left behind when we came home. There is still so much to be done to clean up, to rebuild, to heal. Haiti was a country in need before the earthquake. Now it is crucial to keep them in our minds and send help, even for the ordinary little things. I will forever be grateful for the opportunity to have been there".

Heather Martin, RN, CCRN, SCNI, Clinical Educator for Medical ICU

Certification Corner

Orthopaedic Certification

By: Pauline Esoga, RN, ONC, CRNMS, SCNII and Felicia Orakwue, RN, ONC, Gudelsky 6 Orthopaedics

Orthopaedic nursing is a unique specialty which needs exploration by RNs. As the general population ages and requires more health-care services, the need for certified nurses trained in orthopaedics grows. In addition, having a nursing certification in a specialty area is highly desireable in the 21st century. Therefore, RNs should think of staying ahead in their careers by earning an Orthopaedic Nurse Certification (ONC). Nurses with an ONC can work in the ER, Shock Trauma, Orthopaedic units, rehabilitation, or long term facilities.

The ONC examination is accredited by the American Board of Nursing Specialties (ABNS). The test content areas include: degenerative disease 30%, orthopaedic trauma 21%, neuromuscular/pediatrics/congenital 8%, inflammatory disorders 8%, operative orthopaedics 8%, metabolic bone disease 7%, orthopaedic oncology 3%, and sports injuries 15%. The Registered Nurse must meet the following qualifications to be eligible to take the examination:

- Current and unrestricted US nursing license
- Minimum of 1,000 hours of work experience on an orthopaedic unit or practice within the past three years

The examination fee for the members of the National Association of Orthopaedic Nurses is $275.00, and the non member fee is $390.00. Information regarding membership can be found on their website www.orthonurse.org.

Certifications

Congratulations to the following Clinical Nurse Specialists who recently received their Board Certification as Clinical Nurse Specialist:

Shock Trauma Center

Gena Stiver Stanek, MS, RN, CNS-BC

Karen McQuillan, MS, RN, CCRN, CNRN, CNS-BC

Kathryn VonRueden, MS, RN, FCCM, CNS-BC

Women's & Children's Services

Mary McCaffrey, MSN, RNC-OB, CNS-BC

Living Excellence

City Uprising Event

By: David McAllister, RN, Nurse Manager, 11 East

Baltimore is facing a health crisis. HIV/AIDS is the fourth leading cause of death in Baltimore according to the Bureau of Vital Statistics. How do you test for HIV in a non-threatening atmosphere and link people to care so we can change that statistic? This is done with community partners, clinics, such as The Jacques Initiative and UM School of Medicine, along with inpatient partners like 11 East at UMMC.

Just recently, Baltimore hosted the City Uprising Event. The purpose of the event was to provide a warm and inviting atmosphere in multiple locations throughout Baltimore City to those possibly infected with HIV and those affected by AIDS. The inpatient unit, 11 East, sent 43 people consisting of student nurse residents medical students, direct care RNs, PCTs, as well clinical students doing senior clinical practicums from JHU and UMSON.

Eleven East staff provided safe sex education and HIV testing services. This was an excellent opportunity to teach basic HIV education to many in one day. Our partners from Gallery Church lined up 12 churches as testing sites. The Jacques Initiative led the effort to bring volunteers, testers, and peer counselors in partnership with the Maryland state mobile units to test a total of 2000 citizens and link them to care.

A total of 48 people were found to be positive and 8 were found to be newly positive. This event provided a means to quickly connect and reconnect many people that need the combined services for treatment and support. It also provided the Baltimore community with another example of how 11 East and UMMC stand by it's mantra - "We Care".

Aiming for the Top Decile: The Concurrent Review Approach

By: Crystal Evans BSN, RN, Senior Core Measure Coordinator

Why concurrent review?

