In the recent Joint Commission mock surveys (internal and consultant), during unit rounding, and through feedback from direct care nurses, we have identified significant issues related to registered nurses practicing outside of the scope of nursing practice. A task force, led by Paul Thurman, MS, RN, ACNPC, CCNS, CCRN, CNRN, facilitator of the Clinical Practice Committee, has been developed that consists of representation from the various nursing governance councils. This task force has examined the problem in depth and has made recommendations to the Nursing Coordinating Council. You will receive further information about this in the near future. The purpose of this article is to improve your knowledge of the scope of nursing practice so that you can take immediate corrective actions to eliminate the practices that have been recognized as out of scope.

Let’s start with the following scenarios. Have you ever?

1. Initiated care because it is “the standard of practice and the right thing to do” but did not have a written order from an LIP (Licensed Independent Prescriber);
2. Inserted or discontinued urinary catheters, continuous IVF, feeding tubes, or monitoring devices without a written order after a verbal conversation with a provider;
3. Taken verbal orders on night shift because a physician was not available to place the actual order in the computer;
4. Been instructed verbally on physician rounds to initiate care (adjust IVF rates, increase or decrease infusions of IV medications, obtain blood for labs, etc.). You did so, believing the LIP would write the order, but hours passed and there was a delay in writing the order or it was never written at all; or
5. Taken a verbal order because the physician does not have a password.

When nurses pass their licensing examination, they are issued a license to practice by the Maryland Board of Nursing (also known as the “Board”). It is expected that registered nurses know, and adhere to, the statutes and regulations applicable to their practice. The failure to do so may lead to claims of medical malpractice and, more importantly, to the loss of a license.

The Maryland State Board of Nursing (www.mbon.org) is responsible for setting the standards and adopting the rules for nursing practice. The standards and rules are to protect the public from unqualified persons practicing in the profession. Remember, nursing is a professional practice that is not a right, but a privilege.

The Maryland Nurse Practice Act (www.state.md.us/comar) is found in the Code of Maryland Administration Regulations (“COMAR”). In essence, the Nurse Practice Act outlines the following components of the nursing process: assessment, analysis, nursing diagnosis, outcome identification, planning, implementation, and evaluation. Much of the nursing process does not put the nurse at risk for violating the scope of practice. Nursing implementation and diagnosis, however, can present situations that put the nurse at risk.

Implementation: Implementation, for the purpose of the nursing process and the Nurse Practice Act, refers to the plan of care. It includes the process of performing, delegating, assigning, supervising, and coordinating interventions. During the everyday process of the delivery of health care to the patient, registered nurses may find themselves at risk of overstepping the scope of their practice in any of these areas of implementation.

Nurses implement not only their plan of care, but the plan of care as determined by other members of the healthcare team (“non nursing functions”). Such non-nursing functions can only be legally implemented with a physician’s or LIP order. These non-nursing functions include many aspects of patient care: administration of medications; insertion and discontinua-
Lisa Rowen’s Rounds

The Medical Intermediate Care Unit Grows Where it is Planted

Some of my favorite things about Spring are the many flowers that return to bloom year after year. Whether they are flowers on dogwoods, cherry blossoms or pear trees; or flowers on lilac or azalea shrubs; or perennial flowers that proudly announce themselves each year like daffodils, irises and peonies, we can depend on them to bloom where they were planted.

“Bloom where you are planted” was the advice of one of my mentors. She told me “… regardless of which hospital you work in or your area of specialization, bloom and grow in that setting or service in a way that others will take note. Add to the variety of the ‘garden environment’ and offer your attributes and energy to make a positive difference for your patients and colleagues and for the profession. Be in harmony with the garden; contribute your unique set of qualities that add to the richness, color and texture. Don’t let the garden grow without you and don’t be a weed that pulls the eye toward the blemishes rather than the beauty.” I’ve always thought this was excellent advice and her words have helped me to take note of individuals and groups that bloom where they are planted. The Medical Intermediate Care Unit (MIMC) is a perfect example. As a result, the MIMC is the recipient of the 2011 CNO Team Award for Extraordinary Care.

Originally “planted” on 5E Gudelsky in September, 2009, the MIMC grew from four to a 12-bed unit over the course of a year. The patient population is most often medical patients who require an intermediate level of care, such as ventilators, some drips, and arterial lines. Occasionally, surgical patients are cared for on the unit as well, and the team is well-versed in a variety of care requirements.

As the MIMC was a new concept for the Medical Center and had not existed previously in another area, nursing staff were hired from outside of the Medical Center to come together to create this new unit. Led by Director of Nursing Tina Caffeo, MSN, RN, Nurse Manager Kerry Sobol, MBA, RN and Medical Director Brian Edwards, MD, the goal was to create a unit culture of collaboration, trust, respect, collegiality, compassion, and excellence.

Seventy-five percent of the nurses selected to work on the unit were new graduate nurses and chosen by their personalities and qualities of enthusiasm and positive attitudes, says Kerry. The remaining nurses had experience in other hospitals and knew they were joining the MIMC to both care for patients and to provide clinical leadership and guidance to new graduates. In addition, Medical Center nurses from both the Surgical and Medical Intensive Care Units (SICU and MICU) worked as charge nurses on all shifts. Growing this garden was a labor of love and many contributed to its ability to bloom.

The medical model is a Hospitalist model and seven or eight physicians serve in this model. Kerry says Brian Edwards is an excellent Medical Director. “When he assumed the leadership role” says Kerry, “he had a lot of experience at the Medical Center. He knows what works well, he is supportive of and open with the nursing staff, he is viewed as a great teacher and leader who is engaged, youthful, fun, and collaborative and holds his colleagues to a high standard.” As Kerry has been promoted to the role of Director, Patient Experience and Commitment to Excellence, Ruth Borkoski, BSN, RN, formerly a Senior Clinical Nurse in the SICU is now the MIMC Interim Nurse Manager. Ruth says Brian Edwards is able to show his genuine care to his colleagues and the patients.

In December 2010, the MIMC was uprooted and planted on N10W, a larger 16-bed newly renovated unit. Let’s consider this for a moment. The unit had not existed prior to September 2009 when it opened with four beds. The MIMC team continued to open additional beds over the end of 2009 and beginning of 2010. By July 2010, the unit had become a fully functioning 12-bed intermediate care unit. Then less than 1½ years after opening, the MIMC moved to N10W and became a 16-bed unit.

During this time, ALL of the nursing staff had to be oriented on other units. Units participating in the orientation of the MIMC staff members included other intermediate, telemetry and acute units across the Medical Center. Imagine keeping up with over 30 MIMC staff members orienting across the hospital. It is a feat that the team members maintained a sense of oneness and mission as they were scattered this way. Kerry says the team stayed engaged by discussing plans for the unit, giving opinions, formulating goals and having fun.

Catherine Zei, BSN, RN, CCRN, the unit’s educator, says she feels “blessed to have been part of getting the unit up and running and to be the educator for the staff. After working in the MICU for almost 20 years, this new role has been a way for me to share my experience and be part of the next generation of nurses learning their profession.” Cathy also credits colleagues in the Clinical Practice and Professional Development group, and especially Danielle Miller, MS, RN, CCRN, for support during the orientation period of the new staff. We are reminded that it takes a village and in fact, when you enter the MIMC and look to the left, you will see a poster board that states “It Takes a Village” and shows photos of preceptors on other units where the MIMC team oriented.

I would like to commend the MIMC team’s many colleagues, preceptors and mentors on these other units – it requires a lot of energy, time and heart to orient someone for another unit. The fact that so many individuals from other units so selflessly participated speaks volumes for our culture at the Medical Center.

see Rounds on page 5
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.
- Focus on divisional, departmental, and/or organizational strategic goals.

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.
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8. Editor will seek expert review of articles to verify and validate content.
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2011 Publication Schedule

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Scope from page 1

A physician or LIP has given a verbal instruction, and the nurse believes that the order has been written or will be written.

2. The nurse is unable to secure an order. However, the nurse believes that refraining from carrying out non-nursing functions will cause a negative patient outcome.

Verbal orders are strongly discouraged by both CMS and the Joint Commission (TJC) because each recognize that anytime an order is verbally communicated there is an opportunity for an error in communication or transcription, thus placing the patient at risk. UMMC’s policy regarding verbal orders mandates that verbal orders be taken only: (1) in emergency situations when the prescriber does not have immediate access to a computer, or (2) in situations where the physician or LIP is involved in a procedure and because of their involvement in the procedure, they are unable to write the order themselves (e.g. Operating Room (OR) or cardiac catheterization procedure). In both of these situations, the verbal order is appropriate because the clinician believes the order is necessary to expedite appropriate care of the patient.

In surveying several nurses, it is apparent that they are frequently taking verbal orders outside of these two situations or implementing non-nursing tasks without an order, thus placing them at risk for exceeding their scope of practice. Below is a list of examples of such instances:

1. Nurses often take verbal orders inappropriately or complete a task prior to an order being written for several reasons. Some nurses have reported that when they have asked a physician to write an order prior to carrying out the order, they have been reprimanded by the physician who tells them they are delaying patient care. Others feel that if they wait for a physician to enter an order, patient care will be delayed to the detriment of the patient. An example would be when a patient is returned to the unit from the OR without appropriate or current orders in Powerchart.

