



UNITED  
HOSPITAL

Allina Hospitals & Clinics

# Nursing Notes

*A quarterly publication for United Hospital Nurses*

## Called to Serve the Community

by Christie Frid, RN, BSN – Nurse Clinician SMOONE

Twelve United Hospital staff members collaborated with Westside Community Health and donated their time and skills to volunteer at the Health Care area of the East Metro Project Homeless Connect on June 29, 2009.

Project Homeless Connect brings together several groups and agencies to work to meet the needs of our homeless population; all under one roof. This year Project Homeless Connect served approximately 1,400 people. While working in the health care area of the event the staff did blood pressure readings, checked blood glucose and hemoglobin levels, provided foot care, counseled on asthma control, provided information on stroke and heart disease and instruction on deep breathing exercises. The health care area served more than 300 people

While the attendees of the event surely received support and care, the volunteer staff also received a rewarding and humbling experience. As noted by one volunteer the reasons for being homeless are many and not limited to a lack of ambition or effort in bettering oneself. Most situations are impacted by a lack of financial resources that occur through loss of employment, under-employment, accumulated debt, chronic illness, trauma, disaster, or violence.

All the individuals who volunteered this year are looking forward to volunteering at the event next year.

### IN THIS ISSUE:

Building a Healthy Community	2
What Happened to the Yellow Burning Questions Box?	4
Consider Patient Privacy Before Posting Online	5
Hourly Rounding	6
United Hospital is Committed to Advancing Nursing Practice and You Can Help	7
Celebrations	7
Diabetes Management Team Pursues Joint Commission Certification	8
United Achieves National Nursing Award	8
Beyond the Hendrich	9
Emerging Trends in Health Care	10
Family Presence and Code 99	11
Service to Humanity honors Dr. Todd Hess and Merry DeCourcy	14
Policy and Procedure Updates	14



L-R: (Back Row) Norma Roberts-Hakizimana, Susan Loushin, Kim Love, Rozann Reyerson and Marguerita Hall. (Front Row) Queen Obasi and Karen Argo

# The Theme of 2009 United Hospital Nurses Week “Building a Healthy Community”

by Susan Loushin, BS, MA, RN Professional Development Specialist, Chair 2009 Nurses Week Committee

In keeping with the theme of building a healthy community, the Nurses Week Committee chose as the gift a coupon holder that contained coupons for local businesses as well as the UH Gift Shop and ExerCare. This gave local businesses the opportunity to honor nursing and for nurses to help the community by frequenting those business.

## Nurses Week gives back to the community

UH nurses helped build a healthy community through the Community Giving book and magazine drive. Nearly 25 grocery size bags of books and magazines were delivered to local shelters (such as Listening House, Dorothy Day Center, Health Care for the Homeless, Love Grows Here Wellness Center, CURE Ministry, Karen Community of Kids, and even the United Hospital Gift Shop). “It was a fabulous effort by the staff of United Hospital. Everyone was very receptive and grateful for the contribution,” stated Karen Argo, RN float pool and chair of the Nurses Week Community Giving book drive.

The first event for Nurses Week was the opportunity for nurses to come together to share stories of nursing and dialogue about our care model, Outcome-based Relationships, and the caring connection. Char Tourville RN Float and Rozann Reyerson RN Birth Center facilitated the discussion. There is no better way to build a healthy community than to develop and maintain excellent relationships with patients, families, and co-workers.

## 2009 Excellence in Nursing Awards

The 2009 Excellence in Nursing Awards celebration, held May 4, 2009, brought together more than 150 United Hospital staff members, award nominees, their co-workers and other family and friends, including special guests, the Apperts (the family of Ann Shiely).

The celebration began with lunch, a delicious cake prepared by the United Hospital Executive Chef, and entertainment of beautiful harp music performed by JoAnn Rivard (Horrisberger). Marie Stuewe, RN, bi-chair of UH MNA and Nurses Week committee member, was mistress of ceremony. Opening remarks were presented by Tomi Ryba, president, United Hospital; Jay Westwater, MD, JD, Medical Director of the Emergency Department and Jeff Wicklander, RN, vice president, Patient Care, United Hospital. All Excellence in

Nursing Award nominees were called on stage, by Stuewe, Wicklander, and Linda Slattengren RN, bi-chair UH MNA, in acknowledgment of their nomination.



