

FALL 2012

Magnet Attractions



When Are
You At Your
Best?

For some colleagues,
it's when they are
on mission trips

PAGE 8

We're on a Mission

When you are at your best, you provide the best possible care wherever you are



Don't you just love the cover of this Magnet Attractions? I think some of you could moonlight as professional photographers. The photos you take on your mission trips are simply amazing. Thank you so much for sharing them.

You may have noticed in the last issue of Magnet Attractions we started to list our colleagues who go on mission trips as part of our Professional Milestones listings (page 11). That's what sparked the idea to do a story on medical missions in this current issue (page 8). Our colleagues have had some incredible experiences while providing

medical care in third-world countries and assisting communities within the United States that have experienced disasters. We are excited to highlight some of these stories, and I think you'll be inspired by the exceptional care our colleagues provide in less than ideal situations.

Patient care is what we do best, and I know it can be very fulfilling to offer it outside our hospital walls. I am proud of you for expanding our reach to other areas of the world. When combined just right, the ingredients of time, trust and teamwork are a recipe for success. We learned that during last year's Mission Possible Summit. Those ingredients need to be combined perfectly here, and while abroad, to continue our tradition of excellence in patient care.

This will be a theme at this year's employee forums. I want to encourage you to attend one, so you can continue to be at your best, no matter where you provide patient care. You can find the employee forum schedule on Mission Central under the Schedules tab.

Anne Panik

Anne Panik, MS, BSN, RN, NEA-BC
Senior Vice President, Patient Care Services



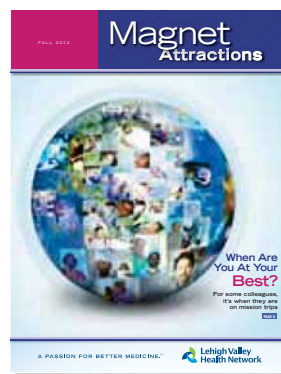
Our Magnet™ Story

Magnet hospitals are so named because of their ability to attract and retain the best professional nurses. Magnet Attractions profiles our story at Lehigh Valley Health Network and shows how our clinical staff truly magnifies excellence.

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INSIDE THIS ISSUE

A Day in the Life	3
What do our nursing research partners do?	
Research in Action	4
EBP FellowS ² program makes it happen	
Preventing Falls, One Step at a Time	7
Work group revises our guidelines	
We're on a Mission	8
Mission trips bring out the best in colleagues	
Can You Call Yourself a Nurse?	10
New law defines who can and who can't	
Professional Milestones	11
Colleagues make presentations and mark career milestones	
Let's Stop Medication Errors	Back Cover
Implementing evidence-based practice helps	



ON THE COVER

It's a great feeling when you are "at your best." Read about our colleagues who capture that feeling when they are on mission trips – and learn how you can feel that way too on page 8.



What is it?

Magnet™ hospitals integrate evidence-based practice and research into clinical and operational processes. Our nursing research partners are here to help guide nurses through original research and ultimately translate best evidence into practice.

A DAY IN THE LIFE OF A

Nursing Research Partner

Tricia S. Bernecker, PhD, RN, ACNS-BC, is an associate professor of nursing at DeSales University and also one of two nursing research partners here at Lehigh Valley Health Network. The other is held by Mae Ann Pasquale, PhD, RN, an assistant professor at Cedar Crest College. The positions are funded by grants from the Farr Endowment Fund and the Dorothy Rider Pool Health Care Trust.

Both Bernecker and Pasquale were trauma intensive care nurses before they became professors, and they specialize in conducting original research. At DeSales, Bernecker teaches acute care nursing concepts for undergraduates, accelerated and evening/weekend students, and research/evidence-based practice methods for masters and doctoral students. She spends eight hours a week within our health network.