2. The nurse carries out necessary non-nursing functions because not doing so may negatively impact patient care.

3. Orders are given during patient rounds but not entered into the computer for several hours. The nurse carries out the orders prior to receiving a written order because not doing so will delay patient care.

4. Others have reported that when they have asked an attending physician to write an order, the attending directs them to the resident. The resident responds that the attending must be consulted before writing the order. Meanwhile, several hours pass without an order for a task that has already been completed.

Can you identify the difficulty with these scenarios? Although the nurses, in performing a task without an order or taking a verbal order inappropriately, are doing so in the interest of patient care, they are putting themselves at risk. First and foremost, anytime nurses execute an order without it being documented in the chart, they have practiced outside the scope of their licenses. Second, in taking an inappropriate verbal order, the nurses could be placing themselves at risk by (1) being accused of in accurately transcribing the order should things go wrong with the patient, or (2) practicing without a valid order should a physician or LIP never sign off on that verbal order. Any of the above situations can expose a nurse to a licensing hearing or medical malpractice lawsuit.

So, what do you do? If you are on a unit where it is customary that the physician or LIP does not write orders following rounds or does so in a delayed fashion, do not implement a non-nursing task until an order is written. Involving your nurse manager, charge nurse, CNS, or SCN I and II to discuss whether an agreement between physicians and nursing regarding when such orders will be entered would be beneficial. If
no consensus can be reached, stay firm in your conviction. If indicated, remind those who request you to implement the task without an order that to do so could put your livelihood in jeopardy. In addition, remind the physician that to take a verbal order, you must document it and perform a read-back from the documented order. This process will not save the physician any time – it would be more efficient for the prescriber to document the order. If you continue to be pressured, go up your chain of command to your nurse manager, director, vice president, CNO, or risk management for support. In short, do not compromise your professional integrity in the name of efficient patient care unless you truly believe patient care will be negatively impacted.

Implementation – Delegation of Care: What may or may not be delegated to an unlicensed person is often an area of uncertainty for nurses. The Nurse Practice Act clearly delineates what tasks may and may not be delegated and under what circumstances such tasks may be delegated. A registered nurse may delegate the responsibility to perform a nursing task to another licensed registered nurse, an unlicensed individual, a certified nursing assistant, or a medication technician. However, the delegating nurse retains the accountability for the nursing task.

When delegating a task to another, the delegating registered nurse must ensure that the delegated task can be safely and properly performed by the individual to whom the task is being delegated. In addition, the registered nurse must supervise the individual performing the delegated task to ensure that the task is being properly performed, particularly when the task is delegated to an unlicensed individual. The Nurse Practice Act is very specific as to what medication administration tasks can and cannot be delegated and under what circumstances such delegation is appropriate. The registered nurse should use critical thinking skills and professional judgment and follow the five rights of delegation: (1) right task; (2) right circumstance; (3) right person; (4) right directions and communication; and (5) right supervision and evaluation. The registered nurse is practicing outside the scope of practice when failing to follow any of the five “rights of delegation”.

Nursing Diagnosis: Physicians are licensed to make medical diagnoses. A medical diagnosis is specific and related to a pathologic disease process. Registered nurses are licensed to make nursing diagnoses. A nursing diagnosis is based on the patient’s physical, socio-cultural, psychological, and spiritual response to an illness or health problem. Nursing diagnoses may be actual or potential problems that a patient may experience. Medical diagnoses include: emphysema, ulcerative colitis, multiple sclerosis, or peptic ulcer disease. Nursing diagnoses include: knowledge deficit, altered thought process, impaired skin integrity, impaired mobility, altered nutrition, ineffective airway management, and impaired tissue perfusion. How could a nurse make a medical diagnosis and not know it? Often the lines become blurred in the ambulatory care setting where nurses “triage” calls for a physician. For instance, a registered nurse working in a busy obstetrical practice is triaging calls after hours. A call is received from a patient who states that she has been contracting every 7 minutes, the pain is 3 on a scale of 0 – 10, and she has no discharge. The nurse, without consulting with a nurse midwife or physician, and with no written protocol authorized by a nurse midwife or physician, concludes (a.k.a. diagnoses) that the patient is not in labor. Labor is a medical diagnosis, not a nursing diagnosis, and the nurse in that situation has just practiced outside their scope of practice.

Consider this case brought against a local nurse and facility: A registered nurse was taking after-hour calls for a pediatric group. Around 11:00 pm, a call was received from a Mom who told the nurse that her 3 year old son was running a fever, pulling his ear, and appeared to be in a lot of pain. The nurse told the mom that it seemed like the child had an ear infection, and instructed her to bring the child to the office in the morning. By morning, the child was extremely ill, and the mom took him to the ED prior to the office opening. The child had meningitis. While he lived, he was left with debilitating disabilities including deafness. The nurse and the pediatric group were both named in a lawsuit, and the case was reported to the Board as the nurse was practicing outside the scope of her practice.

Summary
Nurses are professionals. They must practice within the professional and regulatory constraints placed upon them. Practicing outside of these restraints puts nurses at risk of maintaining their licenses (and ability to earn a living), as well as possibly being found liable for medical malpractice. If you are asked to take a verbal order in a non-emergent situation or when the physician or LIP could easily enter that order into Powerchart, STOP. Remind the physician or LIP of UMMC’s policy and stand by your conviction. If the physician is persistent or otherwise inappropriate, go up your chain of command. If the physician’s behavior is egregious, consider filing a Code of Conduct report. The same holds true for a “discussion” of the plan of care that is not properly entered in the chart as an order. Do not perform that task until the order is written, or you will be functioning outside the scope of nursing practice.

When delegating any nursing function, follow the five rights of delegation. Inappropriate delegation has been the source of many licensing hearings, as well as malpractice cases. Use your critical thinking skills in determining all aspects of delegation: Should this task be delegated? Is this the right person? Are these the right circumstances for delegation? Have I clearly communicated the task and my expectations? Am I giving the appropriate level of supervision? When in doubt, consult with your colleagues and superiors. We all want to be efficient in rendering safe care to our patients, but we also must remember that to practice outside our scope is to put our license, our livelihood, and the safety of our patients at risk.
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Considering the challenges related to orientation, opening a new unit and moving a new unit to a new floor, we have to reflect on this enormous growth and change for one unit. The MIMC team has been impressive in remaining positive and focused on teamwork during these changes. In fact, over the past 1 ½ years, I have routinely heard about their excellent teamwork, collaboration and communication from a variety of team members. As they speak about the unit, I have watched listeners light up and say “Wow! I’d like to work there.”

Tina and Kerry Sue Mueller, MS, RN, Nurse Manager of the MICU made the initial hiring decisions before Kerry Sobol came on board. They carefully and selectively hired team members, focused their orientation on learning new skills and critical thinking abilities, and deliberately grew their patient care from a place of safety and competence to confidence.

The group is innovative and created a process for Charge Nurse shift report modeled on the report processes used in the MICU and 13 E/W. The goals are to ensure continuity and enhance communication. Sheila Marshall, RN, CNII explained, “We update the Charge Nurse Shift Report twice a shift and an audit sheet is filled out before change of each shift.”

Jennifer Bethell, BSN, RN, SCNI, took the initiative to begin a quarterly newsletter called Dose. As the Editor of the newsletter, Jennifer’s goal for Dose is to inform team members about clinical and service issues, enhance teamwork by including a welcome to new members where they can share some information about themselves, highlight events and birthdays, and provide a fun diversion and way to learn. Other staff members contribute ideas, stories and photographs; it is a great team product. Margaret (Meg) Aeschliman, BSN, RN, writes the clinical pieces. Jenny explains Dose is also published in a “green” way. She prints only 10 copies and sends the newsletter out in a PDF.

In addition to the “It Takes a Village” poster, upon entering the unit you will see many other poster boards. “We Rock Around the Clock” includes photographs of all of the staff, a great way for new team members, patients and families to learn staff members’ names. The MIMC team also has a poster entitled “Commit to Hourly Rounding on our MIMC Patients”. This poster explains the rounding and how it benefits the patients and team. On a lighter note, the team also has a poster board entitled “IMC Festivities”, where they illustrate some of the fun activities the group has engaged in, such as baby showers, April Fools Day, Ravens games, a bachelorette party (all tasteful photographs, of course!) and the mega-snow event of 2010.

The MIMC is a fun-loving team that has adopted a unit mascot, the Squirrel. This ceramic squirrel showed up at the Nurses Station one day and has never left. It has been photographed all over the unit, especially during the construction phase of N10W, when the Squirrel could be found in a hard hat standing on the architect’s plans. Spawning a series of many uses, the Squirrel is the unit unofficial logo, along with the words: Compassion in a Nutshell. When the MIMC moved to N10W, the entire team donned tee shirts with an image of the Squirrel (see photo). The Monthly Education Board that Cathy oversees is called “In a Nutshell.”

