Evidence-Based Poster Presentations

A total of 19 posters were entered for the Evidence-based Poster Presentation held September 28 and 29 in The Medical Center auditorium. Judges for the event were Drs. Mary Bennett, Eve Main, and Donna Blackburn from Western Kentucky University Nursing Faculty. Congratulations to everyone who prepared posters, and a big “thank you” to all those who assisted with the event.

1st Place: *Healing Through Quiet Time*, submitted by Paula DeVore, BSN, RN from OHR.

2nd Place: *Evaluating Parental Stress in the Neonatal Intensive Care Unit*, submitted by Ruth Gott, MSN, RNC from NICU.

Tied for 3rd Place: *Early Ambulation*, submitted by Jaclyn Dugan, BSN, RN from Cath Lab.

Tied for 3rd Place: *To Bend or Not to Bend*, submitted by Sherese Baily, RN, from 3D Ortho Neuro unit.

Commonwealth Health Corporation’s nursing mission is to care for people and improve the quality of life in the communities we serve through our practice, education, research, innovation, and collaboration.
It is hard to believe that October is here and almost gone. My mother always told me that the older you get the faster the years go by, and I am beginning to believe that. We have had a very busy and challenging year.

I hope that most of you have had an opportunity to meet the travelers that we have contracted to help with our vacancies. I have received positive remarks regarding their performance from the managers and staff alike. We will be placing the August graduates in open positions in the near future as well as interviewing the December graduates in November. If you would like to be a part of that interview process, please contact Michelle Mefford in Human Resources or your clinical manager. The interview process will be on November 2 from 1:30 until 8:00 p.m. This is an excellent opportunity to participate and select the best candidates for our nursing department.

I greatly appreciate everyone’s recent attendance at the care plan classes. Your emphasis on individualizing our patient’s care plans is evident in my chart reviews, and the documentation of the care plan in the nursing notes has greatly improved. Research shows that the more individualized a patient’s care plan is the better the outcomes are. With patient-specific care plans and sharing them at the bedside with the patient at each change of shift, our patient outcomes and satisfaction should greatly improve.

We have received several positive comments from patients regarding the bedside shift report which supports the evidence for this nursing practice. We will be beginning our hourly rounding initiative in the very near future, which also is best practice for nursing and all ancillary staff. The reason for hourly rounding is for patient safety and to provide quality care as research has shown by decreasing call lights by 37.8%; decreasing falls by 50%; decreasing hospital-acquired pressure ulcers by 14% and improving patient perception by 12 mean points on patient satisfaction scores. A study was done on 27 nursing units in 14 hospitals where hourly rounding was initiated. The study showed that call lights reduced by 4,901 in this four-week period. If each call light was an average of 4 minutes, these nurses and CNAs saved 326 hours per month or 81.5 hours each week responding to call lights. These hours could be used for improving our patient interactions and care on a daily basis. With sharing these research statistics, I hope that everyone will embrace this practice as a means to save you time and improve patient outcomes.

We are currently interviewing for the Director of Critical Care and Director of Med-Surg positions. I will let you know when those are filled and by whom hopefully at our next shared governance meetings. The internal agency positions are posted and interviews for those positions will begin in the coming week.

Michelle Marshall has accepted the CCU Clinical Manager position and will be transitioning into that position in the near future. I am currently interviewing for the replacement House Administrator position to replace Michelle.

It is a very busy time of year at The Medical Center with lots of change occurring, which is only going to make us a stronger and better nursing department. We have many more opportunities to make improvements, but we need everyone’s assistance in identifying those needs and being a part of the change.

We will celebrate our new Clinical Ladder recipients as well as our past recipients with a dinner on Thursday, November 3. Invitations will be sent with the details of the event.

Thanks to everyone for your hard work the past several months during our very busy summer. As a team we can continue to accomplish great things and provide nursing excellence to our patients and community.

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**Retirements**

Chesa Montgomery, RN (third from left), Nursing Notes co-editor, retired after 18 years of service. Congratulating Chesa are (left to right): Gary Spradlin, House Administrator; Betsy Kullman, Chief Nursing Officer; and Elaine Priest, House Administrator.