**LPN Practice & Service**  
Barb Salter, LPN, SKI,  
Rehab 8940



**Nursing Leadership**  
Jeanette Maruska,  
RN ACM, NHC,  
Critical Care



**Nursing Practice & Service**  
Naomi English MPH, RN,  
Resource Float Pool



**Jane Kostecka Teaching & Mentoring**  
Tina Anderson, RN,  
Medicine 4500



**Ann Shiely Community Involvement**  
Robin Henderson, RN,  
Main OR

## The following nurses were the recipients of the awards:

Stephanie Cook, RN, director of SMOONE and Mental Health, on behalf of Jane Kostecka, RN, introduced the newly designated Jane Kostecka Teaching & Mentoring Award. Jane Kostecka, RN, has been a nurse on the Medicine unit at United for many years. She was instrumental in developing and implementing the new graduate nurse orientation program and mentoring other nurses to be orientation facilitators and preceptors. Many nurses can attribute their post-education acquisition of nursing skills to Jane Kostecka’s teaching &

## The Theme of 2009 United Hospital Nurses Week “Building a Healthy Community” (continued)

mentoring. She is gifted at sharing not only her nursing skills but critical thinking. Jane could not be at the Awards presentation, but was very honored and humbled by the teaching and mentoring award being designated in her name and was very proud that Tina Anderson, RN, Medicine was the first recipient of the newly designated Jane Kostecka Award.

This was the second year for the Ann Shiely Community Involvement Award. Ann Shiely was a registered nurse who taught nursing, including at United, and was on the United Hospital and United Hospital Foundation Boards. Shiely, who was passionate about serving the community especially focusing on children’s health and welfare, received the Service to Humanity Award in 1987. Robert Appert (son of Shiely) presented a plaque to Robin Henderson, RN Main OR, the recipient of the Ann Shiely Award.

### Nurses Week celebrates diversity

Many of the activities to celebrate Nurses Week centered on cultural diversity. Each event featured ethnic food or snacks prepared by the executive chef for UH catering service. There were several opportunities for nurses, hospital staff, and even community members to find out about the wonderful work UH nurses, physicians, and staff are doing locally and globally.

Chris Tupy RN, NHC 3300 enlightened us about the healthcare mission trip she recently completed in Haiti. Queen Obasi RN float pool, Stephanie Veldman RN critical care float, and Kathy Shimada RN NHC 3500 gave a



wonderful presentation on their recent mission with Dr. Talbert and Robert Taylor HUC to Nigeria.

Nursing staff also had the opportunity to

gain awareness of the Mexican cultural tradition of celebrating “Day of the Dead”. Katherine Baumgartner, RN Augsburg College and Susan Loushin RN UH professional development specialist shared their experiences in Oaxaca Mexico during the Day of the Dead celebrations.

Der Her, Outreach Coordinator – Program Assistant at Sexual Offense Services of Ramsey County (SOS) gave powerful presentation on Hmong culture and sexual violence. Besides

nurses, the event was attended by chaplains, MDs, social workers, housekeeping, and other staff of UH. Another learning opportunity was a training session on Caring for Survivors of Violence by Megan Close, Health Outreach Specialist for the Sexual Violence Center

Rounding out the week’s celebration was a wonderful panel discussion on building a healthy community through a diverse workforce. The panel of Queen Obasi, RN (Nigeria), Del Conrad, RN (Philippines), and Suad Saleh, RN (Eritria) provided insight into the challenges faced by nurses from another culture entering the Midwestern nursing culture. They also shared stories of growing up in their native country and of their educational background. During dinner there was wonderful dialogue on cultural differences and similarities and how both can work to our advantage especially in this increasingly global world.

Some other activities that took place during the week were:

- Cookies for Caring compliments of the Medical Staff (more than 800 cookies were handed out during the physician rounding)
- Mantoux testing for any employee (55 staff took advantage of the opportunity)
- Education and Volunteer opportunities Fair (several nurses planned to volunteer at the Project Homeless Connect on June 29, 2009 as a result of the fair)
- Waffle Bar for Night Shift was co-sponsored by Children’s (more than 300 waffles were served)

### Thank you to the 2009 Nurses Week Committee

Thank you to the 2009 Nurses Week Committee for all the planning and hosting of this fabulous event: Karen Argo, RN, Float; Wendy Wimmer, RN, Pain Center; Cathy Colletti, RN, DSC; Marie Stuewe, RN, MNA bi-chair and Cultural Diversity Coordinator; Susan Loushin, RN, Professional Development Specialist; Naomi English, RN, Float; Annie Retter, RN, Float; Katie Westman, RN, Nurse Clinician II; Melissa Fritz, RN, Nurse Clinician II; Kimberly Love, RN, NHC 3500 and Tanya Schally, Marketing and Communication.

