MIAMI CHILDREN'S HOSPITAL®
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PURSUIT OF EXCELLENCE

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Rapid Response Team

By Linda Nylander-Housholder, MSN, ARNP, CCRN

The Rapid Response Team (RRT) is a hospital service to improve patient outcomes. It does not replace any existing services or processes. Anyone can call RRT if they feel their patient is getting worse or just doesn't look right. An experienced clinical team is dispatched to evaluate and triage these patients. The goal is to prevent any codes on the floor and to identify patients at risk for deterioration. The team will offer suggestions to management and if the team feels the condition warrants, the child would be moved to the ICU. This is not a Code Blue team.

Why do we need RRT?

Each year, approximately 15 to 20 children code (mostly respiratory arrests) in physician offices and units other than the intensive care units at MCH. The goal is to identify patients at risk for an arrest, and to take appropriate steps to prevent an arrest from occurring.

The MCH RRT team includes:

1. Pediatric resident: PL3
2 PICU senior RN
3. Respiratory therapist
4. PICU fellow (Backup)
5. PICU attending (Backup by phone consultation)

When do I call the RRT?

The RRT unit should be called when:

- Child's condition is deteriorating (trigger criteria)
- Worsening respiratory distress
- Worsening perfusion
- Change in mental status
- Altered lab values
- Caregivers are worried about the patient's condition (irrespective of vital sign numbers)

The RRT can be called by dialing 811 and should respond in less than 15 minutes.

The RRT was called 35 times in 2007. Three patients later became a code, but had been moved to the ICU when they coded, ensuring optimal speed in addressing their needs.

Nurse Leader In the Spotlight

Michelle Burke, MSN, ARNP, CPON

Education:

- MSN, ARNP Florida International University
- BSN, University of Florida

Career Highlights:

- 1992 – 2000 - MCH 3 North RN
- 2000 – 2002 - Clinical Specialist, 2 East and 3 East
- 2002 – present - Clinical Specialist, Cancer Center

Certifications/Awards:

- 1999 Certified Pediatric Nurse
- 2002 Certified Pediatric Oncology Nurse
- 2004 APHON Pediatric Chemotherapy and Biotherapy Instructor
- 2007 APHON Jean Fergusson Excellence in Pediatric Hematology Oncology Nursing Educator award

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Nurses Week Activities 2008

Sunday, May 4	Sandwiches - Publix Tray Day & Night Shift
Monday, May 5	Breakfast - Opening Ceremony & Awards Starting at 8:30 am
Tuesday, May 6	Dinner Nursing Event Unit Presentation
Wednesday, May 7	Massage Day
Thursday, May 8	Cultural Bazaar 10:00 a.m. - 2:00 p.m.
Friday, May 9	Lunch 11:30 a.m.
Saturday, May 10	Sandwiches - Publix Tray Day & Night Shift

In this issue

Nurse Leader

In the Spotlight

Michelle Burke, MSN ARNP, CPON

Publications/Presentations:

- Hematology chapter to be published 2008: Chapter 33 "Maternal-Child Nursing: Mothers, Children, and Families Across Care Settings." Editors: Susan Ward and Shelton Hisley
- Pediatric Nursing, "Nurses' Job Satisfaction, Stress and Recognition in a Pediatric Setting," May /June 2004
- Clinical Journal of Oncology Nursing, "Acute Lymphoblastic Leukemia in Children," Sept/ October 2003
- Clinical Journal of Oncology Nursing, "The ABCs of Low Blood Cell Counts," January/ February 2002

Hobbies:

- Fishing
- Traveling
- Spending time with family

From the Desk of Jackie Gonzalez

Dear Nursing Team:

During the past several years, the nursing staff of Miami Children's Hospital has continued to develop and grow, with so many nurses stepping up and demonstrating leadership in many organizations locally, statewide and nationally. There has been a flurry of excitement and activity surrounding evidence-based practice and basing clinical decisions utilizing best practices and benchmarks that result in excellence in care. Last week, we were able to present many of the department's achievements as we were fortunate to have our first ANCC Magnet site re-designation visit. This was another first for us here at the hospital, but one that was long in preparation and one that was truly a proud occasion for all who have helped prepare. The site visit lasted three days with three appraisers and one fellow performing the assessment. What was wonderful to watch, was the way the entire nursing department came together, across inpatient, outpatient, ambulatory lines and everywhere nursing is practiced, to demonstrate the pride and professionalism in nursing practice that exists here. In the few meetings that I was "allowed" to participate in, I could not have been more proud myself, as I did not have to say very much, the answers came from those who love and practice the art and science of nursing with children every day.

At the end of the visit, after a very busy three days, the appraisers were extremely complimentary of the leadership of Debbie Hill and the Magnet Committee, all of the Nursing Leadership Team who assisted in preparation of the documents and site visit and of the entire staff for the warm welcome and hospitality. Debbie did a tremendous job in writing the volumes of documentation that were submitted and in final preparation of the department for survey, as well as in communicating and hosting the appraisers. Thank you Debbie! Critically important also to the visit, was the embracing manner and genuine collegiality of the entire organization, including the medical staff, other clinical and support departments and the food and environmental/hospitality services. Please join me in thanking those that made this site visit successful. We will receive notification of our results in April or May and hope to have something to celebrate then. I will notify everyone immediately when I hear.

I absolutely loved watching so many of you that were so willing to share your love for your profession and for what you do best every day! I could not have been more proud of all of you. Thank you all!

Jackie Gonzalez, ARNP, MSN, CNAA, BC, FAAN
Senior Vice President / Chief Nursing Officer

Don't Take Your Organs to Heaven Heaven Knows We Need Them Here

By Bing Wood, MSN, ARNP

Please call Life Alliance Organ Recovery Agency ideally within one hour of any of the following clinical triggers being met:

- Severe, acute brain injury requiring mechanical ventilation, and a Glascow Coma Scale less than 5
- Physicians evaluating a diagnosis of brain death
- Physicians order to withdraw life-sustaining therapies pursuant to family's decision (call prior to discontinuation of support)
- All deaths must also be referred

We are required to notify the Organ Procurement Organization (Life Alliance) about the death or imminent death of a patient in the hospital, in a timely manner. This is a CMS compliance measure for all hospitals and JCAHO element of performance for standard PI.1.10.

MCH received a Hospital Achievement Award for the conversion rate of 75 percent in 2006. This is in recognition for extraordinary efforts made towards achieving the conversion rate goal established by the U.S. Secretary of Health and Human Services in the "Gift of Life Donation Initiative."

The phone number for Life Alliance is 1-800-255-GIVE (4483).



Heparin: Handle with Care

By Ingrid Gonzalez, RN, MSN, CPN

Anticoagulants are high-alert medications that carry a significant risk of causing serious injuries or death to patients if they are misused. Errors with these products are not necessarily more common than with other drugs, but when used or omitted in error, anticoagulants can cause life-threatening or fatal bleeding events or thrombosis.