The team also works together to benefit the community. Jane Hannon, BSN, MPH, RN, spearheads the team’s collective effort to help others by collecting food for the Food Bank.

In addition to their fun and charitable aspects, the team has a serious, patient centered approach to their care. One of their Performance Improvement projects is to eliminate patient falls. They now track, on a daily basis, their progress in remaining fall-free. On their PI bulletin board, they state: “Don’t be a Geek and Break the Streak.” They note the number of days they have gone without a patient fall, similar to the way a factory focuses on and notes the number of days without an accident. This focus on safety pays off – their longest streak was 84 days without a fall.

The MIMC team regularly reviews the patient and staff satisfaction scores. Kerry says that almost all indicators in both the Employee Opinion Survey and the National Database of Nurse Quality Indicators have improved from last year. Many of the staff members are in school and many are studying for certification exams. The team is a group of motivated individuals!

One of the most impressive achievements of the MIMC team is a study they are conducting on determining the safest and most evidence based way to transport patients. Jane Hannon, BSN, MPH, RN, Margaret (Meg) Aeschliman, BSN, RN, Michele Frock, BSN, RN, and Jessica Schneehagen, BSN, RN, all relatively new nurses to the Medical Center, with the guidance of Kerry made the decision to study whether or not a nurse should travel with a patient who needed to go off the unit. The group noted that off-the-unit travel was a dissatisfier for staff members and a potential patient safety issue. After reviewing a paper about a step down unit at the University of Pittsburgh that had developed an algorithm to support decisions of whether a patient should or should not travel with a nurse to tests and procedures, the small group adopted a similar algorithm for the MIMC patient population. With the Medical Director’s support, the algorithm, based on medical criteria, was launched in January of 2011. The staff members are working well with the tool and the group has been able to analyze some data from the start of the pilot period and has determined that decisions based on the algorithm have been safe.

The small group of nurses, led by Jane, wrote an abstract to share their project at The Center for the Advancement of Patient Safety at the University of Maryland (CAPSUM) Conference in March. The abstract discussed the problem as an inconsistency with transport practices, related to both whether a nurse travels with a patient as well as if patients should be transported on monitors. It described the background, research, and plan for the study. The abstract, along with the algorithm and a tracking sheet (see page 6), was one of four selected to poster present at CAPSUM. There were over 50 submissions for presentation! In addition, the poster was selected as the best poster of the event, a wonderful recognition of the team’s innovative work to improve patient safety and of nurses driving change.

When you speak with the staff members, you will hear great things about the unit and team. Linsey Vollmer, BSN, RN, says the best things about the MIMC are “the people I work with – the teamwork, the new and beautiful unit, and a great variety of patients.” I stopped and spoke with three family members who echoed Linsey’s words. They said, “Everybody has been great. They are super caring and help each other care as they provide patient care. The nurses, techs, doctors and secretaries have all been totally responsive to our needs.”

Yulonda Taylor, BSN, RN, said “I’m learning a lot. It was suggested to me to apply to the MIMC because of my former experience as a Patient
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Care Technician. I’ve been able to apply my experience here.” Jane said “I like having the physicians here, I like the hospitalist model. It’s a supportive group with excellent teamwork.” Stacey Hoover, a student nurse on both 13 E/W and the MIMC said, “I like all the people and the patient acuity. It’s higher than an acute unit but not as high as an ICU.” Elizabeth Spessert, a University of Maryland School of Nursing student said, “I really like this unit, the staff works well together. It’s a new, pretty unit… I think it makes the patients happier.”

The MIMC is a beautiful unit and the team has repeatedly demonstrated their ability to beautifully grow where they are planted. If you have a moment, make a trip to the unit and enjoy their welcoming ways and excellence. See if you agree with me that they have created a wonderful garden on the MIMC. No matter where they are situated, the MIMC team blooms where it is planted.

**HIPAA Reminders**

By: Christine Bachrach, Vice President and Chief Corporate Compliance Officer

Printed documents are also considered Protected Health Information (PHI) and should be treated as confidential.

*Do:* Black out patient names when presenting materials for educational purposes.

*Don’t:* Create print screens with patient PHI included.

Remember that visitors and others may know a patient based on room number or other patient characteristics (even if you don’t say a name).

*Do:* When discussing patients with other treatment providers, talk in low tones away from other patients and visitors.

*Don’t:* Discuss identifiable patients in the elevator, cafeteria, or other public areas.

Remember what type of privacy you expect if you or a family member becomes a patient.

*Do:* Access patient PHI for anticipation of clinical needs when you are informed that a patient is to be received or transferred to you.

*Don’t:* Access patient PHI post-treatment (e.g., just to follow up on a patient you had in the ED, ICU, etc.).

For additional information, please contact Christine Bachrach via email cbachrach@umm.edu.
What is the Joint Commission?

- The Joint Commission (TJC) is a regulatory body that establishes standards for hospitals and other health care organizations.
- TJC periodically (18 mo – 36 months) evaluates compliance with these standards and will award accreditation to organizations that satisfactorily meet the requirements.

Why are regulatory requirements important?

- Regulatory requirements are developed to identify the minimal processes and care standards that need to be in place to provide safe care to patients.
- Healthcare organizations voluntarily seek Joint Commission accreditation as a means for judging their performance and identifying areas that need improvement.
- The results of the survey are published in a report that is available to the public.
- The Centers for Medicare & Medicare Services (CMS) grants Joint Commission the authority to have the results of their survey findings determine a hospital’s eligibility for Medicare and Medicaid (CMS) reimbursement, and license to operate.
- CMS has the power and authority to shut a hospital down or take away federal funding – if you lose federal funding, most hospitals will not be able to sustain, and will likely go out of business.

What tips do you have for speaking with a Joint Commission surveyor?

- After the surveyors identify themselves, offer to take them to a conference room.
- Gather what you need (patient charts, WOW or computer, eMAR, etc.).
- Two nurses are helpful in this situation. One to navigate the computer; the other to answer questions.
- The surveyor wants you to simply answer about the care that you give.
- Answer the question. Be careful not to provide additional information if not requested.
- Take your time and think before you answer.
- Be honest. Answer what you know and don’t make up information.
- Be OK with silence.
- Avoid answering questions with responses that can indicate practice variation like, “I usually…”, “we often…”, “I believe…”, or “I hope…”
- Use statements that describe less variation like, “Our procedure/policy is…”, “An assessment requires…”, and “We have guidelines that…”
- Listen carefully to any question that starts with the five W’s (when, what, who, where, why) and answer in the specific context of the line of questioning.
- Questions seldom require a “yes” or “no” answer.
- If you think you’ve answered the question just stop. The surveyor will ask you another question if they need more information.

New Code Status Policy Changes

By: Karen Kaiser, PhD, RN-BC, AOCN, CPHN, Clinical Practice Coordinator

Policy PROE-003, formerly titled Withholding and Withdrawal of Life Sustaining Procedures, has been revised and is now called Code Status (Full Code, Withholding and Withdrawal of Life Sustaining Procedures). The revised policy, which effects inpatients and emergency room patients (Adult, Pediatrics, PES, and the TRU), will take effect in May.

The revised policy simplifies the code status ordering process. All inpatient code status orders will be entered into the electronic medical record. Licensed independent practitioners (attendings, fellows, residents, nurse practitioners, and, in non-emergency conditions, physician assistants), will be able to write code status orders. Co-signatures by an attending will no longer be required. Also, code status orders will no longer need to be renewed.

The policy explicitly states that a MIEMMS Do Not Resuscitate and Medical Order/Form, which is used in Maryland community settings, may serve as the patient’s code status until a code status order is placed. Other patients without a documented code status will still be treated as a full code. In an effort to meet new policy requirements, inpatients without a code status order 24 hours after admission will have a Full Code order automatically entered into the electronic medical record.

There will be three possible code status orders: full code, do not intubate (DNI)/do not attempt resuscitation (DNAR), and DNAR. For patients with a DNI/DNAR order, supportive respiratory therapies would be provided up to, but excluding, intubation and cardiopulmonary resuscitation. For example, cPAP, bi-PAP, Vapotherm, etc. would be provided, but intubation and cardiac resuscitation would not be initiated. If a patient has a DNAR order, cardiopulmonary resuscitation would not be initiated.

For additional information related to this policy, please contact Karen Kaiser via email kkaiser@umm.edu.
Why Pay Attention to National Patient Safety Goals?
The Joint Commission processes, including surveys and adverse event reporting, provide an opportunity for the identification of safety concerns emerging nationally. The Joint Commission (TJC) established the National Patient Safety Goals Program (NPSG) in 2003 to assist TJC accredited organizations, such as the Medical Center, to address these specific safety concerns. The Joint Commission’s Patient Safety Advisory Group annually reviews the literature and available databases, solicits input from practitioners, organizations, purchasers and other groups to determine the highest priority National Patient Safety Goals. Their deliberation results in recommendations to the Joint Commission. Some NPSGs are retired when evidence demonstrates that the safety concern no longer needs focus. Others are added to spotlight associated safety issues.