One of the known barriers to improving Joint Commission core measure compliance is untimely data. Core measure cases are identified after discharge and reviewed retrospectively. Any opportunities for improvements are often identified months down the road resulting in non-compliant cases and delayed action plans. Nationally, many hospitals are facing this same dilemma. In reviewing best practice standards, we find that hospitals listed among the top 10% are hospitals that (1) have instituted the concurrent review approach in identifying opportunities for improvement, and (2) are taking action while the patients are still in the hospital. This approach has now been initiated at University of Maryland Medical Center, and the priority is to reach the top decile in all core measures by 2011.

In October of 2009, we started the concurrent review process, monitoring the vaccination compliance. This process was linked to establishing Powerchart vaccination assessment documentation standards, as well as providing each unit with a daily list of patients that required vaccination on the current admission.

What was the initial process for concurrent review?

The focus was on those patients with a diagnosis of Pneumonia, Sepsis, Respiratory Failure, or Respiratory Abnormality. All units were included with the exception of the Intensive Care units, Pediatrics, Psychiatry, and OB-GYN. If the patient met criteria based on the assessment in Powerchart and the vaccination was not given or the assessment was not completed, the unit was visited by the Senior Core Measure Coordinator. The staff was reminded to administer the vaccine or complete assessment documentation in Powerchart. Any barriers to compliance were addressed at that time. Any information or suggestions received from staff about making the process easier or more efficient was shared with those that could address the concerns. At the end of every week, a report was sent to all Nurse Managers and later included Nursing Directors and the Chief Nursing Officer regarding areas of compliance and non-compliance.

What did we learn?

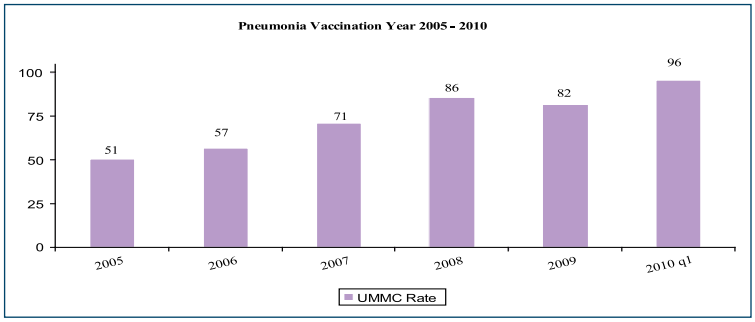
The ability to speak with the nurses regarding this process concurrently was extremely valuable for the following reasons:

- Some nurses believed that the vaccinations should be given on discharge. However, waiting until discharge often results in the patient not receiving the vaccine. Vaccinations should be administered after the assessment is completed.
- Some nurses felt patients were too sick to receive the vaccination. Patients that meet criteria for vaccination should be vaccinated or these patients will fail the measure. Concerns can be discussed with the physicians.
- Some were concerned about not knowing if the patient had previously received the vaccine and the effects on the patient if the vaccination was repeated. If the patient does not have written documentation of being previously vaccinated, the CDC recommends vaccinating the patient.
- One of the most frequent concerns by nurses was administering vaccinations to patients that could not consent. At the University of Maryland Medical Center, consent is not required to administer vaccinations.

Did vaccination compliance improve using the concurrent review approach?

When we started concurrent vaccination review, the rate for Pneumococcal vaccinations had declined significantly in both 1st and 2nd quarter of 2009. In the first quarter of 2010, the data showed a significant increase in compliance with vaccinations.

Concurrent review allows many issues to be identified and addressed while the patients are still in the hospital. We were able to speak to the staff and ascertain system and non-system issues. In some cases immediate resolution was accomplished such as IT fixes and re-education.