Anticoagulants are currently among several high-alert medications that have been targeted for enhanced safety by the Joint Commission–through its 2008 National Patient Safety Goals–and the Institute for Healthcare Improvement–through its 5 Million Lives Campaign (www.ihi.org/IHI/Programs/Campaign/). To assist with these important, nationwide medication safety efforts, the Institute for Safe Practices has identified common risks associated with unfractionated heparin, low-molecular weight heparin, and warfarin, as well as recommended safeguards.

Common risks associated with heparin, low-molecular weight heparin, and warfarin include:

- Duplicate or concurrent therapy
- Accidental stoppage of therapy
- Look-alike bags, vials or syringes
- Look-alike names
- Dosing/infusion errors
- Calculation errors
- Patient monitoring problems
- Drug and food interactions
- Adverse reactions

Recommended safeguards for Heparin at MCH

- Standardization of heparin Concentration
- Simplification-All heparin drips prepared by pharmacy
- Externalize error-prone processes-Unit dose syringes available(flushes vs. drips)
- Improved access to information-Use smart pumps, bar-coding technology, and second witness policy.
- Differentiation or constraints-Store anticoagulants away from other drugs with look-alike names or packaging. Restrict access to multiple/high concentrations of heparin (in vials and/or syringes) on patient care units. There is no override for heparin. MD order must be obtained and entered by pharmacy.
- Redundancies -Consistently employ independent double-checks (e.g., a second nurse checks the drug, dose, patient, line attachment, and pump settings before administration)
- Patient monitoring

HEPARIN SHOULD NOT BE REMOVED FROM THE PYXIS WITHOUT A PHYSICIAN ORDER.

ISMP Medication Safety Alert, Nurse Advise-ERR, Dec, 2007, Vol 5, Issue 12

Heparin Mishaps in the News

It's been headline news for the past year: three infants at one of the most reputable hospitals in California received 1,000 times more heparin than intended when vials containing 10,000 units/mL instead of 10 units/mL were used in error to flush the infants' vascular access lines. No doubt the intense media attention given to these errors is related to the fact that two of the infants are the newborn twins of Hollywood celebrities Dennis and Kimberly Quaid. Fortunately, according to news reports, none of the affected infants suffered lasting adverse effects from the error.

These events are remarkably similar to a case in Indiana in 2006. In that case, three babies died after receiving overdoses of heparin while flushing their vascular access lines. According to news reports, in both the Indiana and California cases, pharmacy technicians accidentally placed vials containing more concentrated heparin (10,000 units/mL) in storage locations in patient care areas designated for less concentrated heparin vials (10 units/mL). The different strengths of heparin looked similar.

Did You Know? A Solution to Enhance the Knowledge of Nurses

By Carla Leblanc, MSN, RN, CPN

Purpose: Nurses take an oath to become life-long learners and this commitment never fades. An innovative solution to increase the knowledge of nurses and assist them in remembering some facts and trivia related to practice was developed using a Rolodex® to store such information in a convenient location.

Description: The Rolodex®, titled "Did You Know?" was placed in the central nursing station of the Pediatric Intensive Care Unit (PICU). After compiling useful information and helpful hints to include in the reference tool, the data was printed on self-adhesive mailing labels and adhered to Rolodex® cards. This information was gleaned from articles in nursing journals, from doctors during teaching rounds, from hospital policy and procedure forms and from the concurrent sessions attended by staff members at the National Teaching Institute (NTI). To continue updating the Rolodex® with new advances in healthcare, information is added as needed and a notice is posted on the education board alerting staff to "check for new information."

Evaluation/Outcomes: The usefulness of "Did You Know?" was rated by staff nurses using a short questionnaire. The forms returned indicated an enthusiastic response to the project and nurses return to it often to retrieve important information and practice updates. The ultimate goal of this project is to involve nurses in evidence-based practice and to stimulate learning and research in the PICU.



Daisy Award Winners

Daisy Award
January Winner for 2008
Liza Rodriguez, RN
3 East

Liza was nominated by Nilsa Suarez, who wrote, "The nurse that I would like to nominate for the Daisy Award is someone I believe deserves recognition for her hard work and dedication to her profession. I nominate Liza Rodriguez. Liza is the nurse who in one hour will assess her patients, help others, will feed and bathe a patient that is alone and be current with charting. When she is charge and there's only one care assistant she helps with vitals and other family needs.

Liza is not only an outstanding team player, but on a personal note, a great friend. Liza will be there to assist with any problems no matter how big or small. You can always count on Liza to be by your side if you're drowning in work or behind schedule. That is just the person she is, selfless. You can always count on Liza's sense of humor and experience to make the night go smoothly."

Daisy Award
February Winner for 2008
Beverly Kram, RN
3 South

Beverly was nominated by a patient's mother, who wrote, "Beverly has been so kind and caring about my son. She stays on top of his meds and amount of seizures. She has tried to comfort us through this very difficult time and we are very grateful for her. I specifically remember a time when she wasn't our nurse, but went out of her way to help us. I feel comfortable turning to Beverly whenever I have a question or issue. Beverly always has a smile for us and has made this tough time a little more bearable for us.

Beverly is amazing! I understand why this hospital won an award for nurses. She is caring and is right here when you need her. She is knowledgeable about medicines and seizures. I felt my son was in good hands with her! Thank you for going above and beyond. Beverly engages with her patients and their families. She takes care of everybody in the room! We love her. My mother and I are from out of town and Beverly tried to help us with the area. She is the all around perfect nurse!"

Daisy Award
March Winner for 2008:
Ana Fauni, RN
3 East

Ana was nominated by Inga Bolanos, RN 3 East. Inga wrote, "In January of '08 a dialysis patient had a 'near code' in the parking garage. The patient's mother called the dialysis unit and the dialysis nurses called Ana to cover that unit while they investigated the problem. Ana designated me to cover her patients on 3 East while she made sure that the patient in the dialysis unit was okay.

Before coming to 3 East full time, Ana spent half of her budgeted hours in 3 East and the other half of the hours in the dialysis unit, within the last year. She switched full-time to cover only 3 East. No longer a "physical" dialysis nurse, she continues to display genuine concern for all of her patients, past and present. Her heart remains all over this hospital. It was also very impressive watching her care for and show deep concern for patients in both units. Ana's compassion for patients and their families is always outstanding."

Clinical Scenario

By Debbie Salani, ARNP, MSN, CPON

A 15-year-old adolescent was having a MRI with contrast to rule out a brain tumor. Upon receiving the contrast, she began to have erythema, urticaria (on the chest, and face) and angioedema. The patient became restless, anxious, and apprehensive with the complaint of a sense of impending doom.