# What Happened to the Yellow Burning Questions Box?

by Christie Frid, RN, BSN – Nurse Clinician SMOONE  
& Co-Chair Nursing Research Council

The Burning Question process was implemented in 2006 to allow staff to put forth questions relating to clinical practice and decision-making. Many great initiatives have been generated through this process.

The Burning Question process has been updated! Questions should now be submitted electronically via the following weblink: [akn.allin.com/united/policies/nursing/index/htm](http://akn.allin.com/united/policies/nursing/index/htm)

Click on the Burning questions: Clinical Inquiries link. From here you can type your question. Please make sure to enter the unit name or practice area in the subject line; this gets the request routed to the applicable unit council for follow-up.

The screenshot shows a Windows Internet Explorer browser window displaying the Allina Knowledge Network website. The address bar shows the URL <http://akn.allina.com/united/policies/nursing/index.htm>. The page title is "Nursing practices, resources & information". The website header includes the Allina logo and navigation tabs: HOME, INSIDE ALLINA, TOOLS & SUPPORT, PATIENT CARE, EMPLOYEE RESOURCES, and EDUCATION & RESEARCH. The main content area is titled "UNITED HOSPITAL" and "Nursing practices, resources & information". It features several sections: "Nursing evidence-based practice guidelines", "Nursing ethics resource manual" (with a table of contents), "Burning questions: Clinical inquiries" (with a form for submitting questions), "Minnesota Nurses Association" (with links to decision logs and forms), "MNA/United committees" (listing Health and Safety, Labor Management, Nursing Practice Care Delivery, Nursing Research, and Staffing Advisory (SAC) and JCI), "Nursing organizational charts", and "Magnet recognition program". The footer includes a search bar and a "Trusted sites" notification.

## Consider Patient Privacy before Posting Information Online

The popularity of blogs and online sites like Facebook, MySpace, LinkedIn and Twitter have changed how people communicate – virtually. Online social networking sites give people opportunities to share, create and communicate in ways that have never been possible before. The positive effects of social networking are seemingly endless; you can contact old classmates create an online newspaper and stay better connected with friends and family. However, industry insiders warn users that information they share on social networking sites should be considered “public information” even if accounts are set to private.

“Lots of people have the misconception that if their Facebook or MySpace page is private, they can reveal private information without risk,” Linda Zdon, IT director of security, quality and compliance, said. “That’s not true, there is always an electronic trail, and these sites don’t necessarily guarantee privacy.” Keep in mind that individuals can be held personally responsible for comments that violate an obligation of confidentiality, that violate the rights of others, or that are defamatory, libelous or obscene.

It is especially important to be mindful of patient privacy requirements when using these sites. Sharing information about a patient via a social networking site or a personal blog is a violation of patient privacy laws, professional and ethical obligations to maintain patient confidences, as well as Allina policies and procedures. Never share information about a patient’s care, or identify a patient on these sites.

*“Protecting our patients’ privacy is one of Allina’s top priorities.”*

“Protecting our patients’ privacy is one of Allina’s top priorities,” Vice President of Audit and Compliance, Mary Jo Flynn, said. “Employees should not share patient information for non-patient care purposes in any circumstance. This includes verbally at your dinner table, via email, on your blog or on your private Facebook page.” A good rule of thumb is to keep details concerning patients off of any of these blogs and online sites.

Patient health information cannot be posted online, even if it is in response to false or inaccurate information that is already posted. For example, if a patient leaves a negative



comment on RateMyDoctor.com, it is a violation of patient privacy laws to respond to that comment with details about the specific case.

Allina may periodically monitor the posting of information pertaining to Allina in any internet communication. Employees will be subject to corrective action for violating privacy requirements for patient health information.

For more information about HIPAA privacy regulations and how to handle private patient information:

- View the HIPAA Information & Procedures and Guidelines
- View the HIPAA Self-Study Training Guide
- Confidentiality of Patient Information Policy (policy on MyAllina)
- Confidentiality and Non-Disclosure Policy (policy on MyAllina)
- Allina Code of Conduct (policy on MyAllina and full Code of Conduct on AKN)
- Contact Corporate Compliance 612-262-4900

# Hourly Rounding

by Steve Horstmann, RN – Patient Care Manager Unit 4500

Patient satisfaction is up, pressure ulcers and patient falls are reduced, and nurses are walking nearly a mile less per day at a medical center in Alabama. So what's their cloak-and-dagger? Hourly rounding is the secret.