Connie Smith, President and Chief Executive Officer, congratulates Stephen Wade, Pharmacist (right), who retired after 30 years of service.
Notes from Shared Governance
by Kathleen Riley, BSN, RN, MA, NE-BC

The October Shared Governance Meetings were held a week later than usual to accommodate the expected decrease in census and staffing during fall break.

Standards and Practice Council
Willa Miller, Clinical Manager of 5A and 5B, presented the most recent data in Immediate Action Results (IARs) monitoring. While some units are consistently hitting the 90% or above threshold, others are still struggling to achieve the stated goal. Special focus will be given to those areas in the coming months to identify any barriers that may affect success in this “critical” area.

Bill Singletary RN, Director of Care Coordination, shared our progress on the stroke indicators. Data for July showed that we were at 100% compliance in 3 of the 6 indicators. Compliance with all 6 indicators was 100% except for one patient. Much improvement has been accomplished thanks to the attention and diligence of the staff.

Medline, the new skincare line of products, has been well received. Positive comments were made by the nurses on the Council who have used them for patient care.

The educational training on Pressure Ulcer Prevention (PUPP) is to be completed November 7. This was sent to RNs by Carolyn Burton as an email with a link to the site. Check with your Clinical Manager if you cannot locate this email message. This is a mandatory education opportunity.

Recruitment, Retention, & Recognition
A pilot project was recently approved to add a CNA to 7–3 and 3–11 Monday through Friday for two units. This project is in accordance with the implementation of a formalized hourly rounding process that is designed to produce positive patient outcomes. Nursing literature supports the impact of hourly rounding on patient falls, pressure ulcer development, patient satisfaction, and staff satisfaction by reducing the number of call lights. The success of this pilot will be measured by improvements in specified patient outcomes.

We currently have agency nurses among our staff due to the recent increase in nursing vacancies. While we are not accustomed to using agency nurses, they have been well received and have gotten positive feedback. Everyone is encouraged to provide them with assistance and support as they help us while our vacant positions are being filled.

The Annual Food Drive is being kicked off with a “Stuff the Turkey” theme. The Council’s goal this year is 3,000 cans or items of food which will be donated to the Salvation Army. This is an exciting and rewarding opportunity for us to help those in our community who are less fortunate. Boxes will be delivered to each unit and department in the hospital and CHC departments by mid-October. The date for delivery to Hospital Administration has been set for November 19.

Research Council
This year’s Evidence-based Poster Presentation was impressive with 19 posters entered for judging. The winners were announced earlier and a picture of each winning poster can be found in this edition of Nursing Notes. Congratulations to all who prepared posters and assisted with this event. Thanks also to the judges from WKU Nursing faculty: Drs. Mary Bennett, Eve Main and Donna Blackburn.

There was discussion concerning various ways to improve this annual event including creating a template for formatting the material, with emphasis on the grading rubric and ensuring those preparing the posters have a clear understanding of the judging criteria, and assisting with the layout and printing of the posters to enable their submission to nursing conferences. A subcommittee was formed to work on these recommendations for improvement.

An article from the Journal of Healthcare Leadership, entitled, “Entice, Engage, Endure: Adapting...

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evidence-based retention strategies to a new generation of nurses” was presented by Teresa Stidham, BSN, MSN, RN, APRN chair of the council. The members will review the article and discuss at the November meeting.

**Nursing Quality Improvement Council**

The units reporting their Performance Improvement activities this month were Cath Lab, 5B, and L&D. Angie Hardesty, Cath Lab Clinical Manager, and Renee Coombs, RN, discussed their positive results for early ambulation for post-diagnostic cath and first quarter data for door-to-balloon time of 64 minutes with the benchmark goal of 90 minutes. Everyone involved in achieving these results — ED, the interventional cardiologists, EMS, as well as the Cath Lab staff — all played a vital role.