The MRI staff brings the patient to the ED immediately. What would be your initial nursing actions?
Administer oxygen, increase the HOB and comfort the patient and family.

What type of reaction is occurring?
Anaphylactic reaction

What agents do physicians typically order in these cases?
Anaphylactic reactions can be a life-threatening event. It is important to recognize the steps to take to treat this reaction.

Primary treatment for an anaphylactic reaction is to immediately discontinue the causative agent. Listed below are some of the medications that may be used to treat an anaphylactic reaction:

Administer epinephrine (0.1 ml/kg 1:10,000) SQ ***** **always give SQ**
Administer corticosteroids (usually 1-2 mg/kg/IV)
Administer antihistamines (Benadryl) 1 mg/kg/IV) usually 25 -50 mg, 50 mg is the maximum dose to be given.

Risk Factors:
- Antibiotics (Penicillin, Bactrim)
- Blood products
- IVIG
- L-Asparaginase, VP-16, VM-26
- Radiological contrast media
- Administration of medications or chemotherapeutic agents.



Needle-free Jet Injection Technology: A New Procedural Pain Management Tool

By Cindy Garlesky, MSN, ARNP, CEN, RN-BC

What, no owie? Just ask any child or parent who's experienced the 'soda pop thing' before an IV start and you'll hear them state that the needle "didn't hurt at all." It seems hard to believe that a clear plastic pen-like tool could be so effective in helping reduce needle-related procedural pain.

Needle procedures are a necessary component of treatment for many children. The most common needle procedures include venipuncture for lab specimens, IV access and injections. And for many children and parents, these procedures can be both painful and distressing.

- Many children view receiving needles as one of the most traumatic aspects of being in the hospital (Cordoni & Cordoni, 2001).
- Parent's rate needle procedures as the second-most distressing event during their children's hospitalization (second only to waiting for their child during surgery) (Caty, Ritchie, & Ellerton, 1989).

Jet injection has been used for medication administration for more than 50 years. The first injectors were reusable and were much larger and louder. They were primarily used for mass vaccinations in school settings and the Armed Forces.

The J-Tip needle-free device was introduced to select areas of Miami Children's in November 2007. These areas included the IV Team, Same Day Surgery and MRI Sedation/Recovery. From the first "pop," the J-Tip (used with a local anesthetic) was a success with children and parents. Sleeping children remained sleeping and awake children waited to feel the pinch that had already occurred.

Before the needle or catheter touches the skin, nurses (and physicians) can use the J-Tip, filled with buffered lidocaine, to numb the skin at the insertion site. In a fraction of a second, the J-Tip injector, powered by carbon dioxide, releases the high-pressured gas to force the local anesthetic under the skin, resulting in instantaneous numbing of the area. Nine times out of 10 it is painless, although some individuals may perceive the pressure as discomfort.

Pending final approval, the policy and procedure for use of the J-Tip with buffered lidocaine will allow nurses to use it prior to a needle procedure. Currently, nurses are required to obtain an order (i.e. IV start with buffered lidocaine prn).

The J-Tip with buffered lidocaine is just one of a number of strategies being implemented to minimize the pain and distress associated with needle procedures here at Miami Children's. Continued implementation is ongoing as the J-Tip supplies become available in every Pyxis supply station.

Integral to the success of all procedural-related pain management (and all pain management) is the continued inclusion of age-appropriate non-pharmacological interventions and adequate preparation of the child and family prior to and during the procedure.

The great news is that children screaming from the pinch of an IV stick will soon be a sound of the past. In this case, silence will be golden!

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Concerned about Investment Risk?

Playing it safe when planning for your retirement might be the biggest risk of all

A Tale of Two Friends

Bill and Steve, same age, start work on the same day at the same place. Each friend has $4,000 per year contributed to his retirement account. So far – everything is the same. But let's see what investments they choose, and see if that makes any difference. Bill decides to "play it safe" – selecting a conservative investment so that he doesn't expose his account to market risk. With a predictable rate of return, his principal steadily accumulates interest over his entire career. He retires 30 years later with $251,176.

Steve, on the other hand, takes more risk and invests in a diversified portfolio of stocks and bonds. His account's return varies over his career—some years up more than 15 percent, others down more than 15 percent. Still, he retires 30 years later with $546,248 – more than double Bill's total!

How can playing it safe be so risky? By investing too conservatively, the risk is that Bill does not have enough money accumulated to fund his retirement.

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Promote Health with a Smoke-free Hospital Campus

By Jill Tahmooressi, RN-BC, MBA, BS and Lynn Yu RN-BC, BSN

In 1992, the Joint Commission on accreditation of Healthcare Organizations (JCAHO) introduced standards to enact smoke-free hospital buildings, resulting in the nation's first industry-wide ban on smoking in the workplace. The California Air Resources Board has determined that second-hand smoke is a toxic air contaminant (TAC)—an air pollutant that may cause or contribute to an increase in death or serious illnesses. The 2006 U.S. Surgeon General's report on The Health Consequences of Involuntary Exposure to Tobacco Smoke concluded that there is "no risk-free level of exposure to secondhand smoke." The report states that "secondhand smoke contains many chemicals that can quickly irritate and damage the lining of the airways. Even brief exposure can result in upper airway changes in healthy persons and can lead to more frequent and more asthma attacks in children who already have asthma." Knowledge and awareness of the health hazards associated with exposure to tobacco products is well established. With hospitals' mission to promote health, it is only natural and logical that the smokeless environment be extended to the outside and not just the inside of hospital buildings.

It is important for healthcare institutions to serve as community leaders and to educate and model healthy behaviors for consumers of their services. By continuing to have designated smoking areas present on hospital campuses, this tactic merely moves the smoker to a certain locale and does not assist the smoker in going tobacco free. Designated "no smoking" areas provide partial to no protection from tobacco smoke (Tobacco Control, 2004).

There is a movement nationwide towards the elimination of tobacco smoke on and within healthcare premises. Despite limited formal examinations of hospital outdoor smoke-free policies appearing in the literature (Nagle, 1996) and indeed with the lack of published data on such policies, many organizations across the country are considering the adoption of such policies, or have already implemented a smoke-free campus. According to the American Nonsmoker's Rights Foundation as per report dated July 3, 2007, "there are at least two national hospitals, clinics, and insurers that have adopted 100 percent smoke free policies nationwide which extend to all their facilities, campuses and office buildings. There are at least 537 registered state hospitals and clinics that have adopted 100 percent smoke-free campus grounds policies that protect all employees, visitors, and patients from secondhand smoke exposure within the campuses-including but not limited to facility building, outdoor areas, and parking lots" (http://www.no-smoke.org, accessed 8/15/2007). One state has gone as far as to legislate change. The state of Arkansas recently passed legislation (effective October 1, 2005) prohibiting the use of all tobacco products in and on the grounds of all medical facilities within the state (http://www.arkleg.state.ar.us/bills/2005/ public/HB1193, accessed 02/15/2006).