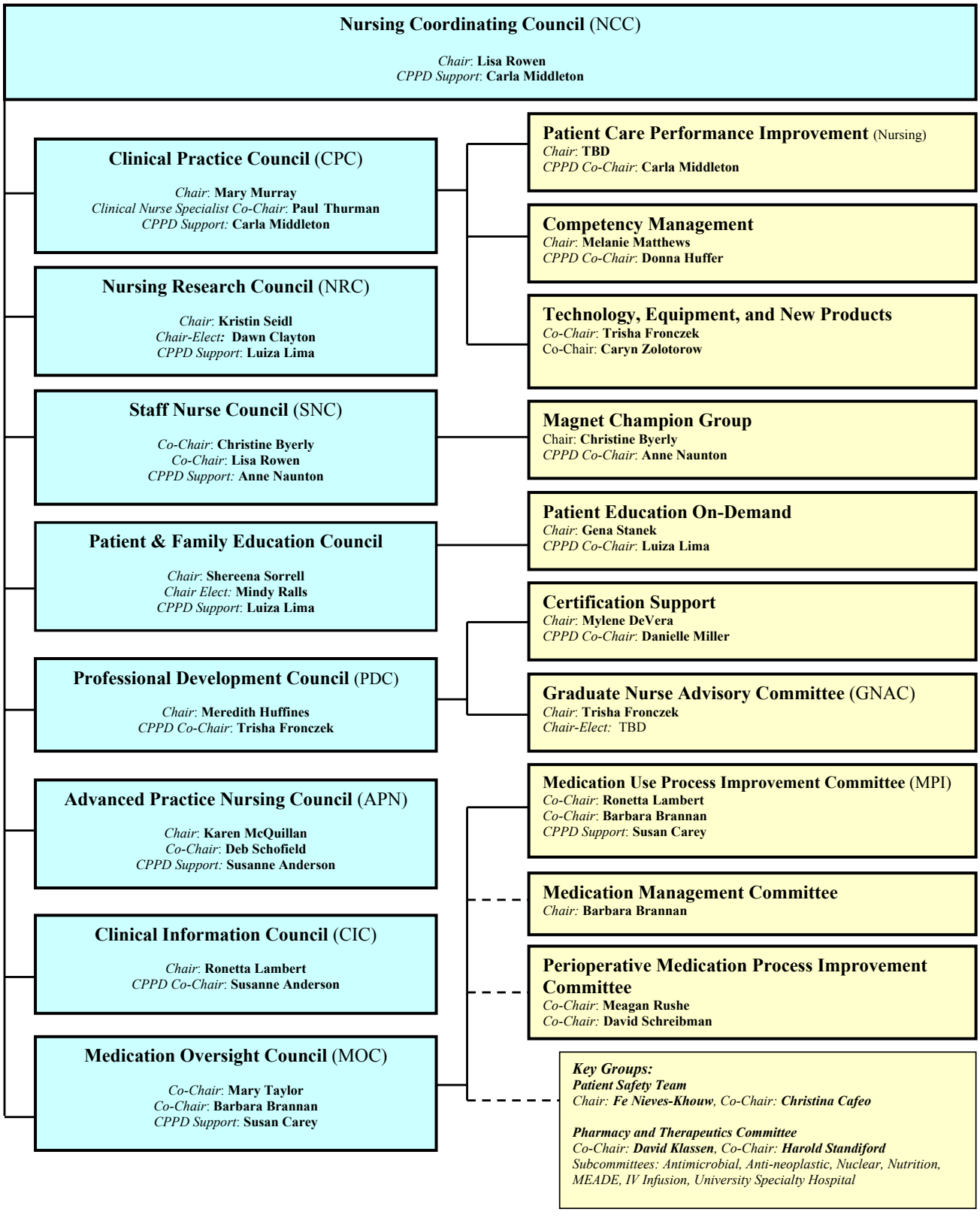


Today concurrent reviews are being done in every core measure set, and we acknowledge all staff for their willingness and cooperation. The goal is to identify opportunities for improvement as early as possible, and facilitate the actions necessary to become a hospital that has reached the top decile. For more information concerning the core measure sets, please contact the following:

- Sylvia Daniels, BSN, RN, Manager, Regulatory Compliance & Outcomes ext. 8-3269
  Surgical Care Improvement Project Reviewer
- Crystal Evans, BSN, RN, Senior Core Measure Coordinator ext. 8-3044
  Heart Failure/Acute Myocardial Infarction Reviewer
- Anna Marie Moko, MSN, RN, Quality Measure Coordinator ext. 8-3840
  Hospital Based Inpatient Psychiatric Services/ Asthma Reviewer
- Patricia Dumler, BSN, RN, Quality Measure Coordinator ext. 8-3762
  Pneumonia Reviewer

Nursing and PCS Governance Councils

Structure for FY'11



Summary of Work Accomplished FY'10

A professional practice environment is supported at the Medical Center by nursing involvement in decision-making processes related to clinical, professional practice, and patient care matters. This is accomplished through the membership of nurses at all levels on governance councils within the Department of Nursing and PCS, with oversight by the Nursing Coordinating Council (NCC).