What Do You Need to Know?
- You need to know the NPSGs that apply to hospitals. Some NPSGs apply to long-term care, free standing surgical centers, etc. UMMC is surveyed under the Hospital Accreditation Manual so hospital standards apply even if you work in an ambulatory or procedure care area.
- Behavioral Health programs follow the Behavioral Health NPSGs except for inpatient units that are surveyed under hospital standards.
- There are seven broad NPSGs but underneath each one are specific practices. These specific practice requirements are evidence of safe practice.

National Patient Safety Goals – Highlights

Goal #1 - Improve accuracy of patient identification
- Use the patient’s full name and date of birth to match with medication, specimen label, orders, etc. You may know the patient, but you have to be sure that what you are about to do, administer, transfuse, or draw is for the patient in front of you.
- Label specimens in the presence of the patient. This decreases the likelihood of error. Take a brief moment to read all the labels. You may have labels that do not belong to your patient.

Goal #2 - Improve effectiveness of communication among caregivers
- Critical test results are communicated by Laboratory personnel to providers, not nurses. However, in Ambulatory, critical lab results are allowed to be communicated to specific clinic personnel who, in turn, are responsible for reporting results to the provider.
- Procedure care areas follow the process for inpatient, not ambulatory.

Goal #3 - Improve the safety of using medications
- All medication containers should be labeled including syringes, medicine cups, basins, etc.
- Label each medication container as soon as it is prepared, not before. Discard any medication found unlabeled.
- Educate patient receiving anticoagulant medication on the importance of:
  - Compliance;
  - Follow up monitoring;
  - Food drug interaction; and
  - Potential for adverse drug reactions and interactions.

Goal #7 - Reduce the risk of healthcare associated infections
- Perform hand hygiene.
- Follow infection prevention practices related to multidrug resistant organisms.
- Hold others accountable to follow infection prevention practices.
- Educate patients/families with MDRO about infection prevention strategies.
- Use UMMC’s central venous catheter insertion checklist.
- Disinfect catheter hubs and injection ports prior to accessing.
- Remove non-essential lines.
- Avoid use of femoral vein unless other sites are unavailable.
- Teach patients/families about surgical site infection prevention.

Goal #8 - Accurately and completely reconcile medications across the continuum of care

Admission
- A home medication list is documented at the time the patient is admitted.
- Medication documentation includes dose, route, and frequency.
- Medications ordered are compared to those on the list.
- Any discrepancies are reconciled.

Transfer within hospital
- When the patient is transferred within the hospital, the sending provider informs the receiving provider about the reconciled medication list and documents this communication.

Transfer from one hospital to another
- The most current reconciled list of medication is communicated to the next provider, and this communication is documented.
- The transferring hospital informs the next provider how to obtain clarification on the list of reconciled medication.

Patient Discharge
- At discharge, the current list of reconciled medication is provided and explained to the patient. This interaction is documented.
- Remind patient to discard their old list and to update medication records with all providers.

Episodic Care Settings
In these settings, medications are used minimally or prescribed for short duration. Modified medication reconciliation is performed.
- A home medication list (including allergies) is obtained to safely prescribe setting-specific medications and assess for potential allergies or adverse drug reactions.
- When only short term medications will be prescribed and no
The Joint Commission National Patient Safety Goals

Patients should be screened for pain if they report pain (state “it is sore”, “aches”, “hurts”, etc), you suspect pain (a groan or facial grimace during movement), when pain is expected (such as during a procedure), and at routine intervals (with vital signs at each outpatient visit, every 4 hours, or per unit standard). A pain screen can be a simple yes/no answer to the question “Are you in pain?” So, any health care personnel (HCP), such as a technician or transporter, can screen for pain. HCP who have been trained and are competent in the use of a pain measurement tool (such as the numerical rating scale), can use that tool to screen for pain. When pain is found during a screen, it should be reported as soon as possible to a health care professional, such as a nurse or physician, so that a comprehensive pain assessment and a timely intervention can be performed. For outpatients, according to policy, only pain relative to the visit (such as post-op pain following a procedure), and at routine intervals (with vital signs at each outpatient visit, every 4 hours, or per unit standard). A pain screen can be a simple yes/no answer to the question “Are you in pain?” So, any health care personnel (HCP), such as a technician or transporter, can screen for pain. HCP who have been trained and are competent in the use of a pain measurement tool (such as the numerical rating scale), can use that tool to screen for pain. When pain is found during a screen, it should be reported as soon as possible to a health care professional, such as a nurse or physician, so that a comprehensive pain assessment and a timely intervention can be performed. For outpatients, according to policy, only pain relative to the visit requires a comprehensive pain assessment.

A comprehensive pain assessment is an essential key to effective pain management. Using the evidence based OPQRSTU format will assist you in obtaining critical information that is important in helping you manage your patient’s pain optimally.

### OPQRSTU Acronym

- **O** = onset
- **P** = provoking factors
- **Q** = quality (characteristics or words the patient uses to describe pain)
- **R** = region, (pain) radiation, relief (from medication and non-medication treatments)
- **S** = severity, (associated) symptoms and (medication) side effects
- **T** = timing including frequency and duration
- **U** = “You”, where “you” refers to the patient and may include the patient’s/family’s pain goal (pain score < 4/10), what pain means to the patient (my cancer has returned), cultural issues (pain is to be endured) or developmental issues (use of the term “boo boo”, “sore”, or “achy”).

The following case study illustrates the usefulness of this acronym in routine practice.

Mr. Smith is a patient who had abdominal surgery 2 days ago. When doing your routine head to toe assessment, using OPQRSTU, you ask him to describe his pain to you and you discover the following:

- **Onset** = post operatively.
- **Provoking factors** = upon movement.
- **Quality** = sharp.
- **Region** = incisional. **Radiation** = none. **Relief** = his IVPCA is somewhat helpful, but upon questioning you find out that he is only pushing the button once 10 minutes prior to movement because of nausea.
- **Severity** = 2/10 at rest and 6/10 with movement. Associated symptoms = pain is causing a reduction in his ability to ambulate. **Side effects** = nausea with PCA use.
- **Timing** = pain starts when the patient moves and lasts for 30 minutes.
- **U** = Pain goal < 4/10.

Consider your actions using the above information. Did you think about discussing the following with your patient and documenting it on the patient education form?

- The importance of movement to recovery;
- How to access the prn anti-nausea medication while consideration of the offer to place this medication on a scheduled basis; and
- The need to push the button and wait for 6 to 10 minutes, then push the button a second time and wait another 6-10 minutes prior to initiating walking, coughing, and deep breathing.

Since PCA is considered a scheduled medication, you use your routine pain screens (and PCA assessments) to reassess the effectiveness of your interventions. If this was a prn medication, you would reassess at the medication’s peak effect. For inpatients, you are notified that it is time to reassess prn analgesics on the eMAR. The blue ‘flag’ turns ‘red’ at the time of peak effect. Peak effect times are also found on the Pain Management Flow Sheet (PMFS), on the Pain Intranet page, as well as attached to the pain policy/guideline, and on some WOWs. They soon will be released in a pain pocket tool format.

Upon reassessment you find that the patient is able to ambulate and comply with ADL and treatments, indicating that no change in the pain plan is necessary. The day progresses and it is time for a PCA check (see times in the order set or printed on the PMFS). Think about the elements you are going to assess. Did you include OPQRSTU? Let’s see what we find out when we add this to our routine pain assessment.

- **Onset** = a couple of hours ago a new pain developed
- **Provoking factors** = none
- **Quality** = dull

We have been using different terminology for years to obtain most of the OPQRSTU items in the Pain Assessment History Form (PAHF). The PowerChart form has been recently reformatted to match the acronym. “U” is the new item. Reducing pain to less than or equal to the patient’s pain goal within 48 hours after admission has been adopted as a measure of an institution’s pain management quality.

The completion of the PAHF is required whenever the patient initially complains of pain, whether it is upon admission or anytime during the patient’s stay/visit, such as direct admission to an ICU post-operatively. The PAHF is attached to the intake form for outpatients and to the intake/triage form for inpatients. The stand alone paper and electronic (available via ad hoc charting) PAHF forms are available for use at other times.
The break down in communication between healthcare personnel has long been recognized as a threat to patient safety. For instance, almost 70% of sentinel events each year are related to communication (see graph below). The majority of these result from errors during patient hand off.  

The omission or delay of accurate, timely, and vital information significantly increases the risk of patient harm and has major implications for health care. Recognizing the importance of communication at all points of patient exchange, The Joint Commission, in 2006, introduced a National Patient Safety Goal that requires hospitals to implement a standardized approach for “hand off” communications. This has now moved from a goal to a TJC standard.

A hand off may be defined as the transfer of roles and responsibility from one person to another in a physical or mental process such as seen with the communication of essential information between nurses at change of shift or when patients are moved from unit to unit.  

Effective patient hand off uses a standardized approach that supports the transfer of critical information in an accurate and timely manner, identifying issues before they occur and allowing intervention, when necessary, at an earlier point in the continuum of care.  