JCAHO initiated a first-of-its kind study of smoke free hospital campuses in June 2007 with the project comprised of an electronic survey distributed to more than 4,200 JCAHO-accredited hospitals in the United States funded by a grant from the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program (SAPRP). This study represents the first systematic evaluation of the challenges to implementing, or the impact of transitioning to a smoke-free hospital campus (http:// www.facilitiesnet.com, accessed 08/15/2007). With the emerging trend of the smoke-free hospital campus, with smoking prohibited outdoors, at entranceways, on grounds, and in parking areas, children's hospitals in particular are positioned to lead this change. By mandating the absence of second-hand smoke on their campuses designed to protect the children they serve as well as to educate the children's caretakers to the dangers that second-hand smoke creates, the message of health promotion is clear. Patient/family centered care has permeated many children's hospital care models with education and health promotion extended to the entire family. Implementation and enforcing a smoke- free campus sends a clear message of the hospital's commitment to health promotion not only for the child but the entire family.

There is a dearth of research regarding second-hand exposure among children, an especially vulnerable population. Even small amounts of secondhand tobacco smoke can damage a child's arteries (Stoddard, 2007). A study of 175 discarded, fresh (within four hours of voiding) urine specimens available at Miami Children's Hospital laboratory from patients seen in the emergency room were tested for cotinine (inhaled nicotine by-product). The test strip is 98.8 percent sensitive and 97.5 percent specific for urine cotinine. The age and gender of the patients tested were noted from the urine specimen label with 51 percent male and the ages ranged from 1 month to 19 years, median six years (SD=5.97). Of the 175 subjects, 58 percent had cotinine levels indicating passive nicotine exposure between the ranges of 10ng/ml -100ng/ml (Siqueira & Tahmooressi, 2007).

A caring environment must coincide with the smoke-free campus as in having available resources for the smoker such as available web-based phone counseling to provide smoking cessation information, research, web links and information about trying to quit. As the largest group of healthcare providers, nurses work in a variety of settings and have tremendous opportunities to help implement tobacco-cessation strategies. Funded by the Robert Wood Johnson Foundation, the national Tobacco-Free Nurses Initiative was the first to promote the role of nurses in tobacco control, and

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Investment Risk

Market Risk

There are all different kinds of risk, but most people, like Bill, worry about market risk—the risk that the stock market might drop and an investment may lose value. From a distance, this makes sense since, historically, the stock market is more volatile than bonds or stable-value investments, especially in the short term.

Inflation Risk

People tend to forget that there are other kinds of risk that can be equally dangerous to their long-term financial goals. One of the greatest risks is inflation. Over the last 10 years, inflation has steadily eaten into the buying power of money at an average rate of about 2.51 percent per year. To get ahead, your retirement accounts will have to grow faster than the dollar is shrinking. That's why Steve was wise to choose a mix of investments that minimized his reliance on the performance of any one investment and gave himself a better chance at outperforming inflation.

What's One Way to Help Manage Risk?

You've heard the old saying, "Never put all your eggs in one basket." Many people find that to be particularly true when it comes to investing. Of course, you are looking to try to limit your exposure to both market risk and inflation risk. So how can you do that? Asset allocation can be one way. When you use asset allocation, you invest your money in different kinds of asset classes—such as stocks, bonds and stable value investments. Another similar investment tool is diversification. You use diversification whenever you invest in a variety of investments within each asset class. Asset allocation and diversification are investment strategies; they do not offer guarantees. Application of asset allocation and diversification concepts does not ensure safety of principal and interest. It is possible to lose money by investing in securities.

Investing for Retirement is a Long-Term Proposition

It's easy to get distracted by what happened today, this week, or this month in the financial markets. But don't risk your future on today's market activity. Think long term. If you're in your 20s and just starting out, you may have three or four 10-year blocks of time to invest your retirement account. And even if you're, say 42, and hope to retire at 62, you still have two 10-year blocks of time prior to retirement, and perhaps two or more in retirement.

For more information . . .

To learn more about risk, return, and tools available in the Miami Children's Hospital Retirement Plan, you can contact your onsite representative, Erubey Perdomo, at 305-624-4594.

A Brief History: Association of Preoperative Registered Nurses

By David Aguero ORRN and Agustin Peralta OR RN

The Association of Preoperative Registered Nurses AORN has been around for over 50 years. After the second World War, the United States experienced an exponential growth in population and thus a greater demand for the number of surgical procedures performed. Around 1949, AORN began to standardize the manner in which registered nurses or perioperative nurses communicate and perform their jobs in the operating room. AORN continues to be a source of guidance and communication to operating room nurses around the world. AORN sets the recommended practices which become policy and procedure throughout hospitals around the world.

Unites Nurses

Perioperative nurses have the opportunity to come together through local chapter meetings and Annual Congress. This provides a forum for all nurses to share their nursing practice experience. Perioperative nursing is dynamic and requires that all nurses stay informed of all current, new or changes in nursing practice. Through AORN, nurses are able to learn from each other and share experiences. Local AORN chapters meet once a month and organize events at local or area venues to socialize and share their experiences.

Education

Educating nurses and perioperative managers is probably the most valuable attribute AORN has to offer. AORN is considered the leader in educating nurses of all backgrounds, whether you are a beginner or a seasoned nurse. AORN offers correspondence courses for perioperative nurses, on-line education, and continuing education for nurses, and patient safety in the operating room courses. CNOR course is also offered for those perioperative nurses who wish to be nationally certified.

Representation

Since 2006, the AORN Congress and the AORN House of Delegates approved that each specialty assembly seat two delegates, for a total of 46 delegates. There are 23 specialty assemblies that offer a formal structure within AORN to facilitate national networking of AORN members interested in a subspecialty or interested area. The AORN Government Affairs Department in conjunction with the AORN National Legislative Committee established five legislative regions with five regional coordinators. The regional coordinators, board-appointed liaisons, and two members at large make up the NCL.

Uniform Standards of Quality Patient Care

AORN's classic resource for perioperative practice brings together all of the association's official positions and recommendations in one unique volume from professional practice standards to laser safety, from competency statements to aseptic technique and from clinical pathway to patient safety. AORN position statements articulate the association's official position or belief about certain perioperative nursing related topics. Position statements are authorized by the AORN Board of Directors appointees and are approved by the board and the House of Delegates.

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AORN.ORG, 01/30/2008.



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Smoke-free

focused on two key objectives; to support nurses in their efforts to end tobacco addiction and to provide tools for all nurses to help their patient (patient- family care givers) quit smoking.