The membership of the governance councils is interdisciplinary. Direct-care nurses represent all areas where nursing is practiced encompass the majority on all councils, with one exception. The Advanced Practice Nurse Council (APNC) is composed of nurses within this provider category.

The Office of Clinical Practice and Professional Development (CPPD) provides staff support to all councils. All nursing and PCS councils generate a quarterly report that is presented to the NCC. This mechanism links and coordinates nursing and PCS governance initiatives with the UMMC Annual Operating Plan and the Nursing Strategic Plan.

This is a report of the work accomplished by the Department of Nursing and PCS Governance councils for FY'10.

Clinical Practice Council

1. Standardized the process for independent double-check of high risk/high alert medications.
2. Implemented a new policy regarding the management of hazardous medications and waste.
3. Revised clinical practice standards: Seizure Management, Tracheostomy Decannulation, Defibrillation by Nursing in ICUs and IMCs, Oral Care, Equipment Checklist, Standards Development, Therapeutic Specialty Beds, ETT Care, IV Infusion Pump, and Documentation of Patient Care Handoff.
4. Implemented Infection Control practice changes related to signage and the use of personal protective equipment.
5. Evaluated and implemented equipment and/or product changes (e.g. nitrile gloves, feeding pumps, underpads, antibiotic coated central line catheters, disposable wound pump, electrodes, reprocessing of BP cuffs, pulse oximeters, pressure bags, and venodynes, etc).

Staff Nurse Council

1. Discussed actual clinical situations that involved components of and threats to patient safety.
2. Conducted process improvement projects related to missing doses of medications, missing or delayed results for laboratory results, and the Alaris pump.
3. Disseminated best practices related to building a culture of safety, personal protective equipment, and critical thinking huddles.
4. Planned nurses' week activities.
5. Provided feedback on a range of topics such as professional advancement model, work force relations, behavioral standards, professional dress code, environmental sustainability, and numerous clinical examples (e.g. vaccine administration, blood product transfusion, isolation signage, etc).
6. Partnered with UMMC leaders to improve operational support services (e.g. Environmental Services, SOSC Customer Care, medication delivery, H1N1 visitation, and TJC compliance).

Patient and Family Education Council

1. Revised electronic patient & family education tools and improved documentation of patient & family education related to medication, safety and prevention, diagnosis and treatment, and tests and procedures.
2. Implemented Education-On-Demand patient & family education system hospital wide and created a standardized process for adding videos.
3. Redesigned the Patient & Family Education website page to improve access.
4. Revised 48 unit/population specific patient family education handouts and added 41 new handouts to the intranet.
5. Collaborated with IT to develop and deploy the patient education component of the depart process ensuring that all patient education material available via the intranet are accessible via the depart process.

Medication Oversight Council

1. Created a new multidisciplinary council that is co-led by nursing and pharmacy leadership. Council membership includes representatives from nursing, physicians, pharmacy, quality and safety, and information technology.
2. Identified all groups addressing medication related issues (e.g. Medication Process Improvement (MPT), Medication Management, Critical Care Operations, Medication Error and Adverse Drug Events (MEADE), Pharmacy/IT, Perioperative Services MPI), developed inventory of current projects, and implemented tracking process to prevent duplication and monitor progress.
3. Identified issues related to medication management practice and charged appropriate group to address issue (e.g. labeling of refrigerated medications, hazardous medications disposal, etc).
4. Approved the plan for conversion to metric units of measure for all documentation that will be implemented in FY11.
5. Identified subgroups/committees to address specific medication management issues as they arise.