Karen Oliver, RN, reported 5B Performance Improvement, stating that their compliance on DVT Prophylaxis was running between 96% and 100%.

Sarah Harrison, BSN, RN for L&D, discussed three areas being monitored for Performance Improvement: accurate completion of certifications of false labor; birth certificate worksheet completion; and inductions prior to 39 weeks.

Betsy Kullman, CNO, presented the latest data on compliance with CHF indicators. We continue to have an issue with “N/A” being checked for daily weight education on discharge. In an attempt to remedy this, “N/A” will no longer be an option on the discharge education checklist. The responses will be “yes” or “no” with “yes” being the appropriate response.

Gerri Glenn, RN, Director of Quality Resource Management, shared the most recent data from NDNQI (National Database of Nursing Quality Indicators) regarding pressure ulcer incidence in our hospital. Data for the last 8 quarters showed that 13 out of 15 units met the target goal, which is a significant improvement! New mattresses have been put in place on many units and will be throughout the hospital by the end of the year.

For the next several months, we will be monitoring specific aspects of patient care including the teaching of new medications prior to discharge and the implementation, appropriateness, and modification of the Nursing Care Plan. The Clinical Managers will be reviewing random patient records on their respective units to ensure we are meeting these standards of care.

**Nursing Clinical Informatics**

Mark Hanson, RN, Senior Clinical Informatics Specialist, reported that his review of care plans revealed they are being updated and that interventions and problems are being discontinued when appropriate.

Council members expressed positive comments about the recent change from Krames to EBSCOhost for patient education materials and information. Several stated they felt it was easier to access once the initial learning phase was complete.

Vaccine information will soon be electronically transmitted to Pharmacy from nursing documentation. This process was explained to the council by Mark Hanson who also mentioned that vaccine administration will be reported to the State electronically as well. Hospitals on KHIE (Kentucky Health Information Exchange) can share this and other important healthcare information to give providers quick access to needed data for their patients.

An improvement in the Dysphagia screening documentation will be made in mid-October based on input from staff and others.

**Nursing Development Council**

Nursing competencies are due by November 1.

Promotion of nursing certification continues with flyers being distributed for each unit, and a unit walk-through is being planned to share information about certification.

In the upcoming weeks, we will receive the Education Needs Assessment asking for everyone’s input. This information is crucial to assist the Education department in planning and providing the most appropriate and meaningful offerings for the coming years.

**Clinical Ladder Committee**

Discussion and planning for the November 3 Clinical Ladder Celebration was held. Nurses obtaining their CNIIs in April and October of this year and all current CNIIIs and CNIVs will receive an invitation with the time and place of the dinner. This is annual recognition of those RNs who have made the commitment and followed through on achieving advancement in the Clinical Ladder.

There are several nurses who have indicated their intention to advance on the Clinical Ladder and have set a date for accomplishment. During the next month, they will all be contacted by their advisor to determine if they continue to have an interest and to set an agreed date for completion.

**BOWLING GREEN TECHNICAL COLLEGE NURSING PROGRAM**

Since 2008, Bowling Green Technical College (BGTC) has offered an Associate Degree in Nursing at the Glasgow Campus. The pass rate for the NCLEX-RN in 2009 was 100% and in 2010 was 96%. The second class is due to graduate in December 2011.

The Glasgow campus also continues to offer the Practical Nursing Program as it has done for the past 54 years. The Bowling Green Campus began offering a Practical Nursing Program in 2009. The pass rate for 2010 and 2011 classes has been 100%. BGTC also offers a LPN to RN program.

If you would like information on any of the programs, call Mrs. Holland at 901-1200 or Angie Harlan at 901-1201.
Surgical Weight Loss by Keri Clark, RN, Bariatric Nurse Liaison

It’s midnight, the kids and hubby are asleep, and I’m enjoying the quiet time all to myself when it happens: that late night infomercial telling me to “order now” and all my excess weight will magically disappear, practically overnight. “Yeah, right,” I think to myself as I hurriedly dial the number because I’m going to prove to them that their product doesn’t work. Hey, I’ve got 30 days to try it and send it back, no questions asked. If I get it ordered in the next 5 minutes, they’ll upgrade shipping to express delivery! I know the last one I ordered didn’t work, but this time will be different. In fact, I think that one’s in the top of my closet behind the box of jeans I wore in high school. I’ll get back into them, someday….