The Tobacco-Free Nurses Initiative offers easy access to an array of resource materials on its website, including a pocket guide developed in partnership with the Agency for Health Care Research and Quality. All of these tools can be downloaded at no cost to assist health care professionals worldwide in their cessation efforts (http://www.tobaccofreenurses.org, accessed 08/10/2007). Launched in 1995, www.quitnet.com,

QuitNet is the web's original quit smoking resource with free around-the-clock chat support systems, personal quit and medication guides. The American Cancer Society and the American Lung Association also have online resources available 24/7. Having alternative products such as Food and Drug Administration (FDA) over the counter nicotine replacement gum, lozenges, patches for sale in the campus gift shops and out-patient pharmacy is imperative with the ability to access these supplies around the clock. To be most effective, nicotine replacement products should be used in conjunction with a behavior change program with counseling and peer support. Hospital employees as patient and family educators can take advantage of "teachable moments" when enforcing the smoke-free campus rule.

Assisting the caregivers of children with smoking cessation is a socially and ethically responsible action to take. A child requiring the services of a children's hospital or ill enough to seek the services of the hospital should not be exposed to the environmental toxins of second-hand smoke while seeking care. Pediatric emergency rooms may be a setting in which smoking prevention and intervention services can be offered to parents, thus utilizing the wait times effectively. The message is clear when smoking is banned from the entire children's campus: the organization cares about the health of children. Ultimately, study data on the prevalence and challenges associated with adoption of smoke-free campus policies, and the clinical impact of those policies, could be used in conjunction with existing research to demonstrate the benefits of smoke-free policies and increase both consumer and professional demand for their adoption.

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Cellulitis

By Arnold Jumagbas, RN 3NE

Cellulitis is an inflammation of the connective tissue underlying the skin that can be caused by a bacterial infection. It can occur when the skin has been cut, burned, bitten by an insect, or when there is a surgical wound or an IV insertion site. Early signs include redness, swelling, warmth, pain or tenderness as well as fever. The most common areas of the body to be affected by cellulitis include the arms, legs and face. Group A streptococcus and staphylococcus are the most common bacteria associated with these.

Hard-to-treat bacteria or methicillin-resistant staphylococcus aureus (MRSA) are one of the biggest concerns of doctors and parents. MRSA can be acquired within a hospital or within the community. Improper handling and care of a wound may spread it from person to person. So, hand washing before and after contact with an affected wound is a universal precaution for minimizing the spread of MRSA.

Treatment involves a combination of intravenous and oral antibiotics. Bed rest and elevation of the affected area can reduce redness or swelling particularly on arms or legs. Prevention is most important of them all. When you have open wound, clean it with soap and water. Apply a dressing and antibacterial ointment. Proper hand washing before and after wound care must be enforced.

Simple hand washing and proper wound care can avoid another "MRSA scare" in the media.



Opoids Agents

By Marilyn Torres, Pharm D

Fentanyl

Fentanyl is a schedule II opioid analgesic that acts via agonist actions at the mu receptor.

It is indicated for use in the management of chronic, to moderate or severe pain requiring around-the-clock therapy and postoperative pain short-term management only during hospitalization.

It is available as an intravenous, transdermal patch and buccal. Transdermal fentanyl should be administered only to children older than 2 years old and if they are opioid tolerant.

The elimination T1/2 is 7 hours for systemic administration, 3.6 hours if IV and 22 hours by transdermal patch. Doses vary depending on the age of the patient, severity of pain and previous use of opioid analgesics.

Adverse reactions include: pruritus, constipation, nausea, vomiting asthenia, confusion, dizziness, sedation, urinary retention. More serious side effects are: Cardiac dysrhythmia, chest pain, apnea and respiratory depression.

Morphine

Morphine has long been considered the gold standard of opioid agents, and is the most commonly used in treating pain. Dosing requirements with morphine vary according to the degree of pain and a patient's prior experience with opioids. It pharmacokinetics of morphine vary quite considerably in its different formulations. (Refer to table A). The pharmacokinetics of the twice-daily formulation and variability in patient response may require eight-hour dosing in some cases instead of 12-hour dosing

Use morphine with caution in patients with hypersensitivity reactions to other phenanthrene derivative opioid agonists (codeine, hydrocodone, hydromorphone, levorphanol, oxycodone, oxymorphone). Use with caution in patients with biliary tract disease or acute pancreatitis (morphine may cause spasm of the sphincter of Oddi); use with caution and decrease the dose in renal impairment and hepatic dysfunction.

Monitor patient for severity of pain; time to recurrence of pain; patient comfort level and pain scores, respiratory rate; GI symptoms (nausea, vomiting, and constipation) CNS depression.

Table A

Form/Route	Peak	Duration
Tablets	1 h	3-5 h
Oral solution	1 h	3-5 h
Epidural	1 h	12-20 h
Extended release tablets	3-4 h	8-12 h
Suppository	20-60 min	3-7 h
Subcutaneous injection	50-90 min	3-5 h
I.M. injection	30-60 min	3-5 h
I.V. injection	20 min	3-5 h

Narcotic Analgesics Comparison of Fentanyl and Morphine

Drug	Onset (min)	Duration (h)	Equianalgesic I.M. Dose (mg)	Equianalgesic P.O. Dose 1 (mg)	Parenteral Oral Ratio	Partial Antagonist
Fentanyl	I.M.: 7-15 I.V.: Immediate	I.M.: 1-2 I.V.: 0.5-1	0.1-0.2	—	—	No
Morphine	P.O.: 15-60 I.V.: ≤5	P.O., I.V., I.M., SubQ: 3-5 Extended release tablets: 8-12	10	Acute: 60 Chronic: 30	1/6; ratio decreases to 1/1.5-2.5 upon chronic dosing	No



NURSING NEWS

CERTIFICATIONS

The following staff members successfully passed the National Pediatric Certification Exam:
Madonna Cruz, RN, CPN
Ana Ruiz, RN, CPN
Heidi Story-Curran, RN, CPN
Maria E. Sandigo, RN, CPN
LeeAnn Kerr, RN, BSN, CPN
David Pastor, RN, BSN, CPN
Mayra Lee, RN, BSN, CPN

ANNOUNCEMENTS

Sofia Morales, ARNP, MSN, was elected as nominations chair of APSNA for the 2008-2009 term.

PROMOTIONS

Jennifer Ruano, BSN, RN, was promoted to Nurse Manager of the Infusion Unit.
Sarah Taylor RN, BSN, CPON, was promoted to Nurse Manager of 3 North

GRADUATION/BOARDS

Charlene Gabriel-MSN/ ARNP, graduated from Florida International University
Luisa Angel-MSN/ ARNP, CPN, graduated from Florida International University
Monica Brown, RN, MSN, graduated from Florida Atlantic University (educational track)
Jennifer Adams, CA, completed respiratory training, and passed her respiratory therapist board exam

NEW HIRES

New Employees in NICU:
Tahira Memon, RN, Jennifer Vasserman, RN, Adrianna Rodriguez, RN, Jessica Grossman, GN, Suzette Coulton, GN, Sarah Whaley, GN

New Hires in the Emergency Department:
Chad Johns, GN, John Campbell, GN, Henry Taveras, LPN, Georgianne Babones, LPN

New Hires in the CV medical unit:
Chante Washington, RN and **Jaqueline Rodriguez, RN**

Regina Kramer-Temple transferred to PICU

Critical Thinking: Can you Diagnose the Problem?