Bedside report has been implemented on Select Trauma Critical Care (6 South Trauma) as a strategy to improve communication. Using the Hopkins Model, the 6 South staff developed a PICO question: “In the critical care setting, will bedside handoff compared to traditional verbal report improve nursing communication, satisfaction, and patient outcomes?” and reviewed the literature. The gap between what is known (research) and what is done (practice) is at the heart of the research translation problem in implementing a standardized approach to handoff communications. There are barriers with some solutions to implementation that are identified in the table on pages 11-12.

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**Root Causes of Sentinel Events**

- Communication
- Orientation/training
- Patient assessment
- Staffing
- Availability of info
- Competency/credentialing
- Procedural compliance
- Environ. safety / security
- Leadership
- Continuum of care
- Care planning
- Organization culture

Collation of sentinel event-related data reported to The Joint Commission (1995-2005).
### Improving Handoff Communication

#### Barriers to Effective Handoff

<table>
<thead>
<tr>
<th>Communication barriers</th>
<th>Strategies to improve handoff</th>
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<tbody>
<tr>
<td><strong>General communication problems</strong></td>
<td><strong>Communication skills</strong></td>
</tr>
<tr>
<td>• Omissions (missing or incomplete information)</td>
<td><strong>General communication</strong></td>
</tr>
<tr>
<td>• Errors (incorrect, extraneous, duplicate, or irrelevant information)</td>
<td>• Maintain patient and family confidentiality</td>
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<tr>
<td>• Miscommunication (misunderstood information)</td>
<td>• Be concise but thorough in conveying essential information</td>
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<tr>
<td>• Inaccurate recall of information</td>
<td>• Convey information clearly; ask questions if something isn’t clear</td>
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<tr>
<td>• Inability to contact handoff nurse if follow-up questions arise</td>
<td>• Keep report patient centered</td>
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<td>• Failure to communicate the importance of certain items</td>
<td><strong>Preparation</strong></td>
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<tr>
<td>• Failure to understand which information is essential</td>
<td>• Manage your time so that you’re prepared to give report</td>
</tr>
<tr>
<td>• Report becomes too routine; attention lapses occur</td>
<td>• Gather necessary materials (such as patient charts, your own shift notes)</td>
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<tr>
<td>• Disorganized report</td>
<td><strong>Transfer of responsibility</strong></td>
</tr>
<tr>
<td>• Report relies only on documentation; patient’s current status isn’t shared</td>
<td>• Verify that the person receiving report understands and accepts transfer of responsibility</td>
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<tr>
<td>• Report includes judgmental statements</td>
<td>• Delay such transfer if there are concerns about patient status or stability</td>
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<tr>
<td>• Staff members interrupt each other</td>
<td><strong>Language</strong></td>
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<tr>
<td>• Idle chatting during handoffs</td>
<td>• Speak clearly and at a moderate pace</td>
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<tr>
<td>• Illegible handwriting</td>
<td>• Use clear, specific language</td>
</tr>
<tr>
<td><strong>Social and hierarchical problems</strong></td>
<td>• Keep all remarks objective; avoid judgmental statements</td>
</tr>
<tr>
<td>• Relational problems (such as those caused by a lack of peer support, a lack of mutual respect)</td>
<td>• Avoid the use of jargon, acronyms, or abbreviations</td>
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<tr>
<td>• Problems associated with the hierarchical structure of the health care team</td>
<td><strong>Problems associated with standardization</strong></td>
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<tr>
<td>• A “culture of blame” that inhibits questioning</td>
<td>• Lack of standardization (for example, forms in use aren’t standardized; shifts or units use different forms, processes, or documentation systems)</td>
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<tr>
<td>• Confusion about roles and responsibilities of team members</td>
<td>• Problems with the standardized tools or systems used</td>
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<tr>
<td>• Problems communicating with physicians</td>
<td>• System in use isn’t clearly defined or understood</td>
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<tr>
<td><strong>Cultural issues</strong></td>
<td>• Staff resistance to changes in handoff system</td>
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<tr>
<td>• Language barriers (difficulty understanding each other; culturally different uses of a word or phrase)</td>
<td>• Lack of handoffs research and of data to support best practices</td>
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<tr>
<td>• Ethnic barriers (ethnic differences in communication patterns)</td>
<td>• Lack of financial resources to implement recommended changes</td>
</tr>
<tr>
<td><strong>Problems associated with standardization</strong></td>
<td>• Lack of leadership support</td>
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<tr>
<td>• Lack of standardization (for example, forms in use aren’t standardized; shifts or units use different forms, processes, or documentation systems)</td>
<td>• Problems associated with mnemonics (more than one handoff mnemonic in use; inadequate training in or reinforcement for using the mnemonic)</td>
</tr>
<tr>
<td>• Problems with the standardized tools or systems used</td>
<td><strong>Standardization strategies</strong></td>
</tr>
<tr>
<td>• Lack of adequate policies and procedures relevant to handoffs</td>
<td><strong>Standardize the process</strong></td>
</tr>
<tr>
<td>• System in use isn’t clearly defined or understood</td>
<td>• Provide opportunity to ask and respond to questions</td>
</tr>
<tr>
<td>• Staff resistance to changes in handoff system</td>
<td>• Develop guidelines, tools (templates, forms, checklists, scripts), policies, and procedures</td>
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<tr>
<td>• Lack of handoffs research and of data to support best practices</td>
<td>• Use a tool to ensure that essential information is consistently included</td>
</tr>
<tr>
<td>• Lack of financial resources to implement recommended changes</td>
<td>• Tailor report tools as appropriate for different areas or situations (such as change of shift, patient transfer between units)</td>
</tr>
<tr>
<td>• Lack of leadership support</td>
<td>• Report information in the same order every time</td>
</tr>
<tr>
<td>• Problems associated with mnemonics (more than one handoff mnemonic in use; inadequate training in or reinforcement for using the mnemonic)</td>
<td>• Use a verification process (such as reading back) to ensure that information is both received and understood</td>
</tr>
<tr>
<td><strong>Communication skills</strong></td>
<td>• Develop a teamwork contract and have team members sign it</td>
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<tr>
<td><strong>General communication</strong></td>
<td>• Use a mnemonic</td>
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<tr>
<td>• Maintain patient and family confidentiality</td>
<td><strong>During face-to-face communication</strong></td>
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<tr>
<td>• Be concise but thorough in conveying essential information</td>
<td>• Use interactive questioning</td>
</tr>
<tr>
<td>• Convey information clearly; ask questions if something isn’t clear</td>
<td><strong>During walking rounds or bedside report</strong></td>
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<tr>
<td>• Keep report patient centered</td>
<td>• Check equipment</td>
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<tr>
<td><strong>Preparation</strong></td>
<td>• Check for missing information or ask additional questions</td>
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<tr>
<td><strong>Transfer of responsibility</strong></td>
<td>• Include patient and family in discussion of plans and goals</td>
</tr>
<tr>
<td>• Verify that the person receiving report understands and accepts transfer of responsibility</td>
<td><strong>Monitor, evaluate, or audit the process</strong></td>
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<tr>
<td>• Delay such transfer if there are concerns about patient status or stability</td>
<td>• Create an evaluation tool</td>
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<tr>
<td><strong>Language</strong></td>
<td>• Use spot checks</td>
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<tr>
<td>• Speak clearly and at a moderate pace</td>
<td>• Provide direct feedback as soon as possible</td>
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<tr>
<td>• Use clear, specific language</td>
<td>• Modify the process as needed</td>
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<tr>
<td>• Keep all remarks objective; avoid judgmental statements</td>
<td>• Focus on system problems</td>
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<tr>
<td>• Avoid the use of jargon, acronyms, or abbreviations</td>
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</table>
### Improving Handoff Communication