Professional Development Council

1. Initiated evidence-based practice (EBP) project on peer review; review of evidence complete.
2. Increased percentage of direct care nurses with specialty certification from 25% to30% and promoted the importance of certification (e.g. summits, Certified Nurses Day, etc).
3. Collaborated with the Clinical Practice Council to support education and training related to practice and process changes such as The Rapid Response Process Learning Kit.
4. Received approval by MNA as a provider of continuing education.

Clinical Information Council

1. Established new council to improve electronic and manual documentation processes that enhance the patient care delivery process and provider workflow.
2. Participated in the design and roll out of an electronic patient flow sheet pilot (IView) displaying I/Os, VS, and medical device parameters data.
3. Revised and implemented changes to the Patient Summary Page, Suspend/Resume function, Enhanced Clinical Documentation functions, Home Medication List, Regulatory Bundle, Nursing Dashboard, and eMAR.
4. Evaluated compliance with order management standards, identified gaps, and implemented remediation plan to optimize nursing's role in order management.
5. Early design of electronic patient hand off form complete.

Nursing Research Council

1. Offered Evidence Based Practice Workshops - Three 8-hour workshops were offered; 93 nurses participated, including members from all of the governance councils, division directors, managers, clinicians, and CPPD staff. Evaluations were all favorable and noted that the "hands-on" experience was very valuable.
2. Offered Research Education - "We Discover" Series - 9 different workshops concluded in 2010.
3. Revised Nursing Research page on the UMM Intranet.
4. Implemented Nursing Grand Rounds videos on the Intranet and HealthStream, so staff can watch on their own time.
5. Research study status as of FY10:
   - 7 studies complete, all at various stages of dissemination;
   - 4 studies funded by UMNursing in progress;
   - 5 studies received external funding; and
   - 2 studies without external funding in progress;

Advanced Practice Nursing Council

Read about the Advanced Practice Nursing Council in the next issue of News and Views.

UMMC Nurses Oral and Poster Presentations

During FY'10, UMMC nurses participated in a total of 58 oral and poster presentations. There were 20 poster presentations (14 national and 6 regional), and 70% were at national meetings. There were 38 oral presentations (22 national, 13 regional, and 3 international), and 66% were at national or international meetings. The details of the scholarly work for the last quarter of FY'10 (April – June) are summarized in the table below. This list does not include presentations inside the Univ. of MD Medical Center.

The information about UMMC standards for publication and presentations can be located on the UMM intranet under Nursing Research & EBP.

Kathryn Von Rueden, MS, RN, FCCM
- Sepsis: Pathophysiology and Use of Sepsis Bundle/Protocols – *Oral* - SePA AACN Trends in Trauma/Critical Care Nursing, Atlantic City, April 2010
- Evidence-based Practice: Killing the Sacred Cows Part IV - *Oral* - AACN National Teaching Institute, Wash., DC, May 2010
- Agitation: Delirium? Both? And What to Do About it - *Oral* - AACN National Teaching Institute, Wash., DC, May 2010

David Wong, RN, CPAN; Donna Audia, RN; Trisha Klein, RN, ATCN; Sherry Baltz, RN; & Karen McQuillan, MS, RN, CCRN, CNRN
- Perioperative Integrative Nursing Therapy Program – *Poster* - America Society of PeriAnesthesia Nurses, April 2010

Michelle Carter, RN & Gladys Fields, BSN, RN
- The Healing Garden Waiting Area: A Comprehensive Visitation Program for Families During the Phase I Level of Care – *Oral* -America Society of PeriAnesthesia Nurses, April 2010

Deb Schofield, DNP, CRNP; Karen Johnson, PhD, RN; Carmel McComiskey, MS, CRNP; Patricia Morton, PhD, RN, CRNP, FAAN; Erin DeSalvo, MS, CRNP; Carolyn Ramos, MS, CRNP; & Cynthia Salmond, MS, CRNP
- Meeting the Challenges of the 21st Century: An internet-based Module Series on Evidence-based Practice for Advanced Practice Nurses – *Poster* - Nursing Practice Based on Evidence: Quality Care at Risk, Baltimore, April 2010