It is no mystery that nursing is a demanding job. Nurses are constantly being pulled in all directions as we cultivate the care of our patients. One ritual that seems to deplete our time during the day is the use of the call light. What was once used as a staple call of an emergency, has become an all too often scene on nursing units.

Nurses who incorporate hourly rounding into their practice not only give trust and reassurance to their patients, but they also benefit much needed time control of their day by lessening the use of call lights. According to the Studor group, nurses on average are called to a patient's room 12 to 15 times a day for non-urgent needs. By employing hourly rounding into your daily practice, nurses can save an average of one to two hours a day to focus on tasks that require your attention and expertise.

To follow the recommended routine of hourly rounding, the nurse making rounds completes any scheduled tasks, such as a dressing change or scheduled medications and checks the three Ps of rounding: pain, position, potty (the top reasons patients use the call light). Also included in making rounds is assessing the environment to ensure the call light, phone, and trash can are all within reach of the patient. As the

nurse is leaving, he or she asks the patient if they need anything else before they step out, and informs the patient they, or the patient care associate, will be back in an hour. This routine gives the patient confidence the nurse will return in an hour to handle regular tasks, and thus, patients usually only calls for urgent needs.

As nurses incorporate evidenced based practice into our routine daily, like that of core measures, we ensure patients get top quality care while they are under our care. Hourly rounding is evidenced-based. Every study done has concluded that in facilities where hourly rounding is deployed, there is a reduction in falls and pressure ulcers. While patient satisfaction scores also rise so does the morale of nurses. Nurses who have incorporated hourly rounding into their routine report feeling more fulfilled knowing they had more time to dedicate to patient care.

Building hourly rounding into your daily schedule may just be the answer to saving time and energy that we, as nurses, and our patients deserve. Nurses have absorbed evidence-based practices into their realm of tools. With hourly rounding now there is one more best practice that is sure to fit in and have a positive impact, not only for you as a nurse, but for our patients who deserve the very best nursing care.



**HOURLY ROUNDING**

# United Hospital is Committed to Advancing Nursing Practice and You Can Help

by Jeff Wicklander, RN, BSN, MSN, APRN, BC-NE Vice president, Patient Care

The purpose of the Nursing Education Fund is to support all United Hospital employees who are furthering and/or pursuing education, leading to degrees in nursing. Your support of this fund will help further clinical and professional development that may not have been otherwise possible.

During the 2008 Employee & Community Giving Campaign 75 individuals contributed to the fund raising \$15,922. Thank you!

We thank our staff who provides exceptional patient care in an environment that is supportive, compassionate and healing and promotes professional and personal growth.

Watch for additional information over the next several months on accessing and contributing to this fund.

## *Celebrations*

### **CERTIFICATIONS**

CCRN – Certified Critical Care Registered Nurse

**Diane Seguin, RN, CCRN**, Critical Care has been recognized for 30 years of continuous CCRN certification

**Michelle Radtke, RN** Critical Care

**Melissa McLaren, RN** Critical Care

**Carla Fowler, RN** Critical Care

**Alicia Hartquist, RN** Critical Care

**Paul Haas, RN** Critical Care

ONC – Oncology Nurse Certification

**Monica Cook, RN** Unit 2500

ANCC Med Surg Certification

**Jeff Roach, RN** Float Pool

**Lynne Blomquist, RN** Unit 2600

**Norma Roberts-Hakizimana, RN** Unit 4500

CRRN – Rehab certification

**Kofi Boa Amponsem, RN** Unit 8940

### **SPECIAL PROJECTS**

**Laticia Christensen, RN** Critical Care, working on Restraint Reduction project

**Hossein Alimohammedi, RN** Critical Care working on Mobility Protocol project

### **EDUCATIONAL ADVANCEMENT**

BSN

**Nancy Eells Richards, RN** ACM Unit 4500 graduated from Augsburg Summa Cum Laude

**Amy Clark, RN** ACM Unit 2400 graduated from Augsburg

**Mary Feist, RN**, Patient Care Manager Unit 3500 graduated from Augsburg

**Meredith Klein, RN** Unit 2400, graduated from Augsburg with honors

Master's

**Susan Huehn, RN** Unit 2200 obtained her Master's degree in Nursing Education

### **HONORS & SCHOLARSHIPS**

**James Tczap, RN**, ACM Mental Health, has been named a 2009 Health Care Hero by *Twin Cities Business* magazine.

## Diabetes Management Team Pursues Joint Commission Certification

by Richard Shank, MD – Medical Director Medicine Services

Approximately six percent of Americans have diabetes, but among hospitalized patients at United Hospital 22 percent have diabetes or significant hyperglycemia.