By Linda Nylander-Housholder, MSN, ARNP, CCRN

A 3-year-old male is brought in after vomiting blood. He is very l ethargic and was found on floor with an empty pill bottle. Grandmother states pills were for low blood levels and she had about 20 pills left in bottle.

- VS hr 168, RR 42 BP 72/30 t 98.9 ‘F weight 12 kg
- Presentation: Pale, lethargic with bloody vomits on mouth and nose, and bloody diarrhea. BBS clear with equal chest rise, no evidence of trauma,
- Medical history: On no medications, immunizations current
- Capillary refill 4, Pupils equal @ 4 reactive, abdomen slightly distended and tender,

What should you do?

100% O2 via face mask, be ready for BVM and rapid sequence intubation, monitors on. -check EKG, IV access, start NS 20 ml/kg monitor BP & HR for response. Consider 0 nag blood and monitor for on going losses. Ready for gastric lavage. Consider iron chelating with deferoxamine 15mg/kg/hr or 2-5% NAHCO3 gastric lavage to convert iron to ferrous carbonate send labs - TXM, glucose, ABG, CBC, lytes, LFTs, toxicology screen, Iron/TIBC, flat plate of abdomen. Remember you may have to manage complication of iron overdose- GI hemorrhage , liver injury, potential hyperglycemia, metabolic acidosis, elevated liver enzymes, increased PT, leukocytosis

What is your diagnosis?

Did you recognize early warning signs of hemorrhagic/hypovolemic shock, (tachycardic and poor perfusion, change in LOC. Remember low BP is a late sign in children). Did you remember charcoal lavage not ordered as charcoal does not absorb iron.

It is iron ingestion: Did the pill bottle make you think ingestion? Did the grandmother’s statement lead toward iron ingestion?

Palmetto Bay Center MRI Nurses Make A Difference

By Beverly Denis RN, Catherine Harris, RN and Helene Liwanag, RN

What seemed like a normal day for the MRI nurses at the MCH Palmetto Bay Center turned out to be one of the most challenging days of their careers. Catherine Harris, Beverly Denis and Helene Liwanag were finishing up their shift in MRI. The sedation physician had discharged the last patient and had left for the day. A young mother came rushing into the center with her infant son. The nurses heard a commotion at the registration desk and ran to see if assistance was needed. The nurses found the mother holding an infant who appeared to be dusky and apneic.

The infant was immediately rushed to the triage area where the nurses initiated CPR while the registration staff called 911. The nurses were able to resuscitate the infant before the arrival of fire rescue. Rescue arrived and transported the infant to the nearest facility. "We never thought that when we take CPR and PALS that this will ever happen. For the nurses at the Palmetto Bay MRI, it did! The MRI nurses at the Palmetto Bay Center showed great autonomy and acted quickly to save this infant's life.

The Do's and Don'ts of Charting

By Monica H Brown, MSN, RN, CPN

Healthcare professionals have a legal duty to maintain the medical record in sufficient detail. Nurses' notes provide proof of care and carry significant weight in legal proceedings and are scrutinized in professional malpractice. Personal injury, product liability claims, child custody disputes, employment disputes and workers' compensation claims. Therefore, failure to document implies failure to provide care. Consequently, documentation must be factual, consistent, and timely as complete records are your best defense. Remember, "if it isn't documented, it isn't done" remains the prevailing rule.

Defensive Documentation Tips:

Do:

- Be objective. Record ONLY the facts.
- Be specific.
- Be Consistent: Use one format for narrative notes.
- Document as soon as possible after providing care/treatments or noting changes in clinical condition.
- Document the patient's comments. Put them in quotations. It is appropriate and acceptable to use the patient's own words.
- Document any actions taken in response to patient's condition.
- Document all contact with the physician in reference to changes in the patient's condition, including orders received and the patient's response to the treatment provided.
- Document changes in your plan of care as the patient's condition changes.
- Document communication arising out of escalation through the chain of command.
- Follow hospital policy.

Do not:

- Draw conclusions in the documentation.
- Enter personal opinions.
- Generalize. Be specific and say what you mean.
- Use qualitative words such as apparently, frequently, seems, or appears.
- Use unapproved abbreviations or create your own abbreviations (example MIVF).
- Never document in advance.
- Backdate or add to previously written entries.
- Document the completion of an Incident Report or contact with Risk Management or Legal Services.
- Blame other professionals or departments. The chart is not the place for extraneous remarks and feuding among professionals. Besides, this is unprofessional.

Remember: Use only approved abbreviations. Use the appropriate medical terminology. Be sure you know what it means.



2007 Achievements Top 5

2007 Nursing Research Council Achievements
Top Highlights

Carol Roach, RN, PACU and Carolyn Domina, Director awarded Nurse Week Researchers and Carol presented research: "Anxiety Levels of Parents During Visitation in PACU" at University of Miami, June 4, 2007.

Beth Ramey, RN, conducted study on "Use of the Human Patient Simulator to Enhance Critical Thinking Skills in New Graduates."

Allison Schefflow, RN, and Angela Casablanca, RN, PICU presenting "Evidence Based Practice and Deep Vein Thrombosis" project to interested nursing units.

Kris Roberts, CS, and Carla Trueba, CS, conducted the Hill-Rom International Pressure Ulcer Prevalence Study, February, 2007.

Sofia Morales, MSN, ARNP-BC, presented at the STTI 18th International Nursing Research Conference in Vienna, Austria for "Italian Connection: Nursing Care Across the Cultures" and Jeannette Diana Zerpa, ARNP, MSN presented on "Delayed Dressing Changes in Small Partial Thickness Burns" and Pat Messmer, PhD, presented "Nurse-Physician Collaboration" in April, 2007.

2007 Policy & Procedure Council Achievements
Top Highlights

The Policy and Procedure Committee met on a quarterly basis for '07. During the year, 92 nursing policies were identified to be updated. The first step to this process was to identify key personnel within the department having responsibilities/knowledge to review policy. Once this was done, the policy was forwarded to that individual. The individual responsible reviewed the policy and returned it to the chair of the committee at which time the recommendations were placed in a draft format pending final approval. Approval was then obtained from the appropriate senior management personnel. Once this process was completed, the policy was then placed in the portal and emails were sent advising nursing leadership of the updates. The nursing leaders disseminated the information among their staff. Thirty eight policies were completed through the above mentioned process and three policies were developed in 2007. They are:

C8600007 Rapid Response Team
C6000105 Fall Assessment Outpatient portion
C8600006 Propofol

The team also worked with IT recommending for the current system to be reviewed for potential upgrade. This process will be further reviewed in 2008.