While she's here, her job is twofold. She is a co-investigator on a study that will assess the nursing work environment; this involves asking nurses and technical partners about aspects of their work day and clinical environment. The research hopes to answer questions such as: are there ways for nurses and technical partners to feed, turn or walk patients with more ease? If supplies were re-organized, would it allow nurses to get their jobs done in less time? Are there ways to improve teamwork so daily tasks take place more seamlessly? What suggestions do staff nurses have for the processes of care delivery? The findings from this descriptive study will hopefully guide intervention studies in the future.

"These intervention studies will be designed to help nurses better meet their demands and ultimately help patients," Bernecker says.

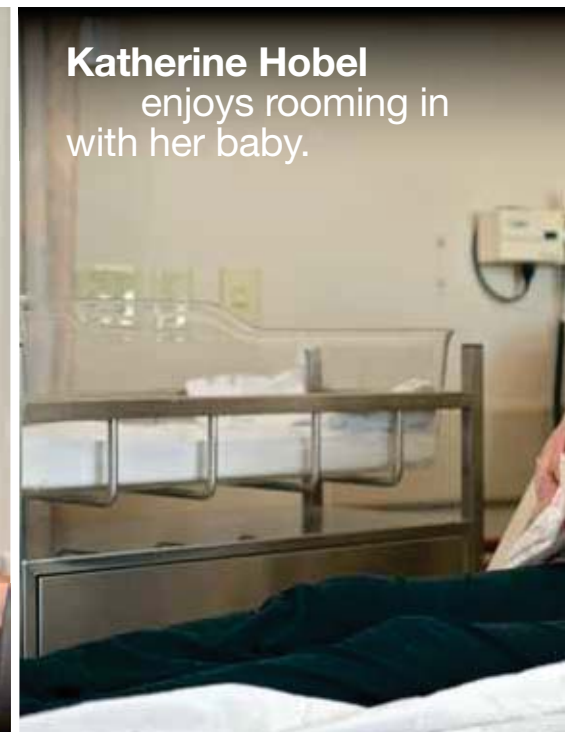
Bernecker and Pasquale are also members of the Nursing Evidence-Based Practice/Research Council – a council that helps nurses implement evidence-based practices. "In our role, we are also here to assist and translate the best evidence into practice," Bernecker says.

The position of a nursing research partner entails true collaboration. It represents an important linkage between academia and clinical practice settings. Bernecker is excited about her most recent research and talking to nurses about what they face on the job. "Nurses are the ones who are with the patients. They know the issues. We're just here to give them the tools and support they need every step of the way so they can be at their best," she says.

"In our role, we are also here to assist
and translate the best evidence into practice."



Lisa Emery, RN, checks a patient's Crit-Line monitor.



Katherine Hobel enjoys rooming in with her baby.

Putting Research Into Practice

EBP FellowS² program makes it happen

The importance of evidence-based practice (EBP) is readily acknowledged, but studies show only a small percentage of health care providers actually incorporate findings into practice. We want to make sure that doesn't happen in our health network, so we developed the EBP FellowS² (S² = Sharing Science) program to ensure evidence is indeed put into practice.

The program includes 12 weeks of didactic offerings and project development, with an additional eight to 12 weeks of mentoring that sees an EBP project through to completion. The inaugural FellowS² group includes six dyads that are each designing and implementing an EBP project. Here's a look at what they are doing:

PROJECT:

Crit-Line Monitoring in the Dialysis Unit

TEAM:

Lisa Emery, RN, CDN, and Jennifer Trubilla, BSN, RN, CDN

PICO QUESTION:

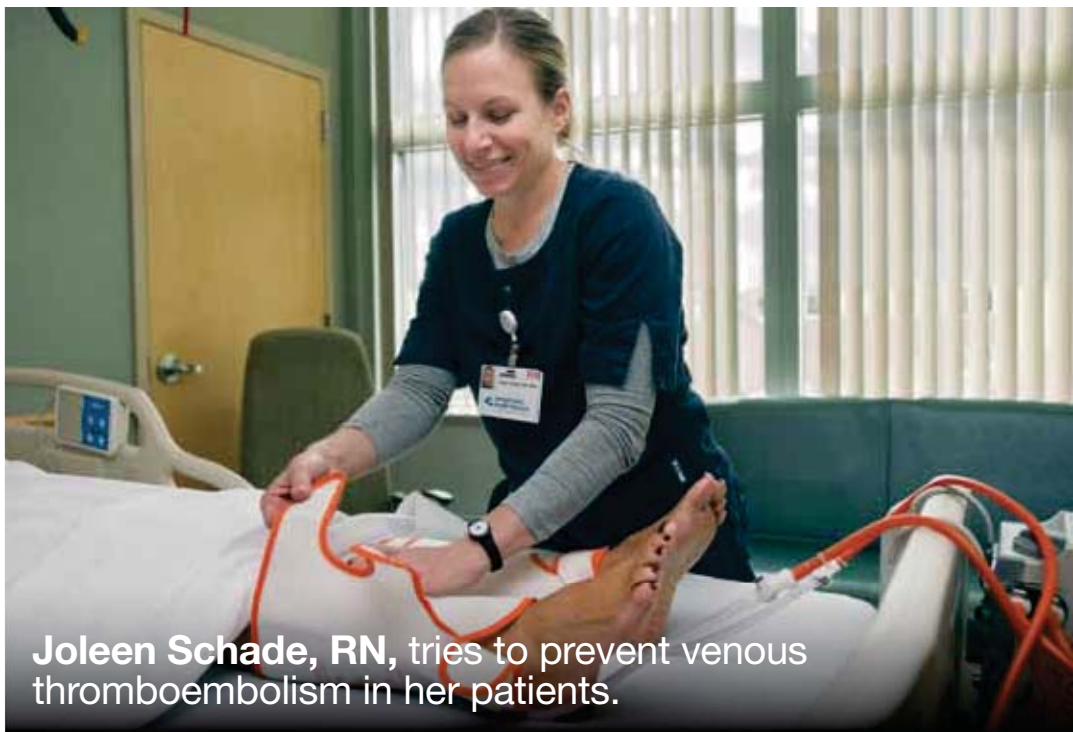
Does using the Crit-Line monitor (a blood volume monitor) affect the ability to aggressively to remove fluid without experiencing hypotension or tachycardia in chronic end-stage renal disease (ESRD) patients admitted to the hospital with a 5Kg or more gain above their established dry weight?

BACKGROUND AND EVIDENCE REVIEW:

The occurrence of intradialytic symptoms will continue to rise with the increasingly elderly patient population and the multiple comorbid conditions associated with ESRD patients. Evidence showed that when combined with clinical assessment, the Crit-Line monitor provides an objective method to optimize fluid removal and reduce or prevent intradialytic events. The Crit-Line provides an algorithm that allows for individualized fluid removal.

IMPLEMENTATION PLAN:

Educate bedside nurses on proper use of the Crit-Line algorithm and reinforce through a quick reference card at the bedside and updated intradialytic hypotension protocol. Outcome will be measured by reduction of intradialytic hypotension and tachycardia, as well as decreased length of stay and transfers to a higher level of care, and increased patient satisfaction.



Joleen Schade, RN, tries to prevent venous thromboembolism in her patients.

TRANSFORMATIONAL LEADERSHIP

PROJECT:

Non-separation of Mothers/Infants

TEAM:

Krista Thomas, RN, and Jennifer King, RN

PICO QUESTION:

In newborns of first-time mothers who have vaginal births, does rooming-in with the mother, compared to staying in the nursery, have a positive effect on mother/baby attachment, as evidenced by positive patient and staff perceptions and a decreased number of babies in the nursery at night?

BACKGROUND AND EVIDENCE REVIEW:

Studies show that rooming-in leads to better attachment between mother and infant, emotional stability, protection from infection and increased breast-feeding rate.