That was me, over two years ago, before I considered having weight loss surgery. A 30-something mother of three boys with hypertension and a family history of heart disease. I was carrying over 250 pounds on my 5’3” frame. My feet and knees hurt most of the time. Sure, I tried weight loss programs throughout the years. Who hasn’t? For me, as with most people, getting the weight off isn’t the problem; it’s keeping it off for a long period of time. That’s where weight loss surgery has helped me.

Weight loss surgery (WLS) is neither a magic cure nor is it the easy way out as some would have you believe. It is the main tool in an arsenal that includes education on nutrition, exercise and support services asked. If I get it ordered in the next 5 minutes, they’ll upgrade shipping to express delivery! I know the last one I ordered didn’t work, but this time will be different. In fact, I think that one’s in the top of my closet behind the box of jeans I wore in high school. I’ll get back into them, someday….

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Weight loss surgery (WLS) is neither a magic cure nor is it the easy way out as some would have you believe. It is the main tool in an arsenal that includes education on nutrition, exercise and support that we are now offering at The Medical Center. As with any tool, proper use of it must be learned and careful consideration of its use must be taken into account before you choose it. So let’s learn a few things about obesity and how we combat it.

The Body Mass Index (BMI) is the standard calculator used by doctors to decide if their patients are in a healthy weight range. It takes into account a person’s height and weight.

**Body Mass Index for Adults**

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>18.5 to 24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25 to 29.9</td>
</tr>
<tr>
<td>Obese</td>
<td>30 to 34.9</td>
</tr>
<tr>
<td>Severely obese</td>
<td>35 to 39.9</td>
</tr>
<tr>
<td>Morbidly obese</td>
<td>40 and up</td>
</tr>
</tbody>
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The Centers for Disease Control has been collecting data on obesity rates in the United States since 1985. At that time, Kentucky was one of eight states who had 10-14% of their population listed as obese. By the millennium, Kentucky’s obese population had grown to 20-24% along with 22 other states. Currently, over 30% of our population is considered obese and that number is not expected to decrease any time soon.

What has caused this rapid increase in obesity over the last 25 years? The simple answer that everyone knows is calories in versus calories out. Taking in more calories than our body consumes in daily activities results in those calories being stored as fat to be used later in times of starvation. This worked rather well when we had to hunt our food before preparing and eating it. Now, we stalk only which restaurant gives us the most food for our money. However, our bodies don’t adjust to the changing times; it just knows what it’s supposed to do, and it does it very well. So well, in fact, that obesity has become a worldwide problem.

There are almost 7 billion people in the world. One billion of them are overweight and 300 million are obese (World Health Organization, 2011). To put this into perspective, the entire U.S. population is approximately 312 million (US census, 2010). Obviously those 3 a.m. infomercials aren’t working, so what does? Education, support and weight-loss surgery. Studies have shown that 95% of people who lose a significant amount of weight without weight loss surgery regain that weight and more within 1–5 years (Grodstein et al, 1996). Weight loss surgery patients, on the other hand, maintain a loss of at least 50% of their excess weight for at least 10–15 years (ASMBS).

I know what you’re thinking. **What’s the complication rate from weight loss surgery?** The rate of complications for Bluegrass Bariatric Surgical Associates, Dr. John Oldham and Dr. Derek Weiss, from 2003 to 2007 is:

- No major complications: 96.4%
- Deep Vein Thrombosis: 0.1%
- Gastrointestinal Leak: 0.2%
- Respiratory complications: 1.5%
- Wound infections: 1.3%
- Mortality: 0.1%

It’s no wonder The Medical Center has contracted with these two wonderful bariatric surgeons, who have been practicing together since 2003, to offer this much-needed service to our area. Their combined bariatric procedures performed since 2003 is over 6,000 and increasing every day. We will be performing all of the surgeries these doctors provide, which are the LapBand, Roux en Y Gastric Bypass, Vertical Sleeve Gastrectomy and Gastric Plication, all of which are performed laparoscopically, and the ROSE procedure which is performed endoscopically.