2007 Finance/Staffing Effectiveness Committee Achievements
Top Highlights

This new committee of staff nurses and managers covered several topics:

The budget process, Delta consulting, call outs, holiday schedule, RN vacancy report and Compass Project.

One of the big topics was late sick calls which included staff calling within the two hours prior to their shift or staff arriving sick and then asking to go home. These are two major issues and hopefully we can come up with a plan in 2008. We also discussed the possibility of the staff calling out that they contact their units versus calling the staffing office.

2007 Nursing Quality and Outcome Council Achievements
Top Highlights

NDNQI participation on all inpatient units (IV infiltrates and pain assessment)

- IV infiltrates continue to be within the benchmark standards for IV infiltrations.
- Pain Assessments- All units except for 2East are at the national standard for reassessing pain. 2East is developing an action plan
- Medical and Surgical units were within the national standards for the number of pain assessments in a 24-hour period.
- All ICUs were well above the national standards for number of pain assessments in a 24-hour period. All ICUs assess pain every hour at the minimum.
- Increased knowledge of staff attending the committee through Quality Indicator presentations from Diane Bowles
- Published article in the Pursuit of Excellence regarding "Do you know About Nurse Sensitive Indicators."
- Established an inservice for each unit regarding Nurse Sensitive Indicators.
- Addressed concerns with the nursing directors regarding perceived views of Intragale and acuity numbers. They suggested for the leadership for each area to reevaluate leveling. They also suggested for the IV team to look at the number PICCs per month and flexing IV team staffing due to the increasing numbers of PICCs



2007 Clinical Informatics/ Documentation Interdisciplinary Council Achievements Top Highlights

This interdisciplinary council which continued to meet monthly on the fourth Wednesday of the month at 9 a.m. achieved the following:

- Selection of replacement mobile carts for in-patient computerized clinical documentation (Eclipse)
- Participation in house-wide selection of new EMR for consideration.
- Registered dieticians went on-line with computerized clinical documentation (Eclipse) thereby complementing the clinicians already on-line (nursing, child life, social services, pulmonary care, rehabilitation/ PT/OT/Speech).
- House-wide clinical documentation education provided.

2007 Medication Safety Council Achievements Top Highlights

- Standard Medication Time was changed to decrease number of errors (omissions committed during the change of shift).
- In collaboration with pharmacy, which had an intern evaluating how much heparin is used by different hospitals for central lines, heparin practice in our institution was reviewed.
- All heparin 100 units and 10 units required a physician order for removal from Pyxis. Flyers were created and sent to all units and discussed with committee members.
- Bar-coding compliance was raised. Effective on first quarter of 2007, the bar was increased to reflect the following criteria: to receive a 5 for the specific standard the employee must obtain 98-100% compliance, to receive a 4 - 94-97% compliance and to receive a 3 - 85-93% compliance. A 1 will be classified as less than 85% compliance.
- A request time change form was created with collaboration with pharmacy to include reasons why there is a need for time change. This helped decreased the number of phone calls made to the department.

2007 Communication Council Achievements Top Highlights

The Communication Council has developed the Pursuit of Excellence Nursing Newsletter quarterly. Many new additional topics areas have been included in the Nursing Newsletter which includes the following:

- Changes in clinical practice, including updates regarding practice changes, clinical alerts, etc.
- Clinical scenarios. These clinical cases were created to provoke critical thinking for our newer nurses.
- Retirement updates. This helpful information is designed to encourage the staff to save more money and to invest wisely. Tips are provided to assist the staff to be more prudent with their finances, to take advantage of the various tax breaks.
- Daisy Award Winners. A brief vignette about each of the monthly winners is included quarterly in the newsletters.
- Pharmacology updates. Our pharmacologists have been very helpful in providing us with exciting new updates on the various drugs that we administer to our patients. These updates are designed to review new drugs that have been recently developed, and to review common medications that are given frequently to the pediatric population.

The Communication Council has expanded its membership which now includes various members from the operating room and surgical services. All members have written for the newsletter, and have played a key role in deciding on the topics and content of the each edition. We are still recruiting new members so if you don't belong to a council and would like to participate please join us.

2007 Equipment Committee Achievements Top Highlights

- Upgrading the autosyringes to new smart pump technology autosyringes in Feb 2007. All members of the committee were required to become super users. The drug library was built with the collaboration of Helen Lee and Marilyn Torres (both pharmacists for CV and PICU), Ingrid G., Elena O. (full names needed) and myself.
- Upgrading the large infusion pumps to Plum A+ smart pump technology in June 2007 and also introducing smart pump technology for the PCA pumps. All members of the committee were required to become super users, too. The drug library was built by me and Marilyn Torres, Pharm.D.
- The Joey Feeding Pump trial was finalized in November and the committee decided to upgrade the feeding pumps. Papers have been submitted to legal by Ed Tironi and waiting for response prior to setting up house-wide inservices.

Ultimately, the first two have been the biggest changes and they are ongoing projects as the drug library needs to be updated every so often.

2007 Patient/Family Education Council Achievements Top Highlights

- Worked with education department on a continuous basis to ensure that the community education calendar remained current on both the portal and the main website

- Education discharge folders were finalized with plans to implement on two units by February and house wide by March

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What Generations Want from Their Careers

This article is printed with the permission of the authors Devon Scheef and Diane Thielfoldt, and The Learning Cafe, a consulting firm that offers educational workshops.

Members of every generation want work that provides satisfaction. So a manager's job as a career coach should be easy, right? Not quite. Each generation has a distinct attitude and approach to careers. Savvy managers tailor their career conversations to the needs of the individual – keeping in mind some significant generational influences.

Here's what we've learned about the career needs of each generation:

The Silent Generation
(born 1933-45)

Members of the Silent Generation initially went to work in companies that valued respect for authority and adherence to rules. They achieved job and career success through their discipline, hard work and teamwork. In their work today, they look for appreciation for their expertise and experience. Many are now retiring, taking their knowledge legacies and corporate know-how with them. A common misconception is that they've stopped growing and learning. In fact, most are eager to continue to learn and build their abilities.

In 2000, Congress eliminated the Social Security earnings test for workers 65 and older, allowing them greater freedom to pursue employment after retirement. Instead of coasting on their existing skill sets, many Silents are eager to continue working and building on their abilities. Silents see themselves as vigorous, contributing members of the workforce and they appreciate help with career planning.