These individuals have had an average length of stay 1.9 days longer than those without diabetes. The Diabetes Management Team is a multidisciplinary group working to improve care for these patients by a combination of data collection, quality improvement activities, and staff and patient education initiatives. Members of this team from nursing include **Patti Long, RN CDE, Sue Truhler, RN CDE, Debra Myhre, RN, Maureen**

**Smith, RN MS CNS, Julie Sabo, RN MS, Pat Dillinger, RN, and Steve Horstmann, RN.** The team includes also members from pharmacy, nutrition and physician staff. Successes to date include improvements in survival skills education, hypoglycemia rates, physician and nursing documentation, coordination of meal delivery with insulin administration, and length of stay reduction of ½ day in the past year.

United Hospital has applied for the Joint Commission/American Diabetes Association Certificate of Distinction for Inpatient Diabetes Care, an award akin to United's Stroke Certification awarded in 2006. That certification

requires demonstration of safe, high quality care, including patient outcomes, documentation, patient education, and communication among caregivers. We anticipate a site visit for this certification in October 2009.

United Hospital Nursing Staff can assist with improved outcomes for these patients by completing diabetes education documentation and by assertiveness with physicians in advocating for improved glucose control. Thank you for your good work in achieving best care for these patients!

## United Achieves National Nursing Award!

by Naomi English, RN, MPH – Staff Nurse Float Pool

The Nursing Department here at United has earned the prestigious Magnet™ Hospital award. News of our Magnet designation came on April 16, 2009 as Jeff Wicklander, vice president, Patient Care Services, made the announcement in the Bentson Room. Many leaders and staff alike packed into the small room to hear the exciting news.

This award places United Hospital in very exclusive company – only four percent of hospitals nationwide have been designated

as Magnet™ hospitals. We easily won the award because of our commitment to patient care, staff development, and our role in the wider community. Our surveyors who visited us in January were very impressed with the strong programs that we have in place – research, patient education, joint efforts between management and MNA, precepting new nurses, safety and injury prevention efforts among them. One benefit of Magnet™ designation is that United Hospital will soon be posted on the Joint Commission

website for our public, other professionals and other interested parties to see.

In October, a small group of staff nurses and leaders will travel to Louisville, Kentucky to attend a National Magnet™ Conference, where United Hospital's Magnet designation will be announced on a national stage, before hundreds of nurses from all over the country. Many of us here at United worked very hard to achieve this goal and we are all proud of this huge achievement!



# Beyond the Hendrich

by Katie Westman, RN, BSN, Christie Frid, RN, BSN & Melissa Fritz, RN, BSN –  
Nurse Clinicians SMOONE

In 2009, United's hospital fall rate skyrocketed. We have a standardized, familiar fall risk tool and multiple nursing interventions, but what else can we do?

The Clinical Nurse Specialist group has identified three potential areas to think about. The first concerns the Hendrich scoring system itself. After reviewing many, many falls and talking with other staff nurses, there seems to be a little confusion around scoring the get up and go, altered elimination, depression and medications portions of the tool. The best advice we have is to use the details box when you chart. After the last Excellian upgrade, the box became interactive, so you can click and chart right from it. The descriptions will change as you move through the Hendrich, presenting what you need to know for each section. If you assess something outside of the detail parameters, go ahead and enter a comment.

The second component is recognizing the dynamics of individualized patient care, on a continuous basis. Look for patterns in behavior, as in does the patient sundown? Most people need to toilet first thing in the morning, and after a meal, so those are times of the day requiring high awareness. Did PT come the same time everyday? Has mobility increased or decreased based on the course of illness?

A patient's diagnosis and/or co morbidities can also affect mobility. For example:

- Arthritis may make it harder to move in the morning, right when your patient may have an increased need to toilet.
- Your patient with Benign Prostatic hypertrophy may make frequent trips to urinate at night, when the room is dark and there are fewer caregivers available.
- Other illnesses like Parkinson's, or a stroke, may contribute to fatigue later in the day, especially after PT/OT, multiple tests, family visits, and not much sleep.
- Think back over the course of illness and hospital stay as well. Someone admitted from the community with a short course of pneumonia will have much different strength and ability, especially in the legs, than a transfer from the ICU.
- Heart surgery will affect someone differently than a hip or knee.
- Think through if your patient is frequently hospitalized, and used to our routine versus someone admitted infrequently and unfamiliar with the routine and physical space.