IMPLEMENTATION PLAN:

Survey colleagues to evaluate scope, attitudes and patients to determine mother's perception of rooming-in. Collect data to measure number of babies taken to nursery and gain insight for why babies are not at the mother's bedside. Initiate a pilot that uses scripting for nurses to encourage rooming-in and perform subsequent evaluation.

PROJECT:

Venous Thromboembolism (VTE) Risk and Prevention Awareness

TEAM:

Joleen Schade, RN, CRNI; Kristina Holleran, BSN, RN, CMSRN; and Debra Peter, MSN, RN, BC, CMSRN

PICO QUESTION:

How does an education program focused on nurse awareness of VTE risk and prevention on a medical patient care unit (5K) compare to a similar medical unit (6K) without an education program?

BACKGROUND AND EVIDENCE REVIEW:

VTE is the most common preventable cause of hospital death and considered a public health crisis. Approximately 51-53 percent of medical patients are at risk for VTE. Studies suggest a considerable barrier to optimal VTE prophylaxis utilization is that health care staff fails to appreciate the need for prophylaxis, and therefore it is underutilized.

IMPLEMENTATION PLAN:

Educate staff on pilot unit about VTE risk and prophylaxis. Continue to collect baseline data on current compliance with prophylaxis and assess staff knowledge and awareness. An educational intervention will be provided, followed by data collection post-intervention.

TL10 and TL10EO: What is it?

The TL10 Magnet Recognition Program® source of evidence describes and demonstrates the structures and processes by which input from direct-care nurses is used to improve work environment and patient care. Based on this valuable input, we are making changes here at Lehigh Valley Health Network, which is the core of TL10EO.

—Continued on next page.



Interruptions During Medication Administration in the Emergency Department

—Continuation from previous page

PROJECT:

What's the Connection Between Toileting, Lasix and Falls?

TEAM:

Marilyn Jimenez, BSN, RN, PCCN, and Christine Hafner, MSN, RN

PICO QUESTION:

In congestive heart failure patients receiving Lasix twice a day, how does administering Lasix at 8 a.m. and 4 p.m. and utilizing a toileting schedule compared to standard BID Lasix administration at 6 a.m. and 6 p.m. affect voiding frequency at night and patient falls?

BACKGROUND AND EVIDENCE REVIEW:

Toileting was implicated in 50 percent of falls on one particular health network unit in fiscal year 2012. Of those, 10 patients were on Lasix. A tool to assess voiding patterns in relation to Lasix administration has been developed.

IMPLEMENTATION PLAN:

Piloting is currently in process to educate colleagues about timing of Lasix administration and the implementation of a toileting schedule. Outcomes will be measured by patient falls, call bells and how smoothly changes are incorporated.

PROJECT:

A Staff-Driven Mobility Protocol: Spring Into Step!

TEAM:

Tracy Gemberling, RN, CMSRN; Amy Keesler, RN; and Christine Yatsko, MSN, RN, CMSRN

PICO QUESTION:

In the cognitively intact, community-dwelling older adult, does adherence to a staff-driven mobility protocol as opposed to a physician-ordered protocol minimize functional decline as measured by a mobility classification tool?

BACKGROUND AND EVIDENCE REVIEW:

Older hospitalized patients spend most of their time lying in bed, despite an ability to walk independently or with minimal assistance. If these adults participate in a mobility protocol, they can maintain or even improve their functional status and reduce length of stay. Nurses play a central role in ensuring hospitalized patients are mobilized and maintain functional status during a hospital stay.

IMPLEMENTATION PLAN:

Establish baseline of current mobility status based on physician-ordered protocol. Educate core nurses and technical partners regarding the mobility protocol. Implement a robust measure (mobility classification tool) to assess patient functional status at admission and discharge. Develop a communication worksheet to individualize the mobility plan of care for the day and track adherence to staff-driven protocol.