<table>
<thead>
<tr>
<th>Barriers to Effective Handoff</th>
<th>Strategies to improve handoff</th>
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</thead>
<tbody>
<tr>
<td><strong>Equipment issues</strong></td>
<td><strong>Technologic solutions</strong></td>
</tr>
<tr>
<td>• Limitations associated with the communication medium (telephone, e-mail, paper, computerized system, audio- or videotape)</td>
<td>Use an electronic (computerized) handoff system</td>
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<td></td>
<td>• Give report in front of computer (makes it easy to look up relevant information)</td>
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<td></td>
<td>Use an audio- or videotaped report</td>
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<td></td>
<td>• Plan ahead what you want to say</td>
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<td></td>
<td>• Report information in the same order every time</td>
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<td></td>
<td>• Stop the recorder when necessary to cut out distractions</td>
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<td></td>
<td>• Listen to your taped reports occasionally to identify areas for improvement</td>
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<td></td>
<td>• Ask a respected colleague to critique your report</td>
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<td></td>
<td>Use a telephone-based voice technology system</td>
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<tr>
<td><strong>Environmental issues</strong></td>
<td><strong>Environmental strategies</strong></td>
</tr>
<tr>
<td>• Interruptions</td>
<td>• Limit interruptions and distractions</td>
</tr>
<tr>
<td>• Distractions</td>
<td>• Create a specific place for report that’s well lit and quiet</td>
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<tr>
<td>• Multitasking during report</td>
<td>• Maintain patient and family privacy</td>
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<tr>
<td>• Chaotic environment where report is given</td>
<td>• Allow sufficient time</td>
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<tr>
<td>• Too much noise</td>
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<td>• Poor lighting</td>
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<tr>
<td>• A lack of privacy; difficulty ensuring confidentiality</td>
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<tr>
<td><strong>A lack of training or education</strong></td>
<td><strong>Training and education</strong></td>
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<tr>
<td>• Staff receives inadequate or no training in handoffs</td>
<td>• Use real-life examples (scenarios, stories) in class and “what-if” scenarios during practice</td>
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<td></td>
<td>• Use role-playing to teach effective handoff skills</td>
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<td></td>
<td>• Teach assertiveness and listening skills</td>
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<td>• Address hierarchical and social issues (for example, by discussing how to communicate effectively with those above and below you in the hierarchy, how social and cultural norms affect communication)</td>
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<td>• Discuss and address human factors (such as stress, fatigue, sensory or information overload)</td>
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<td></td>
<td>• Provide adequate refresher training or education</td>
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<td></td>
<td>• Create posters, pocket cards, Web-based resources, and other tools to reinforce handoff skills</td>
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<tr>
<td><strong>Difficulties related to complexity of cases or high caseloads</strong></td>
<td><strong>Staff Involvement</strong></td>
</tr>
<tr>
<td>• High-acuity patients or those with severe illnesses (more complex handoffs)</td>
<td>• Involve staff in the development of guidelines, tools (templates, forms, checklists, scripts), policies, and procedures</td>
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<tr>
<td>• Too many patients (less time for handoffs)</td>
<td>• Involve staff in the development of a training program</td>
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<tr>
<td>• Increasing volume of patient information</td>
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<td>• Increasingly complex care environment</td>
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<tr>
<td>• Workforce structure doesn’t support adequate handoffs</td>
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<tr>
<td>• Emergent patient condition occurs during handoff</td>
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<tr>
<td><strong>A lack of or misuse of time</strong></td>
<td><strong>Leadership</strong></td>
</tr>
<tr>
<td>• Time constraints (insufficient time allotted for handoffs)</td>
<td>• Have consistent expectations for compliance</td>
</tr>
<tr>
<td>• Process used is too time consuming</td>
<td>• Facilitate nurse–physician dialogue to identify problems and find solutions</td>
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<tr>
<td>• Report is too long</td>
<td>• Allow adequate time to plan an implementation strategy for a new handoff process</td>
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<td></td>
<td>• Find early adopters and champions to help demonstrate effectiveness</td>
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<td></td>
<td>• Link the shift handoff process to performance evaluation</td>
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</table>
Mark Bauman, MS, RN, CCRN, SCNII interviewed Genna Dawson, RN about the process.

Q: How long has your unit been practicing bedside report?
A: We started in March 2010. So it’s been one year.

Q: What prompted the change to bedside report on Select Trauma Critical Care?
A: Actually the change was initiated by the bedside nurses. There were complaints about patients and rooms being left in disarray, tubing that was expired, dressings that weren’t done. The offenders were a small but chronic group, and many of the nurses were uncomfortable confronting them, or, due to scheduling, were unable to address the issue in real time. Sometimes age or experience differences between nurses would be a barrier.

Q: So did you just make a unilateral change and go to bedside report?
A: No, we knew the only way to affect long term change was to get staff buy in and participation at a deeper level. So we vetted the issue in our monthly leadership and staff meetings where we discussed professionalism, personal accountability, and strategies that could be used to improve patient care and nursing satisfaction. We also did a literature search and looked at best practices, including Joint Commission standards on patient hand off. Armed with this information, the leadership group decided to implement bedside report and environmental checks.

Q: What were some obstacles you encountered when trying to implement the change?
A: As with any practice change, getting the staff to see the value of the change was paramount. We needed to explain how bedside report can impact NSQI data, improve patient care and increase both nursing and patient satisfaction. Most of all we had to emphasize that holding peers accountable was not meant to be punitive, but a potential teaching moment and a professional responsibility to the patient. That’s what professionals do; hold each other accountable to established standards and learn from each others mistakes.

Q: What would you say are the keys to successfully implementing bedside report?
A: Education and enforcement. We reviewed standards of care, posted these in the bedside charts, and created a bulletin board. We reviewed quality data and how nursing impacts them at our staff and leadership meetings. We developed an audit tool to assess things like: dressings, tubing and irrigation set expiration dates, compliance with bundles, and environment of care. It is not enough to say, “change this behavior”. We had to create an environment that supported the change. For example we put a locked box in the report room with comment cards for the staff to comment on particular nurses or encounters anonymously, good and bad. We also made sure that the “senior staff” rounded at shift change to support the initiative.

Q: Looking at it a year later, has bedside report been successful on your unit?
A: Overall, it has been. We did a post implementation survey 3 months out and the response was overwhelmingly positive. We had nurses relate their experiences at staff meetings; in one case how a continuous infusion was found disconnected and running and in another how a patient’s arterial line was bleeding at the site. Both picked up when giving bedside report. During the same time our incidences of pressure ulcers have been below the national average and our CLABSI rate has been 0 for 46 weeks. We cannot conclusively say that bedside report is responsible for this, but it does seem more than coincidence.

Q: What are your plans for bedside report and how do you plan on maintaining the momentum?
A: Great question. Once you achieve momentum, you have to keep it going, which in many respects is harder than the actual implementation. Over the last year, we have continued to review best practices and what other units within the hospital and beyond are doing. We continue to evaluate and process as new technologies evolve. For instance, computerized charting and changes in the EMAR have affected our report process. The real key is getting the bedside nurse to believe in the initiative. Educating the nurses to see the value of bedside report, creating an environment that supports it, and empowering them to carry it out is crucial for long term success, which leads to better patient care and improved nursing satisfaction.

Standardization and stabilization of clinical practice related to the transfer of information is an essential aspect of patient safety and improves clinical outcomes. A method reported to help is the oncoming nurse meeting with the off-going nurse for a verbal report on each patient using the familiar SBAR style of communication plus a P for Patient in the following sequence:

**Situation:**
- Review patient’s admitting information, diagnosis and problem list.

**Background**
- Using patient summary tab to review past medical history, resuscitation status, patient social information, current orders, scan med/IV list.

**Assessment:**
- Oncoming nurse will:
  - Verify the most recent patient assessment with off-going nurse.
  - View lab results.
  - View most recent vital signs and note trend.

**Recommendation:**
- Off-going nurse and oncoming nurse will discuss:
  - What needs to be done for the next shift?
  - What is the plan for this patient to move to next level of care?

**Patient:**
- Off-going and oncoming nurses will meet with the patient and signal change of shift.
  - Introduction of oncoming nurse
  - Assess patient concerns
  - Perform bedside safety checks including:
    - Patient’s general appearance
    - Correct IV, PCA, and/ or medications infusing
    - IV tubing and dressing dates
    - Lines and Drains labeled
    - Check environment including call bell and other equipment
  - Discuss plan for the next shift to move patient toward discharge or to the next level of care.
  - Off-going nurse turns over patient to oncoming nurse.

Nursing practice in Select Trauma Critical Care has improved through the implementation of bedside report. Before the initiative, practice issues related to safety/risk management concerns, unsatisfactory patient outcomes, and wide variations in practice were identified. Preliminary feedback after implementation has been overwhelmingly positive. The PDSSA Cycle Improvement Model has been utilized by studying, acting, planning, and doing and is being used to evaluate the process. As the process evolves, knowledge gained from implementation, as well as updated evidence, will improve and refine the initiative. An online educational module and post-test assessment incorporating expectations, practice, and experiences from the last year has been developed to move this initiative to Select Trauma’s sister unit, Select Trauma Intermediate Care. Other units using bedside report are the Medical ICU, Surgical IMC, Weinberg 5, and Shock Trauma Acute (4STA).

**References**
UMMC Step by Step Guide to Equipment Cleaning

Standard cleaning will occur between equipment use on different patients

REMEMBER!!
Contact time * for Dispatch varies based on the organism (germ)

- **1 minute** = effective kill for most organisms (even resistant ones like MRSA, VRE & Acinetobacter)
- **2 minute** contact time for TB
- **5 minute** contact time for C diff

* contact time is the amount of time the solution must remain visibly wet on the surface to kill the germs

ALL EQUIPMENT MANAGED BY EQUIPMENT DISTRIBUTION (EQD) SHOULD BE RETURNED TO EQD FOR CLEANING WHENEVER POSSIBLE!!!