Now it is time to put it all together. For example, Mrs. B scores a seven (7) on your shift. She was admitted yesterday, and this am the MD doubled her Lasix dose, which you gave IV at 1345. How do you think ahead to keep your patient safe on your shift and the next?

- Increase frequency of toileting episodes, and stay with the patient
- Be insistent about going to the bathroom when you round
- Have a urinal close by, if appropriate
- If your patient is deconditioned, frequent toileting can have an effect on their activity tolerance level. While at 0900 they transfer with 1 and a walker, by 2100 you may need a commode or EZ stand.

Mr. Z hasn't moved his bowels in three days, scores a 6 on your shift, is slightly confused, sleep deprived, but asking for help. He doesn't need a tab alarm, as he uses his call light consistently. Over 12 hours, he received MOM, prune juice, senna, and colace. He doesn't exactly fit the altered elimination category, but how can you anticipate his toileting needs over the next 24 hours?

Finally, what tools do you have at your disposal?

- Tab alarms. Remember the new tab alarms can be programmed to record messages and they have locking clips for those clever patients who remove the tab alarm. The recording feature works very well if someone familiar to the patient can record a message – especially for those who are confused or have a language barrier.
- Pressure pads. Along with the black tab alarm boxes, these pads can be hooked up and placed under the patient. When the patient shifts their weight the alarm sounds; when they sit down, it turns off...clever.
- Remember a closely placed commode or urinal can reduce falls as they replace a desperate dive for the bathroom.
- Talk to the patients and families. Explain why you are concerned about the patient falling. Pull out the falls guide from the admission packet for them to review. Contract with them to call for assistance.
- Keep up the hourly rounding! Be specific when asking about the 3 (or 4) P's. Do a quick room scan, pick up and move things out of the way, like garbage cans, things on the floor, etc. Also leave necessary items like a urinal, telephone and call light within easy reach of the patient.

# Emerging Trends in Health Care

by Marie Stuewe, RN, MNA Bi-Chair

The Emerging Trends in Health Care conference is designed to help us look at culture and age and the effect each has on us. Where we come from or how old we are influences how we think, and in fact, everything we do. When we understand each other's culture and how age shapes us, communication is improved – not only between co-workers but also with the patients that we care for. Both of these lead to better patient care and outcomes.

## A more diverse patient population

Today's patient population and workforce are more diverse than ever before. Not only diverse in country of origin, where our ancestors came from, what part of the United States we come from, but also a wide span in age. For the first time hospital employees

come from four or six (depending on source) generations, each with its own history, work and communication style, and problem solving skills. We have nurses from 21 years of age to 65 + working together. For some of them nursing is a second or third career. The self disclosed ethnicity of nursing staff here at United for 2008 indicated:

- 92 percent White/Caucasian
- five percent Black/African American/African
- just more than one percent are Hispanic/Latin
- two percent are Asian/Pacific Islander
- just more than one percent indicated more than two ethnicities
- just more than one percent did not identify their background.

The January 2009 data from the Minnesota Board of Nursing indicates that 2550 RNs, with current licensure, were educated in another country. In 2008 requests for 59 languages and dialects were filled by interpreter services here at United. All of these numbers will only increase as the world changes making the Emerging Trends in Healthcare Workshop a must attend.

So, come spend the day! Hear Henry Lee talk about cultural differences and similarities and Lisa Lind address age and its influence on our behavior. We will close the day with Tou Ger Xiong, Hmong story teller, Hip Hop artist & comedian who uses humor and stories to look at culture, "as much as we are different we are the same".

## Save the Date

All United Hospital Employees

When: October 23, 2009 7 a.m. – 4 p.m.

Why: Emerging Trends in Health Care Conference

*"Making a Difference in a Multicultural & Multigenerational Workplace"*

Where: United Hospital JNMC Conference Hall

Cost: No cost to United Employees

Registration: Through SABA or call 651-241-8225 by Sept. 11, 2009  
Late registration will be accepted.