PROJECT:

Interruptions During Medication Administration in the Emergency Department

TEAM:

Judith Baker, BSN, RN, CEN; Julie Albertson, BSN, RN, CEN, CPEN; Sandra Sabbatini, BSN, RN, CEN

PICO QUESTION:

Do nurses who have received structured education about interruptions during the medication administration process, compared with those who have not received education, have a lower incidence of interruption, guarding themselves and protecting others?

BACKGROUND AND EVIDENCE REVIEW:

The occurrence and frequency of interruptions are associated significantly with the incidence of procedural failures and clinical errors. Nurses interrupting each other heads the list of interruptions. Unfortunately, there are no studies to determine the points in the medicine administration process that are most vulnerable to error. This is compounded by the fact that some of the existing aids to help overcome medicine administration errors, such as bar-coding, currently are not feasible in the emergency department setting.

IMPLEMENTATION PLAN:

Recruit nurses for the study who will be observed prior to education about interruptions, then educated and observed again.

New Plan to Prevent Falls

Work group revises the clinical practice guideline and implements fall-reduction plan for nursing staff

Falls are a top cause of injury among hospital patients, often prolonging and complicating their stay.

To help our nurses better identify patients at risk for falls and keep them abreast of new research, our Falls Clinical Practice Work Group rolled out a new comprehensive fall-prevention plan in March. The work group is one of three Fall Prevention Committee subgroups striving to educate colleagues and help them incorporate fall-prevention strategies into their daily practice.

One piece of the new plan is a revised fall-prevention practice guideline. “Each member of the work group reviewed articles from the research literature to update the guideline,” says Julie Kaszuba, BSN,

RN, patient care specialist on 4K and co-chair of the Falls Clinical Practice Work Group with Jill Hinnerstz, MSN, RN, a products nurse specialist.

The group also created a new “fall” tab in the Centricity electronic documentation system. All fall-related information is now in one place for easy access by nursing staff. Information includes the updated guideline, as well as a revised version of the Hendrich II Fall Risk Model, a tool our nurses have used for years to determine a patient’s fall risk based on gender, medications and other factors. In addition, a new tool called the ABCS Injury Risk Assessment was added to identify additional patients at potential risk for injury from a fall.

“According to the Hendrich II Fall Risk Model, a healthy, 45-year-old knee-surgery


patient wouldn’t be at significant risk for falling,” says Kaszuba. “But the ABCS Injury Risk Assessment would put him at risk for injury if he did fall because of the surgery. Using both tools helps nurses think more critically and lets them individualize a fall-prevention plan for each patient.”

The work group also created a standardized post-fall reference binder to guide nursing care for the patient after a fall.

No data is available yet for the new measures, but Kaszuba believes our fall rates should improve network-wide.

Next steps

Have an idea for a practice change? Talk to your leadership team – director, patient care coordinator, patient care specialist or shared governance council chairs – to begin the process.

A photograph of Julie Kaszuba, RN, a woman with short dark hair, wearing a white lab coat with a name tag and a blue flower pin. She is sitting at a desk in a hospital room, looking at a computer monitor. Her hands are on a light blue mouse. In the background, there is a desk with various items, a water bottle, and a window with blinds. An IV stand with a bag is visible on the left.

Julie Kaszuba, RN,
patient care specialist on 4K,
uses the new fall tab in Centricity.



Healers on a Mission

Colleagues say they are
'at their best' when they give
back through mission trips



Not too many years ago, Holly Tavianini, RN, director of 7A, pondered a sobering question – one that would eventually draw much meaning into her life. This was the question: What would my obituary say?

Her identity as “nurse” didn’t feel like enough. “I kept thinking that I wanted to do more,” she says.

Soon after she pondered that question, spine surgeon Jeffrey McConnell, MD, approached Tavianini and asked if she’d be interested in traveling to Calcutta, India, to care for impoverished spine patients as part of Operation Straight Spine. “That definitely fulfilled my yearning to do something more,” she says.