If the need is urgent, and unit-based equipment is required, follow these steps for general equipment:

1. Take piece of equipment to a cleaning area
2. Always wear gloves to perform any cleaning
3. Wear any appropriate isolation garb if item was removed from isolation patient
4. Clean any obvious soil, fluid spills, or blood off of surface with Dispatch wipe
5. Wipe all surfaces of the equipment with Dispatch wipe including cords & cables
6. Allow solution to air dry, reapply if needed to maintain visibly wet surface for contact time indicated
7. Once item has dried, remove residue/film off with water only & clean damp cloth or paper towel, if desired
8. Attach green CLEAN equipment tag as indicated if not for immediate use

For cleaning Carefusion Infusion pumps—follow these steps:

1. Take pump to cleaning area (in open space if possible) put on clean gloves and isolation garb - if appropriate
2. Remove pump from pole and wipe pole from top to bottom – including wheels!
3. Wipe back of pump first-especially black mounting piece and indentations at bottom on back of the pump
4. Wipe cord from pump toward end—do not saturate prongs
5. Allow to air dry– rewiping as needed to provide adequate contact time
6. Replace pump on pole. Remove all side modules by pressing grey bottom on bottom corner & lifting up towards you—set aside
7. Clean "brain" of pump—wiping all external surfaces—do not saturate IUI connectors (gold metallic strips @ top of pump brain & modules) *
8. Pay special attention to top of pump around handles and front surface where buttons are
9. Clean each module individually paying attention to top of pump where tubing enters fluid path
10. Open door on front and wipe fluid path and clean inside blue clasp area where tubing locks in at the bottom of fluid path
11. Clean door latch area where door catches to the bottom of module. Allow modules & “brain” to air dry before reassembling pump
12. Wipe off film with water on a clean, damp cloth or paper towel, if desired. Apply green Clean Equipment tag if indicated. Pump is ready to use!

IMPORTANT - Never put a pump together when it is wet!
*

If IUI Connectors are loose, discolored, or have lint in the connectors, return to EQD for service
Safe Discharge of Patients on Anticoagulation Medication: Education Matters!

By: Luizalice Lima, MS, RN, Professional Development Coordinator

As healthcare professionals, we strive to provide the best care based on our knowledge and skills while our patients and families are with us and on preparation for discharge. As nurses, education is our very basic tool to keep our patients and families well informed.

However, there are patient groups more susceptible to complications during hospitalization and after discharge, such as patients on anticoagulation therapy. Education before the first dose of a new anticoagulation medication is the cornerstone of preventing these complications from happening. Anticoagulation side effects/adverse reactions, as well as drug/food-drug interactions, should be part of the education content.

Additionally, to take credit for the impressive work nurses do in educating patients and families and to comply with standards of care, make sure the proper documentation is on the patient/family education electronic form.

Patients should know the answers to these 4 questions before discharge:

- What is my problem?
- What do I need to know to take care of myself?
- Why is it important to do that?
- Who do I contact if I have questions?

Anticoagulation therapy:

- Side/Adverse Effects
- Drug/Food-Drug Interactions

Documentation of Patient & Family Education:

- Before first dose of new medication
- Teaching method
- Evaluating learning
- Using method (s) preferred by patient/family (Intake & Triage)

The over arching pain management goal is maximum pain relief with minimal side effects. Ideally, we should try to keep pain scores less than or equal to the equivalent of 4/10, since research shows scores greater than or equal to 4/10 interfere with activities of daily living, ambulation, etc. Sometimes side effects or chronic pain prevent us from achieving this. In the case of chronic pain, our goal is likely to facilitate activities of daily living, ambulation, and treatment in the hospital setting. If we are unable to achieve this in our patients, a change in the pain care plan may be needed.

The incorporation of the OPQRSTU format can assist you to more effectively manage your patient’s pain, reduce length of stay, and improve patient satisfaction. By using this format routinely, you incorporate evidence-based pain management into your clinical practice, improve the quality of your pain care, and meet accreditation requirements.

For additional information related to pain management, please contact Karen Kaiser via email kkaiser@umm.edu.

Pain Screening from page 11

Severity = 5/10 all the time. Associated symptoms = none. Side effects = none.
Timing = all the time.
U = “This is very uncomfortable and I want to get rid of it as it makes me feel anxious”.

What do you think is causing this pain? Would use of OPQRSTU help you identify the probable cause of the pain more quickly? How is your pain management plan going to change based on the data?

By adding the OPQRSTU assessment, you quickly find out that the patient’s bowel function has returned. Knowing that opioids can slow bowel function, you counsel your patient to not use the PCA button for this pain, but to increase ambulation. You document this in the Patient/Family Education form. You also document the pain assessment components that changed (as per best practice and policy) using the ad hoc charting form, the PMFS, or the Daily Profile/ICU Flow Sheet. Can you think of some other examples where use of OPQRSTU could have improved pain control in your patients?
Electronic Clinical Documentation at UMMC: The Next Steps

By: Susanne Anderson, MS, ACNP-BC, CCRN, Professional Development Coordinator

An organizational goal of UMMC is to have an integrated electronic medical record for all of our patients. The next steps toward achieving that goal are underway.

Device integration was successfully piloted on STC 6S. This allows clinical information to flow from biomedical devices (bedside monitors, ventilators, continuous renal replacement devices, and others) to an electronic flow sheet. Vital signs and other patient data can now be remotely viewed by clinicians from any computer connected to our system. No more hunting down the flow sheet to check a patient’s intake and output. The pilot is currently being extended to STC 6N and is expected to roll out to the rest of the STC tower late this summer. Device integration will continue to be deployed to the rest of the hospital as infrastructure upgrades are made to support the roll out.

In the meantime, a multidisciplinary workgroup has been meeting biweekly to tackle the revision of our electronic intake documentation and to begin the work of designing an electronic patient physical assessment. The goal of this design team is to make documentation meaningful. Information captured should logically flow to and support ongoing documentation over the continuum of the patient’s stay. The information identified during an assessment should prompt a plan of care and trigger our educational process. The intent is to streamline documentation workflow while driving best practices. Implementation on all nursing units is planned for this fall.

As more data is recorded electronically, information retrieval will become easier. Data mining can support the ongoing research efforts being undertaken here at UMMC. We will continue our efforts to improve the care we provide and to optimize patient outcomes by implementing practice changes based on data and research.

Living in our current hybrid documentation environment, with some information recorded in the computer and the rest on paper, is challenging at best. The hard work and dedication of our design team will help make this schism a thing of the past.

For further information, please contact Susanne Anderson via email manderson1@umm.edu.


By: Kerry Sobol, MBA, RN, Director, Patient Experience and Commitment to Excellence

Based on feedback from various employee forums, the Patient Experience Team has been hard at work preparing a resource manual for staff that will help guide discussions and provide online resources that pertain to visitors and visitation. Using scenario based scripting, this manual will assist our staff to work through the simplest to the most complex visitor situations we face here at UMMC. The introductory letter from Lisa Rowen, DNSc, RN, FAAN, Chief Nursing Officer and Jonathan Gottlieb, MD, Chief Medical Officer expresses the Medical Center’s continued support of Patient/Family Centered Care, and encourages staff to use this manual to manage new Joint Commission and CMS regulations that went into effect this year. The visitor policy and visitor code of conduct have been revised and will be included. The manual will be printed and distributed to all inpatient areas, as well as outpatient and clinic sites within the Medical Center walls. Educational sessions will be planned, so look for more information as the group finalizes plans.

For additional information, please contact Kerry Sobol via email ksobol@umm.edu.

Honorable Mention

Code STEMI Designation

By: David Hunt, MS, RN, Director of Nursing, Cardiac Care and Radiology

This is a follow up to a recent site visit by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) review team. The site visit team traveled to the Medical Center to formally evaluate our ability to respond to STEMI patients. The team interviewed and evaluated the ED, Express Care, Cath lab, and inpatient Cardiology areas.

It is with great pleasure that I am able to announce that under COMAR 30.08.02.07, MIEMSS proposed to issue full designation to the University of Maryland Medical Center as a Cardiac Interventional Center. This new designation is for a period of three years, provided that the Medical Center continues to meet the new state wide requirements for a Cardiac Interventional Center.

This is a significant award for the Medical Center and represents many months of hard work by the interdisciplinary teams from each of the areas evaluated. The designation is for adult patients. STEMI stands for ST (segment) Elevation Myocardial Infarction. It describes a patient who is actively having a heart attack, and the initiative is focused on identifying and rapidly treating these patients to minimize the potential heart damage that the heart attack can cause. Code STEMI was described in full detail in the Oct-Dec 2010 issue of News & Views.

For additional information, please contact David Hunt via email dhunt@umm.edu.
Core Measures

Core Measures Need You

By: Sylvia B. Daniels, BSN, RN, Manager of Regulatory Compliance & Outcomes Management

Jonathan Gottlieb, MD, UMMC Chief Medical Officer, has set a target for our performance on the core measures at the top decile. This means that for a majority of the measures in Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Surgical Care Improvement Project (SCIP), Children’s Inpatient Asthma Care (CAC), and Hospital Based Inpatient Psychiatric Services (HBIPS), we must reach and maintain 100% compliance with the evidence-based practices the core measures represent. This requires an “all men on deck” approach.

Over the past year, many new practices and documentation standards have been implemented to address the issues identified by the multidisciplinary Core Measure Steering Committees, as reasons for our “average” performance on the measures. As a result, we have met and exceeded the Maryland State Average on many of the measures, but top decile performance continues to elude us.