FYI: ANCC & CEU credits available

*Watch for further details in flyers and in the Weekly Communication© posted on the AKN*

# Family Presence and Code 99

by Marcy Bergie, RN, CCRN – Rapid Response Team

There is a debate going on in hospitals around the world about the risks and benefits of having family members present during resuscitation efforts. Over the past 20 years, hospitals have been challenged by families who refused to leave their loved one's side. Initially this idea was met with much resistance from staff due to perceived risks, including:

- Lack of staff and room to meet family needs
- Violation of patient confidentiality and privacy
- Increased performance anxiety by staff
- Potential family interference with care
- Discontinuing code may be difficult
- Adverse psychological impact on family
- Fear of increased risk of litigation

On the other side of the hospital bed, family members feel very strongly that they “have a right” to stay with their loved one. Advocates of family presence see the perceived benefits as:

- Relieving the family's doubt about what is happening by reassuring them that everything possible is being done
- Allowing the family to participate in supporting their loved one
- Supporting staff to act more professionally and treat the patient with more dignity
- Facilitating the family's grief

Anecdotal evidence also shows that codes are shorter because family members ask that resuscitative measures be stopped. As the family presence movement has grown over the last two decades, this practice has full support of numerous professional organizations such as the Emergency Nurse's Association, Society for Critical Care Medicine, and American Association of Critical Care Nurses.

An increasing number of hospitals now allow family members to be present during the resuscitation of a loved one. United Hospital began that journey back in 2001, when an interdisciplinary team developed the Family Presence protocol. It was met with mixed support. In 2003, another Family Presence Task force reconvened, which launched a pilot program in the Medicine Care Center and the Emergency Department. In 2007, the next step identified was the need to add an RN to the code team to serve as a “*Family Presence Facilitator*”. In 2008, the decision was made that the Rapid Response Team RNs would receive education on fulfilling this role. Recently, the RRT has started a Family Presence Registry to track family presence events (number of family members present, interruptions, if family members felt faint or requested to leave the room). The Code 99 Committee will periodically report on family presence events.

Russ Meyers, D. Min., BCC., Chaplain lead from Spiritual Care and Margo Halm, RN, PhD, CNS-BC, Research Scientist, have created a beautiful presentation about this very subject

that is available for you to watch (1 CEU granted). The powerpoint video may be signed out with Mary Milligan, Nurse Leader of the Float Pool and Rapid Response Team, located on the first floor staffing office at United. If you choose to watch the video, you will meet Doris Stromberg, the wife of a patient that was at United approximately five years ago. She is an articulate and loving wife who was at United when her husband experienced a sudden, unexpected Code 99. She speaks of how she had spent 30 years with a man who had been with her through life and love, births of their children, deaths of other family members, and now he needed her to be with him during his last moments on earth. He did not survive, but Doris felt that she knew everything that could have been done for her husband was done, because she was there as a witness. She speaks highly of a Respiratory Therapist (*Vicki*) who took her to the bedside and explained everything that was being done and why. Chaplain Russ Meyers contacts Doris approximately once each year just to see how she is doing. The way she explains her need to be with her husband will leave you emotionally changed, and intellectually challenged to dispute her right to be at his side during that most precious time. As Doris will allow you to see, the caregivers she remembers are the ones who connected their head to their heart within the framework of the protocol. They were present with her in her hour of need. With the focus on outcomes and best practices which are all connected to our bottom line, it is

(continued page 12)

## Family Presence and Code 99 (continued)

sometimes difficult to remember that we need to be in the present moment with our patients. Our relationship with our patients is not just with their physical body, or their name in a computer, but with their mind and spirit as well. At no time is this more important to remember than during their most difficult experiences. Family presence will leave you thinking and challenging yourself to let go of the illusion of control that is so characteristic of “our old way of doing business”, such as restrictive visiting practices, and hopefully placing our emphasis back on patient autonomy, connectedness, caring relationships, and compassionate care.

During the Magnet Interview evaluation this January, we were asked a simple question. “*How were we caring for our patients together as a team?*” We answered this question with a story that happened this past December. A patient on the fourth floor, a man in his mid-fifties with significant health issues, had just had a major surgery. His wife, an RN herself, had been staying with him constantly since admission. She had gone home for one night to Wisconsin to rest, and so the patient’s brother was the relative staying with him. The sat monitor started to alarm, and when the nurse entered the room, she found the patient struggling to breathe, and initiated a Code 99. During all resuscitative efforts, the brother refused to leave the doorway. He contacted the patient’s wife by cell phone, who was two hours away during a snow storm. She began the long drive in, calling her brother-in-law periodically for updates. As we moved the patient to the ICU, the brother was in constant attendance. All of the personnel involved were aware of and comfortable with his