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What is Therapeutic Hypothermia?
Therapeutic hypothermia is the practice of controlled cooling of the body in order to protect the brain after an event causing reduced circulation. Studies have shown benefits to the brain in the post cardiac arrest patient for the past 20 years. It is already incorporated in many institutions and will soon be a part of The Medical Center as well. Cooling is typically done with mechanical cooling devices as well as ice cold normal saline in a peripheral or femoral line. Cooling must be done rapidly to be effective, and will typically be started by EMS before arrival to the hospital.

Who will be eligible for Therapeutic Hypothermia?
The currently proposed protocol only applies to post cardiac arrest patients. However, with increasing evidence and success, future patients may include stroke and STEMI patients. There are other inclusion and exclusion criteria for the post cardiac arrest patients of which you should be familiar.

What medications are used in Therapeutic Hypothermia?
There are several potential medications that are used for various reasons in therapeutic hypothermia. However, this article will only address those medications to be administered per the currently proposed protocol for The Medical Center.

Electrolytes
Electrolytes will require consistent monitoring. Therefore, there will be sliding scale prn orders for these, so they will already be on the eMAR for ease in documentation. Pharmacy kindly asks for notification when there is a need for calcium chloride as this is a concentrated electrolyte and cannot be on the floor with the diluted electrolytes. Electrolyte replacement may be required for magnesium sulfate to obtain a level between 1.5-2mg/dl, calcium chloride for an ionized calcium level <1.17mmol/L and potassium to maintain a level >3.4mEq. Another important note on potassium is that it must be stopped 6 hours before rewarming to avoid arrhythmias. Therefore, in the typical 24 hour cooling period for a patient, the potassium would need to be stopped 18 hours after initiation of the cooling process.

Analgesia
Analgesia is imperative in these patients as many will require paralytics, and it will be very difficult to know if a patient is in pain. Our current options for these patients are fentanyl and morphine bolus and infusions. Nurses will need to be looking for outward signs of pain such as hypertension and tachycardia; however, it is not known if these patients will still respond in such ways once cooling is started. For example, diaphoresis may not be present. We are currently looking into other options, including BIS monitoring, to assist in knowing if a patient is adequately sedated and without pain.

Sedation
Sedation is as much a necessity in the paralyzed patient as analgesia. Our current options will be midazolam (Versed) bolus and infusion as well as propofol (Diprivan). Once again, it will be imperative to be as watchful as possible in making sure the patient is adequately sedated until other monitoring options become available. There will be no sedation vacations while the patient is being cooled.

Shivering
Several medications may be used to aid in the prevention and treatment of shivering in patients. Our first-line medication will be buspirone (Buspar) per NG q8h for the prevention of shivering. If shivering begins, meperidine (Demerol) 50mg IV may be administered. For refractory shivering, cisatracurium (Nimbex) may be given as a bolus followed by infusion. This medication is a paralytic. Therefore, it is highly important to make sure the patient is adequately sedated and pain controlled before beginning this medication. The cisatracurium should be titrated by Train of Fours every hour until the dose is stable for 4 hours and as needed.

BP and Volume Management
Normal saline every 30 minutes will be given to acquire a SBP <90mmHg. However, the goal MAP is >70mmHg which can be achieved by our typical pressors. These include: norepinephrine, dobutamine, phenylephrine, dopamine and vasopressin.

Other Medications
Lacrilube to both eyes every 8 hours and as needed.
Pantoprazole (Protonix) 40mg IV twice daily.

If you have any questions or concerns about the medications for therapeutic hypothermia, please contact the pharmacy.

References

On Therapeutic Hypothermia by Amanda Walden, PharmD Candidate, approved by Glee Lenoir, Pharm D.