2010 Core Measures Aggregate Rates

As springtime is a time of renewal, it is also a great opportunity for each member of the healthcare team to renew their focus on the core measures and ask “what can I do to help the Medical Center reach and maintain top decile performance?” Better scores on the core measures will be advantageous from a reimbursement perspective and are good to maintain our public reputation when they are reported. Most importantly, our excellent performance will show our commitment to our patients and a continued desire to provide the safest and highest quality of care to each and every patient at all times.

In response to how members of our “magnetized” patient care services team can help, we offer the following suggestions – Documentation, Documentation, Documentation.

In the areas identified below, improved documentation will move the Medical Center toward top decile performance on the core measures. They also represent medical interventions in which the RN plays a pivotal role:

- Be sure the peri-operative checklist is filled out completely when patients are sent from the nursing units to the O.R.
- Give medications as ordered and in a timely fashion – ASA, beta blockers, antibiotics, pharmacological VTE prophylaxis, corticosteroids, and relievers for pediatric asthma.
- When physician’s orders cannot be carried out, document the reason the medications or other medical interventions were withheld.
- Consult with the physician or APN to be sure urinary catheters are removed within 48 hours of surgery, when appropriate, and document the date and time the Foley was removed.
- Document the placement of mechanical VTE prophylaxis within 24 hours of the physician’s order.
- Provide smoking cessation counseling to all patients admitted to the Medical Center, but most importantly to those patients who have smoked within the last year.
- Assess all patients (18 yrs. of age and older) admitted to the Medical Center, and, when appropriate, administer the pneumococcal vaccine year round, especially to patients 65 years and older.*
- Assess all patients admitted to the Medical Center, and, when appropriate, administer the influenza vaccine from October thru March, especially to patients 50 yrs. of age and older.*
- Document the date and time vaccines are given on the e-MAR.
- Document the date and time blood cultures are drawn, being sure to document them as “blood cultures” drawn not “labs” drawn.
- For all patients admitted to our psychiatric services, document two strengths during the admission screening process.
- Also, for our psychiatric population, be sure the Behavior Restraint/Seclusion form is filled out completely for each episode.

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Currently, our focus for the core measures is on inpatient care. However, in January 2012, we will begin to collect data and monitor the care we provide in the Emergency Department for acute myocardial infarction and chest pain patients, ED patient flow, and ambulatory surgery.

If you would like more information on the core measures or have ideas for how we can reach and maintain top decile performance, please contact any member of the Regulatory Compliance department listed here.

Anna Marie Moko, BSN, RN, MBA - CAC and HBIPS via email amoko@umm.edu
Crystal Evans, BSN, RN - AMI and HF via email cevans5@umm.edu
Patricia Dumler, BSN, RN - PN via email pdumler@umm.edu
Sylvia Daniels, BSN, RN - SCIP via email sdaniels@umm.edu

*In the near future, the vaccines will become the Prevention Measure Set.

Patients greater than or equal to 6 months of age will be candidates for receiving the vaccines when they meet the screening criteria.
We Discover

**Nurses Present Oral and Poster Presentations**

By: Karen Johnson, PhD, RN, Director Nursing Research & EBP

During the first three quarters of FY ’11, UMMC nurses have presented a total of 28 oral and poster presentations at regional/national conferences. This includes 12 poster presentations and 16 oral presentations. The details of the dissemination of their scholarly work are summarized in the table below.

The information about “UMMC Nursing Guidelines for Publication and Presentations” can be located on the UMM intranet under Nursing Research & EBP.

<table>
<thead>
<tr>
<th>Presenters</th>
<th>Title</th>
<th>Conference/Location</th>
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<tr>
<td>Kathryn Von Rueden, MS, RN, ACNS-BS, FCCM</td>
<td>Update on Sepsis: Patho to Protocols</td>
<td>Oral</td>
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<tr>
<td>Karen Johnson, PhD, RN, Amanda Mielke, BSN, CRNFA, CNOR, Beatrice Hazzard, BSN, RN, CPAN, &amp; Trish Klein, RN</td>
<td>Integration and Translation of Evidence to Improve Preoperative Patient Outcomes. ANCC National Magnet Conference®, Phoenix, AZ, October 2010.</td>
<td>Oral</td>
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<tr>
<td>Michele Zimmer, MS, RN</td>
<td>Nurse Driven Prescription for Medication Success. ANCC National Magnet Conference®, Phoenix, AZ, October 2010.</td>
<td>Poster</td>
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<tr>
<td>Kim Saddler, MSN, RN, PMH, CNS-BC</td>
<td>Pediatric Nursing Education. Institute of Pediatric Nursing, Gaithersburg, MD. November 2010.</td>
<td>Oral</td>
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<td>Implementing Sustainable Health Care at UMMC – A Case Study. Professional Nursing Education and Development Annual Conference. Baltimore, MD. October 2010.</td>
<td>Oral</td>
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<tr>
<td>Karen McQuillan, MS, RN, CCRN, CNRN, CNS-BC</td>
<td>Preventing Infectious Complications in Trauma Patients</td>
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<td>Identification and Treatment of Sepsis</td>
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<td>Update on Shock Trauma Nursing Research</td>
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<td>Role of the Nurse in Decision Making and as a Key Member of the Trauma Team</td>
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<td>Trauma 2010 International Congress, Indian Society for Trauma and Acute Care. New Delhi, India. November 2010.</td>
<td>Oral</td>
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<tr>
<td>Kristin Seidl, PhD, RN &amp; Ann Regier, MS, RN</td>
<td>Strategies to Create and Sustain a Healthy Work Environment and Improve Nurse Satisfaction. 5th Annual National Database of Nursing Quality Indicators Conference. January 2011. Miami, FL.</td>
<td>Poster</td>
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<tr>
<td>Danielle Miller, MS, RN, CCRN, Kristy Gorman, MS, RN, OCN, Krystle Reddish, BSN, RN, &amp; Veronica Rosales, BSN, RN</td>
<td>From books to the bedside: Supporting the new graduate nurse transition. The Maryland Association of Nursing Students January, 2011.</td>
<td>Poster</td>
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changes are made to patient’s long term or chronic medications, the patient is provided with a list of short term medications.

• When a patient leaves this setting, a list of the original known and current medication is not provided unless the patient is confused.

• A complete medication reconciliation process is necessary when:
  - New long term medications are prescribed;
  - There is a prescription change for any of the patient’s long term medication;
  - The patient is subsequently admitted for ongoing care; and
  - If complete medication reconciliation is necessary in this setting, a complete list of reconciled medications is given to the patient, the patient’s PCP or referring provider, or the next known provider of care.

Goal #15 - The hospital identifies safety risks inherent in its patient population

• This applies to a patient with a behavioral or emotional disorder diagnosis.
• Conduct a suicide risk assessment and address the patient’s immediate safety needs.

Universal protocol for preventing wrong site, wrong procedure, and wrong person surgery

• Wrong site, wrong person, wrong procedure events do occur.
• A proper “Time Out” requires an actual pause - Stop What You Are Doing - listening, and active communication by each member of the procedure team.
• A proper time out is done immediately before the procedure, not 10-15 minutes before.
• A proper time out includes verification of the patient’s name, date of birth, validation of the procedure, site, and that site is appropriately and correctly marked if indicated.
• A time out is held when there is a change in the team and in between multiple procedures it must be documented.
• The time out requirement applies to all invasive procedures irrespective of the location of the patient.
• A proper time out takes about a minute to hold and provides a significant safety net for catching any patient identification or scheduling error that was not previously caught.
FIRE SAFETY INFORMATION

Essential Elements
In the event of a fire in your area- the process we use is called:

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<td>RESCUE - Rescue any patients (or staff) from imminent danger.</td>
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<td>ALERT – Activate alarm – pull alarm &amp; call 8-2911. Tell the operator you have a CODE RED.</td>
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<td>CONFINE – Close all doors and windows.</td>
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<td>Extinguish – Extinguish the fire if possible!</td>
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Did you know?
- All staff should know where their fire pulls, hoses, extinguishers and escape routes are located
  - Never place ANYTHING in front of a fire pull, extinguisher station, or hoses
  - Always keep hallways clear in case the need for evacuation occurs
  - Close Doors to prevent fire from crossing to another location
- Know where your 02 cutoff valve is- use at the direction of your charge nurse, manager, or senior tech
- Healthcare facilities rarely perform a full evacuation – the idea is to defend in place if it is safe to do so, but think about what you would do if you had to move!
- Units may need to cohort patients in a safe area of the unit or move laterally to another building- horizontal evacuation is a last resort
- Full Building Evacuation should occur at the direction of fire department or safety officer

Important Points to remember:
- You can use a fire extinguisher if there is one accessible- USE PASS
  - P – Pull pin from Extinguisher
  - A – Aim the nozzle at the base of the fire
  - S – Squeeze the handle to activate flow
  - S – Sweep from side to side to dispense the solution or foam

For further information, please contact Allison Murter via email amurter@umm.edu or ext. 8-7696