presence. In the ICU, the patient coded again. As the brother spoke with the wife by phone, she was able to make the difficult decision to change his code status, because she knew he was in the best of care, and his brother was witness to this fact. Her request to change code status was relayed to the staff, and the physicians spoke directly with the wife on her cell phone. During all this time, the brother stayed at the bedside, remained calm and only requested a glass of water and a Bible. We explained there was a chaplain-on-call and he agreed that it would be helpful if a chaplain could offer spiritual care to the family. We contacted the chaplain-on-call and she was able to make it to the bedside before the patient’s wife arrived. Hospital security was notified and they agreed to meet the wife in the ED parking lot, escort her to the ICU, and park her car for her. They sat in the lot and waited for her car to pull in, knowing that she was alone and dealing with an extremely difficult decision. As the family spent their last moments with their loved one, they were surrounded by people at United who cared about their situation and the family could feel it. No one involved had trouble connecting their head and their heart to this situation. United Hospital came together that night for that family in a way that should make us proud.

I agreed to write this article because it is a subject so close to my heart. I would give anything to be among those few caregivers who have never been on the other side of the fence. Many of us have been the family presence, when we so desperately did not want to be. My turn came 25 years ago while the staff in the labor and delivery area tried unsuccessfully to revive our full-

term, perfectly healthy son, Eli. It was not to be. I knew, because I was there, that everything had been done to the best of their capabilities. My husband and I received grief-counseling at Children’s Hospital with the help of the pastoral care staff and the social workers who facilitate support groups for parents who have lost infants and children. We found comfort in the nurses who came to Eli’s funeral and cried with us through it all. We connected with the staff in the way that only nurses can connect with patients and families. When I come to work, I look around at others at United who have lost children, significant others, parents, brothers and sisters, nieces and nephews. Some of us, more than once. They are the staff who are comfortable with family presence and understand its value. In a job where the focus is so much on tasks and intellect, let us not forget to connect our heads to our hearts. Try to take the time to be present with yourself and with your patient. It’s a step you’ll never regret.



## Service to Humanity honors Dr. Todd Hess and Merry DeCourcy

by Janet Olariu-Tau – United Hospital Foundation

Get ready for the 25th Service to Humanity Gala on Saturday, September 26, 2009, at Saint Paul RiverCentre. The 2009 Service to Humanity Award honorees are Todd Hess, MD, Medical Director of United Pain Center and an anesthesiologist specializing in pain management, and Merry DeCourcy a professional artist specializing in oil portraiture and a board member of United Hospital Foundation. The Service to Humanity Award is presented to individuals associated with United Hospital who have demonstrated selfless dedication and exemplary leadership in improving the health and welfare of St. Paul residents and the communities we serve.

This year's Gala features a raffle for 2010 Mercedes-Benz GLK 350 4MATIC. Tickets for the raffle are 1 for \$100 or 3 for \$250.

Proceeds from the Gala will benefit the Peter J. King Emergency Care Center at United Hospital. The 2008 Gala raised \$1.55 million to benefit the Peter J. King Emergency Care Center at United Hospital, and 1,500 people attended the event. Your sponsorship and silent or live auction donations will ensure another successful event and the promise of a new ED that will meet the needs of the Saint Paul community well into the future. For more information, please contact David Byrd, United Hospital Foundation, at 651-241-8025 or david.byrd@allina.com.

## Policy and Procedure Updates Summer 2009

- Cooling devices for Febrile Patients –  
New Policy! Education in 3rd Q packet
- Newborn nursery order set –  
Addition of order set # 30772 Level I  
Newborn Care for Late Preterm Infant  
(34 0/7 - 36 6/7 Weeks Gestation)
- Prolactin Levels – Minor revisions
- Code 99 – Reviewed no revisions
- Death of Patient/Post mortem care –  
Addition of requirement to call CMS with  
death potentially related to restraint.

**Managing Editor:** Tanya Schally, marketing communications specialist, 651-241-8514, tanya.schally@allina.com

**Editor:** Margo Halm, RN, PhD, CNS-BC, 651-241-8536, margo.a.halm@allina.com

**Editorial Board:** Susan Loushin, RN, MA; Margo Halm, RN, PhD, CNS-BC; Glenda Cartney, RN, ACM; Nancy Roberts, RN; Julie Sabo, RN, MN, CCRN, CNS-BC, CNS; Tanya Schally.

**Design:** Creative Services

*Nursing Notes* is the official newsletter of United Hospital nurses. *Nursing Notes* is published quarterly by the United Nursing Care Delivery Board.

*Nursing Notes* editorial board reserves the right to edit material based on content and space and to change this policy at any time.

United Hospital, 333 N. Smith Avenue, Mail Route 61760, St. Paul, MN 55102

*Nursing Notes* is also available under United/Employee Communications/Newsletters on the AKN.