During her mission trip to India, Tavianini worked 16-hour days for two weeks straight. While assisting in the hospital’s antiquated operating room, she was startled by birds that occasionally flew into the room. She and other staff wore used surgical gloves that had been sterilized from the previous day. She also walked patients, changed dressings and administered medications. She was on her feet almost all day. It was grueling work, but Tavianini fell in love with it.

When she returned home, she knew she would go again. “The patients are so appreciative,” she says. “One woman said she would remember me until her death – that I was her angel. I left with a warm, ‘Wow, I really made a difference!’ feeling.”

So far Tavianini has gone to India five times and plans to return again this winter. Over the years, she’s witnessed several stunning surgical successes. One year, she nursed a woman with spinal tuberculosis who was paralyzed from the upper chest down. When Tavianini left, the patient was still recovering and immobile. A year later, when Tavianini returned, she met the woman again. This time: the patient was walking and dancing. “It was absolutely amazing,” Tavianini says.

Tavianini is one of many colleagues who find meaning in mission trips. We’ve had colleagues from throughout the health network participate in trips around the globe that forever change their lives – and the lives of their patients. Recently, a group of five colleagues from the operating room at Lehigh Valley Hospital–Cedar Crest, including four nurses and a surgical technologist, traveled to Guatemala to help pediatric surgical patients. Hope Johnson, director of operative services, supported the staff to assure the schedules would al-

low all to take off on the same week during the height of vacation season.

“Compassion is contagious,” Johnson says. “We are all in health care to make a difference, and trips like this make you feel like a better person. Some colleagues even say they are at their best when they’re on a mission trip. I am proud of that spirit.”

If you’d like to donate your time and skills to help less fortunate in third-world countries, use this advice from Johnson and Tavianini:

Research available missions. Choose an established, reputable organization such as Doctors Without Borders, Operation Smile or Operation Straight Spine. The more established the organization, the more likely your costs (airfare, hotel, food) will be covered.

Schedule your vacation around a trip, or consider taking a leave of absence (of up to 60 days) for longer missions.

Ask for help. Helping Hands might be able to donate equipment or medicines. Companies such as Medtronic have donated necessary equipment for missions. The Friends of Nursing program also provides funds for medical mission trips.



Nightingale Finalists

Jayne Febbraro, MSN, RN, CRNP (left), an educational specialist in our division of education, and Carolyn Davidson, PhD, RN, CCRN, FNP-BC (right), administrator of evidence-based practice and clinical excellence, were recently named finalists for Nightingale Awards of Pennsylvania. Febbraro is a finalist in the nurse educator-staff category. Davidson is a finalist in the nursing research category. The awards recognize and honor exceptional nurses who practice in the state. Our health network has had at least one Nightingale Award finalist in 21 of the 22 years the program has been in existence. Sixteen of our nurses have been named recipients during this period. We'll find out if we can add more names to that list during the Nightingale Awards Gala on Oct. 26.

What's in a Name?

The title of 'nurse' now protected by state law

When is a nurse really a nurse? As of May 2012, the Commonwealth of Pennsylvania has officially answered that question.

In May, Gov. Tom Corbett signed the Nurse Title Protection Act into law, making Pennsylvania the 37th state to do so. The legislation limits the patient care title of "nurse" to only those educated and holding a license to practice in the commonwealth. The law is primarily designed to guard against misrepresentation by an unlicensed individual who may give inaccurate or even dangerous advice to a patient.

According to the legislation, a licensed nurse in Pennsylvania must be an individual who has completed a state-approved school of nursing program and who has successfully passed a state board of nursing licensing examination for either a Registered Nurse or a Licensed Practical Nursing program.

State Rep. Jim Cox of Berks County and state Sen. David Argall, who represents parts of Berks, Lehigh, Northampton, Monroe, Carbon and Schuylkill counties, sponsored the bill.

