Welcome to D8 Team

Brett Mentuck – Night shift RN
Sharon Leach- Day Shift RN

Partners in Excellence

The **2016 Partners in Excellence** program is now accepting nominations.

Please take a moment to submit a nomination for a colleague who exemplifies excellence. Click here to complete an individual or team nomination.

Congratulations to Maxine….Our first Peak Article Raffle Winner!!!

Thank you for your ongoing commitment to the delivery of safe, patient-centered care.

The next raffle will be held on October 31st, so complete the peak articles in the reference folder and return to Eileen by Oct. 31st to have a chance to win!

D8 Weekly Gazette

September 2, 2016

Madonna Cruz
Nursing Director
Davenport 8

Eileen Hillick
Nurse Educator, D8

Joint Commission Series

Communication among all members of the interdisciplinary team is crucial to safe patient care. Communication might be observed during MDR, nursing shift handoff, transfers between units or to procedural areas and within our documentation.

Some types of communication are more vulnerable to mistakes than others and those will be a priority for the Joint Commission to check out while they visit us. They might ask you to describe our process around verbal and telephone orders. (Hint: Verbal and telephone orders are only taken in circumstances when the physician cannot process the order. When taking a VO/TO at NSMC, we *write* down and *read* back and *receive confirmation.*) Or, maybe they will want to know what our process is when the lab reports a critical result by phone. (Hint: RN must receive the critical result, **write it down and read it back to laboratory personnel and receive confirmation**. Then he or she notifies the prescriber and documents the result in CPOM. The acceptable time frame from the time the result is available in Lab to the time responsible prescriber notified is **60 minutes**.)

Survey Readiness

Patient Rights

North Shore Medical Center respects the rights of each patient and provides an environment free from abuse/neglect. Each patient is an individual with unique health care needs. All NSMC staff provides safe, compassionate care and attention to each patient's individual needs and respects each patient's personal dignity. Staff is reminded of these rights every year through the Annual Mandatory.

These rights include:

- The right to know the identity of the caregiver
- The right to be treated in a respectful manner
- The right to have a family member or friend present for emotional support
- The right to have their concerns or wishes heard

GREEN CUROS CAPS: Applied to all needleless connectors and IV tubing access ports/Y ports and IV tubing of central line patients.
WHITE CAPS from saline flushes- NEVER TO BE USED TO CAP IV TUBING!!
BLUE CAPS- only used to cap IV tubing for patients with a peripheral line (and no **central line).**

What do patients Say …

Tom, Rose and Amanda– "*They went above and beyond to provide the best care for me. They were genuine in showing their care and concern.*"

Jill –"*She is a great nurse, very attentive to my needs.*"

Phil - "*I felt all the tension gone when I heard his music.*"

Thank you for making a difference…

Messages from Maureen

- If your patient is refusing to drink prep for GI testing, you must notify the MD for an alternative prep immediately and not leave for next shift as this may delay their test.
- Joint Commission walk through are for our benefit to get us JC survey ready. Please accept their constructive criticism and adhere to their recommendations.
- Front Med cabinet must be locked at all times!

CAM/Delirium Series

Week 6 – The Delirium Order Set

When you identify a patient experiencing delirium you must communicate this to the provider and suggest that they order the **"Delirium Order Set".** The order set contains orders for labs, nursing orders geared toward patient safety and reorientation, and medications that can be used to treat agitation.

Labs such as a basic metabolic panel or a urinalysis help us to determine the cause of delirium and look for things like electrolyte imbalances or infection. In addition, the physician may choose other diagnostic tests such as CT or EEG to look for other reasons the patient may be disoriented.

You will see nursing orders such as vital sign frequency, toileting schedule, ambulation and maintaining a normal sleep/wake cycle. These are all helpful to maintain patient safety as we try to bring the patient back to their baseline mental status. Ambulation is key! For the patient who wants to get out of bed, take them for a walk (if able)!! It will help your patient refocus while expending some energy!!

You may also see orders for Haldol. **Haldol is the drug of choice for treatment of delirium.** Use the lowest dose possible for the shortest duration and after a 24 hour report of clear cognition and absence of agitation consider discontinuing this medication. EKG monitoring is required for patients on Haldol to watch for lengthening of the QTc interval. **Note: Benzodiazepines such as Ativan are not recommended for delirious patients.**

Philip Wyman is one of the success stories of D8.

He was a once a D8 patient, got bored and started playing Guitar in his room. Some of the patients heard him and stated listening. Then he started playing in the waiting room.

Now, Phil is one of the Volunteer Musicians on D8. Phil and his group bring smiles to patients, helping them to feel relax and calm.

Thank you Phil and thank you to the Volunteer Services.

Please remember to date all IV tubing and IV fluids. Tubing is good for **4** days; IV fluids once spiked are good for **24** hours. **IV bags** opened from the plastic package in the med room are only good for 15 days. Please date them. We have a temporary sticker to put on the IV bag. Thank you to our JACHO Champions – **Janet and Taylor.**

National Patient Safety

Improve staff communication by reporting critical results of tests and diagnostic procedures in a timely way

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life threatening situation. The objective of this Safety Goal is to provide the responsible licensed caregiver these results quickly so that the patient can be promptly treated.

NSMC Critical Test Reporting Process
(Lab to patient's nurse)

- The lab calls the nurse on the patient's unit with the critical results (only nurses can receive critical test results from the lab)
- The nurse receiving the critical result writes it down and reads it back to laboratory personnel and receives confirmation
- When the RN receives the result, he or she notifies the appropriate provider (MD/PA/NP) and/or follows the appropriate protocol immediately.
- The acceptable time frame from the time the result is available in Lab to the time the appropriate provider is notified is no more than 60 minutes
- Information concerning the critical test result should be documented in CPOM, MedHost or documented in the medical record and should include test result, time result available, responsible provider notified, and time of notification.
- Ordered treatments related to the critical test results should be processed and administered promptly.

Upcoming Events:

Na Skills Fair: Salem and Union Campus in August and September. Please see Madonna, Wendy or Eileen to sign up! Raffle prizes being offered!

September 7th (Union) & September 8th (Salem) 11:30-1:30: eCare information fair..... Have your questions answered by the experts!

Super User Orientation Sessions: September 12, 14, 17 @ Salem Campus. September 13, 15 @ Union Campus. Wendy will be scheduling you for this 1 hour session so check your emails!!

September 9 – NA EKG Class.

September 14th, Wednesday, from 7:00am to 10: am next PUP on the Salem Campus.