Carmel McComiskey, MS, CRNP; Erom DeSalvo, MS, CRNP; & Kristin Seidl, PhD, RN
- Improving the Process of Care in the Emergency Department - *Poster* - Nursing Practice Based on Evidence: Quality Care at Risk, Baltimore, April 2010

Lisa Rowen, DNSc, RN, FAAN
- Transformational Leadership - *Oral* - Nursing Practice Based on Evidence: Quality Care at Risk, Baltimore, April 2010
- Quality and Safety – *Oral* - Northeastern University, Boston, MA, June 2010

Karen Kaiser, PhD, RN, RN-BC, AOCN®, CHPN; Meagan Rushe, PharmD; Trisha Fronczek, MS, RN-C, CCRN; & Michele Bennett, BSN, RN
- Ensuring Safe, Evidence-based Medication Processes for Disposable Elastomeric Pain Pumps – *Poster* - Nursing Practice Based on Evidence: Quality Care at Risk, Baltimore, April 2010

Lena Stevens, MS, RN; Eun Shim-Nahm, PhD, RN, FAAN; Pam Scott, MS, RN; & Kristy Gorman, MS, RN
- A Web-based Preoperative Educational Program for Patients who Undergo Ambulatory Surgery – *Poster* - Nursing Practice Based on Evidence: Quality Care at Risk, Baltimore, April 2010

Linda Byrne, BSN, RN; Jane Aumick, RN, CCRN; Lynn Armstrong, BSN, RN; Karen McQuillan, MS, RN, CCRN, CNRN; & Deb Stein, MD, MPH, FACS
- Improved Patient/Family Satisfaction After Implementation of Family Rounds – *Poster* - Nursing Practice Based on Evidence: Quality Care at Risk, Baltimore, April 2010

Trish Klein, RN, ATCN
- Development of an Algorithmic Approach to Trauma Patients' Pain in the PACU – *Poster* - Society of Trauma Nurses, April 2010

David Wong, RN, CPAN; Donna Audia, RN; Trisha Klein, RN, ATCN; Sherry Baltz, RN; & Karen McQuillan, MS, RN, CCRN, CNRN
- Perioperative Integrative Nursing Therapy Program – *Poster* - American Society of Perianesthesia Nursing, April 2010

Denise Choiniere, MS, RN & Barb Sattler, DRPH, RN, FAAN-FCH
- Nurses Leading Change – *Oral* - CleanMed 2010, Baltimore, May 2010

Christina Goatee, MS, RN
- Pandemic Staffing Pilot - *Poster* - AACN National Teaching Institute, Wash., DC, May 2010

Suzanne Sherwood, MS, RN; Lynn Gerber Smith, MS, RN; Paul Thurman, MS, RN, ACNP, CCRN, CNRN; & Karen McQuillan, MS, RN, CCRN, CNRN
- Trauma Cycle: From Resuscitation to Rehabilitation – *Oral* – AACN National Teaching Institute, Wash., DC, May 2010

Karen Johnson, PhD, RN
- Act with Intention! Using Evidence-based Practice to Optimize Patient Outcomes – *Oral* – AACN National Teaching Institute, Wash., DC, May 2010

Karen McQuillan, MS, RN, CCRN, CNRN
- Acute Cervical or Upper Thoracic Spinal Cord Injury – *Oral*
- Saving Injured Brain Cells: Current Management of Severe Traumatic Brain Injury – *Oral*

Both presented at the AACN National Teaching Institute, Wash., DC, May 2010.