An annual "Honesty and Ethics" survey done by Gallop indicated this issue is important among Americans. Eighty-one percent of respondents said nurses had very high or high honesty and ethical standards.

"Countless people have gone into a doctor's office and heard the phrase 'the nurse will be right in,' only to find out that it's not a nurse who comes in, it's a medical assistant or someone else," says Kim Hitchings, RN, the manager for the Center for Professional Excellence. "The public has a right to know who is a nurse and who is not. People should know the credentials behind the title. It's a safety issue."

Representatives of Lehigh Valley Health Network, working with the health network's Office of Government and Legislative Affairs, did their part to advance this cause in Harrisburg. Last summer they invited state Rep. Julie Harhart, who represents parts of Lehigh and Northampton counties and also chairs the House Licensure Committee, to a roundtable discussion on licensure issues. The health network's nurse leadership took the opportunity to explain the importance of enacting the Nurse Title Protection legislation.

The bill was pushed quickly through Harhart's committee and eventually moved to the legislative floor, where it passed both the state House and Senate unanimously.



Governor Tom Corbett, flanked by state Representative Jim Cox, right, and Senator David Argall, left, signed the Nurse Title Protection Act in May.

EP1 and EP1EO: What is it?

These Magnet Recognition Program® sources of evidence fall under the Exemplary Professional Practice Magnet™ model component. In this section, you'll read about your colleagues who made presentations at regional, state and national conferences, as well as were published in peer-reviewed journals and participated in mission trips.

PUBLICATIONS

Marie-Claude Gutekunst, MSN, RN, PCCN, **Jeanine Delucca**, MSN, RN, BC, and **Beth Kessler**, RN-BC, wrote, "The Use of an Advanced Medical-Surgical Course for the Retention and Professional Development of Medical-Surgical Nurses in an Acute Care Hospital" in *Journal of Continuing Education in Nursing*, July 2012; 43 (7): 309-14; date of electronic publication; April 9, 2012. Doi: 10.3928/00220124-20120402-18.

Holly Taviani, MSHA, BSN, RN, CNRN, and **Marjorie Lavin**, MS, RN, CNRN, wrote "Eliminating Green to Go Green: Using Web Technology to Increase Clinical Documentation" in *MedSurg Matters!*, March/April 2012; Vol. 21, No. 2: 6-8.

Tami J. Meltsch, BSN, RN, CNML, PCCN, wrote "Got Accountability? Increasing Data Transparency" in *Nursing Management*, Vol. 43, 13-15, June 2012.

Maureen Smith, MSN, RN, CNRN, **Lorraine Valeriano**, BSN, RN, CNRN, and **Bonnie Wasilowsky**, BSPA-HCA, RN, CNRN, wrote "Nurses Helping Nurses: A Proactive Approach

to Stress Management in a Neuroscience Intensive Care Unit" in *Pennsylvania Nurse*, Vol. 67, Issue 2, 12018, June 2012.

Jayne Febbraro, MSN, RN, CRNP, and **Deborah Arnold**, MSN, RN, CMSRN, wrote, "Emergency Department Recalculating Labor and Delivery: Delivering Education Utilizing Adult Learning With a Blend of Teaching Strategies" in *International Journal of Childbirth Education*, July 2012, Volume 27, Number 3, 81-85.

Lauren Simko, BSN, RN, FNP, wrote "Breaking Sterility: Dealing With Procedural Violations in Health Care" in *Nursing* 2012, August 2012, Volume 42, Issue 8, 22-26.

Beth Kessler, RN, BC, **Marie Claude-Gutekunst**, BSN, RN, PCCN, **Ashley Donchez**, **Rachel Dries**, BSN, RN, CMSRN, and **Megan Snyder**, BSN, RN, BC, wrote "The Merry-Go-Round of Patient Rounding: Assure Your Patients Get The Brass Ring," in *MedSurg Nursing*, July-August 2012, Volume 21, Number 4, 240-245.

Nedesda Mack, MBA, BSN, RN, OCN, wrote "Growing a Navigation Program: Using the NCCCP Navigation Assessment Tool," for *Oncology Issues*, July-August 2012, Vol. 27, No. 4. pp. 36-45

POSTER PRESENTATIONS

Judith Pfeiffer, BSN, RN-C, and **Denise Keeler**, BSN, RN-NIC, presented "Normal Newborn Nursery – Neonatal Intensive Care Unit: What's in Between?" at the Association of Women's Health, Obstetric and Neonatal Nurses in Washington, D.C. in June.

ORAL PRESENTATIONS

Courtney Vose, MSN, MBA, RN, and **Robert X. Murphy Jr.**, MD, MS, FACS, presented

"Bringing the Gemba and C-Suite Together" at the American Hospital Association Health Forum Leadership Summit in San Francisco in July.

SPECIALTY CERTIFICATIONS

Jennifer Tokarick, RN, CMSRN
Vicki Salsano, RN, BC
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Lori Fick, RN, CMSRN
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Maxine Voorhis, RN, CMSRN
Susan Bosnick-Sinift, RN, CMSRN
Kelly Stivala, RN, CAPA
Stephanie Grazel, RN, CNOR
Susan Buchman, RN, CGRN
Kathleen Klokis, RN, CAPA
Karen Boutron, RN, BC
Beth Beatty, RN, CGRN
Kelly Tripp, RN, CGRN

MISSION TRIPS

Erin Miller, certified surgical technologist
LOCATION: *Guayaquil, Ecuador; Length of time: 1 week; Organization: Community Cares for Kids; Responsibilities: Triaging potential patients; assisting during surgical procedures; cleaning, wrapping and sterilizing instrumentation*

Kathleen Marie Bolsover, RN, operating room/weekend program
LOCATION: *Belize; Mile 39 and Happy Tomorrow, 2 villages near the city of Belmopan; Length of time: 11 days; Organization: International Service Learning and Cedar Crest College; Responsibilities: Primary care and provide medicine and vitamins to the people of the communities*

Magnet Attractions

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NOMINATE A COLLEAGUE

Friends of Nursing recognizes and promotes excellence in nursing practice, education and research. Now is your chance to nominate a colleague (or colleagues!) for one of these prestigious awards. The nomination booklet, which lists all the awards and associated criteria, can be viewed electronically on the Center for Professional Excellence (CPE) webpage, found on the intranet. **Nominations are due Dec. 7.**

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Medication Errors

We're incorporating the latest evidence-based practice to improve our rate

[INDICATOR]

Medication errors contribute to more than 7,000 inpatient deaths each year in the United States. According to the most recent data available from the Institute of Medicine, a patient is subjected to one medication error per day. The staggering reality of this preventable adverse event is the focus of this section and how our health network is implementing evidence-based practice to avoid such events.

[PROCESS]

Our health network commits significant fiscal resources and patient safety tools to assist nurses in safe medication delivery. Those resources and tools include: bar-coding with patient profiling; automated dispensing cabinets (Pyxis); smart pumps for IV infusions; online IV drug calculators; double checks of high-alert medications (Heparin); and most recently the implementation of the LITER Tags on IV pumps (Library, Identify [solution], Tubing and Trace [line], Execute [infusion running], Rate [check with drug calculator])

[ANALYSIS]

Our medication error rate is static at 0.06 errors/1,000 doses of medication. The IV and PO raw number of errors have steadily declined over the past three quarters.

[OUTCOME]

In addition to reviewing the medication errors for type and potential root causes of the error, unit staff is monitoring compliance for use of the yellow line reconciliation labels, use of the calculator, and clearing of the pump volume every eight hours.

[NEXT STEPS]

Work to hardwire the LITER process continues, as does thorough investigation of errors for additional process issues and following through utilizing the principles of Just Culture.