Suzanne Sherwood, MS, RN
- Trauma and the Substance Abuse Patient: A Deadly Combination – *Oral* - AACN National Teaching Institute, Wash., DC, May 2010

Lynn Gerber Smith, MS, RN & Timothy Smith, BSN, RN
- Relaxation Using Self-Hypnosis: Learn to Decrease Your Stress – *Oral* - AACN National Teaching Institute, Wash., DC, May 2010

Barbara Miller, MS, CRNP; Deb Schofield, DNP, CRNP; & Carolyn Ramos, MS, CRNP
- Nurse Practitioners in the Surgical IMC: A Leadership Model for Implementation – *Oral* - National Conference for Nurse Practitioners, Chicago, IL, May 2010

Shari Simone, MS, RN, CPNP-AC, FCCM & Jamie Tumulty, MS, CPNP-AC, CRNP
- Current Trends in Pediatric Ventilation – *Oral* - AACN National Teaching Institute, Wash., DC, May 2010

Shari Simone, MS, RN, CPNP-AC, FCCM & Judith Ascenzi, RN
- Name that Shock: Case Studies in Pediatric Critical Care – *Oral* - AACN National Teaching Institute, Wash., DC, May 2010

Paul Thurman, MS, RN, ACNP, CCRN, CNRN
- Continuous Renal Replacement Therapy 101: Tricks for the Advanced Practice Nurse – *Oral* - AACN National Teaching Institute, Washington DC, May 2010

Mary Ann Bautista, BSN, RN, CNRN; Brigid Blaber, , MS, RN; & Sheree Chase-Carter, MS, RN, MBA
- Using Simulation to Train Neuro ICU Staff Nurses How to Respond to Inadvertent Tracheostomy Decannulation - *Poster*

Excellence in Teaching in Nursing, Baltimore, May 2010

Theresa Johnston, BSN, RN, OCN
- Journal to Chemotherapy – *Oral* - ONS Congress, San Diego, May 2010

Donna Huffer, MA, BSN, RN, OCN
- Bone Marrow Transplant Nurses Complete "Boot Camp" – *Poster* - ONS Congress, San Diego, May 2010

Mary Rudder, RN, OCN & GCC PI Council
- Beating the Clock to Attain the Golden Hour in Febrile Neutropenia – *Oral* - ONS Congress, San Diego, May 2010

Denise Choiniere, MS, RN
- Working the Green Shift - *Oral* - Alliance for Nurses for Healthy Environment - University of MD, June 2010
- Working the Green Shift - *Oral* - UNC/Duke, June 2010

Mary McCaffrey, MSN, RNC-OB
- Influenza A – ARDS, ECMO and Miracles – *Oral* - AWHONN, Nashville, TN, June 2010

Brigid Blaber, MS, RN & Mary Ann Bautista, BSN, RN, CNRN
- Cultivating Exceptional Preceptors for All Generations – *Poster* - Mid-Atlantic Nursing Leadership Conference, June 2010

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Clinical Practice Updates

What's On Deck

Clinical Practice and Compliance…
Safe, Quality Care

Catheter Associated Urinary Tract Infection (CAUTI) Prevention

- **Beginning in September**, nurses will be visiting clinical areas with a roaming CAUTI Prevention cart that will have information about foley removal guidelines and a manikin that will be used to show proper foley insertion and maintenance.
- Looking for volunteers, please contact Cynthia Bauer, cbauer@umm.edu

Practice Guidelines for Drug-Food Interaction Education

- An attachment is being added to the hospital policy EDU-001 Patient Education about Food- Drug interaction patient/family education.
- Education sheets will be available at the following website: http://intra.umm.edu/ummc/patient_ed/food.htm or under Nursing, Patient & Family Education, and Food-Drug Interaction Guides on the Intranet beginning **mid-September**.
- Pharmacy Services will flag the selected medications and provide a notation on the electronic Medication Administration Record (eMAR).
- The drug-food interaction alert will also appear on the initial label for the first dose of the medication dispensed by the pharmacy to the unit.

PowerChart / FirstNet

- Look for enhancements to Medication Request function and Perioperative Checklist

October 19th – UMMC is going Metric!

- We will exclusively use centimeters, kilograms and celsius for height, weight and temperature charting. This consistency and standardization will improve patient safety.
- **Training** courses will will be offered through the beginning of October. Registration is managed through Healthstream.

For more information about topics in this What's On Deck, contact Carla Middleton at cmiddleton@umm.edu.