Tips for Working with Silents:

- Value their experience by creating ways that they can mentor others
- Provide part-time jobs and job sharing for those who want to continue to work.
- Consider phased-retirement options, which gradually ease employees out of the company at a mutually agreeable pace

The Baby Boom Generation
(born 1946-64)

Baby Boomers have had a huge influence on the corporate environments that we work in today. Boomers applied their competitive nature and industrious work ethic to building their careers. Their willingness and ability to sustain hard work through mid careers is the topic of much research. Today, as they face increasing responsibilities for the care of aging parents and growing children, they are re-examining their careers and looking for ways to bring new balance to their lives.

As Boomers take stock of their careers, many are seeking ways to revitalize themselves. Others are looking ahead to retirement or exploring their next set of career options (consulting, managing franchises, doing temp work, freelancing). Boomers are rewriting the retirement rules too – shuffleboards are out, spas are in. Many are looking forward to more time freedom, but a recent American Association of Retired Persons (AARP) poll found that 90 percent plan to work at least part-time in their retirement years.

Tips for Working with Boomers:

- Help them explore their next set of workplace options and demonstrate how your company can continue to use their talents
- Walk the talk on work/life balance be redesigning their jobs to accommodate multiple life demands
- Encourage them to enrich their present jobs and grow in place if they need to slow their career pace

Generation X
(born 1966 – 76)

Generation Xers went to work in a chaotic, no guarantees work world. For many, their independent childhoods led them to seek autonomy and independence in the workplace. Today they are seeking opportunities to make a visible difference and use their creative abilities.

Generation Xers absorbed the workplace lessons of the Baby Boomers. In the view of many Gen Xers, Baby Boomers devoted their lives to their work and corporations, putting personal fulfillment ahead of marriages, families and balanced living. And Generation Xers have carefully watched the changing work environment. Their goal is to mitigate the possibility of layoffs in unstable corporations by putting their own skill sets first.

They realize the need to be employable because no organization can guarantee employment. Generation Xer's career goals are often different than their older bosses. They value diverse experiences and are comfortable with job "hopping." They also are committed to work/life balance and see it as a priority.

Tips for Working with Gen Xers:

- Talk to them about their reputation, not just job tasks; they want your candid perspective and feedback
- Acknowledge their ability to work independently and encourage them to leverage their entrepreneurial abilities
- Help them get the most out of every job position by discussing what the job can do for them and what they can learn from it



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2007 Achievements Top 5

The Millennial Generation (born 1977 - 98)

As the oldest Millennials come into the workplace, they are seeking stable jobs and corporations. Their group-orientation and civic-mindedness are likely to continue in the corporate environment. They are being dubbed "the confident generation" at work.

When Millenials and their employers talk about career development, they are often speaking different languages. Millennials think in terms of their personal fulfillment, asking, "Is the job interesting and satisfying? Is the work meaningful and important?" Employers want to know, "How long will you stay and do the job?" Offer training opportunities to build basic business skills (beyond training for their current job), and help them find their best job fit early in their careers. Managers who help Millennials find a career path, or set of career paths, will be acknowledged as valued mentors. Researchers predict that Millennials will be loyal, committed employees as long as their organizations provide them with variety and opportunity.

Tips for Talking with Millennials:

Demonstrate the stability and long-term value of your company. Also show how your organization is flexible and filled with learning opportunities for them. Provide work schedules that help them build careers and families at the same time. Make groups and teams part of their job.

- The committee compared the current TEACH file topics to those in Micromedix and MD Consult to ascertain which ones we needed to keep in the file and which topics could by retrieved from the other two sources since these are updated on a ongoing basis. (Two main factors considered were Spanish, and pediatric oriented materials availability.)

2007 Clinical Practice Council Achievements Top Highlights

In collaboration with the equipment committee, the biggest achievement was the roll out of the new Medfusion 3500 pumps, large volume Hospira pumps, and PCA pumps. Ten hours were spent exchanging pumps in collaboration with Clinical Engineering and Technical supply. Drug libraries were built for each piece of equipment. Countless hours were spent developing the library. After the libraries were created another set of experts checked each drug for accuracy and delivery specifics to make sure that patient safety was not compromised. This project overall had to be the most tedious and time consuming for last year. It was a success thanks to all the work from the different departments involved.

P.S.: The work is never finished because theses smart pumps must be updated regularly to meet the changes of the drug libraries.

2007 Advance Practice Nurse Council Achievements Top Highlights

The Advance Practice Nurse Council group has provided a forum for the advance practice nurses in all specialty areas. Approximately 25 staff have attended monthly. We have provided educational sessions on different specialties, promoted certification within these specialties, a group of 5 attended a review course for PNP certification course, 1 staff member (Jeannette Diana) passed certification testing, others are waiting for response to sit for the test. We have provided at each meeting evidence-based practice articles and encouraged staff members to work on research projects.

2007 Nurse Manager Council Achievements Top Highlights

- Enhanced communication across all departments
- Completed a workload study and plan with directors to improve effectiveness in the role for each nurse manager
- Planned curriculum and three-day class in leadership and development which was held January, 2008

2007 Rewards and Recognition Council Achievements Top Highlights

- Conducted the welcome back breakfast in recognition of 2007 hires, including a short survey on orientation feedback to be used as framework for 2008 goals.
- Quarterly mentoring classes planned by CS for 2008
- Celebration with Daisy Foundation co-founders and recognition of nine Daisy winners. Web access on all winners' info.
- Nurses week events especially the cultural show.
- Changed name of council to "Rewards and Recognition."

2007 Professional Development Council Achievements Top Highlights

- Freida Hill Beck conference application developed, now available on MCH portal under "forms" – nursing.
- Staff surveyed on APEX.
- APEX changes implemented for 2008 based on survey and committee suggestions
- House-wide inservices Oct 2007 for APEX changes

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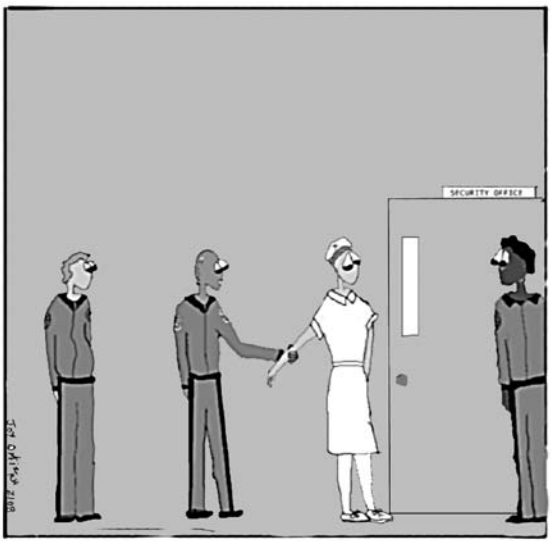

"We caught this woman trying to enter the building, sir. We knew she couldn't be a real nurse, just based on the way she's dressed..."

Food For The Soul

Food for the Soul is a regular feature of the Pursuit of Excellence newsletter. MCH nurses share favorite recipes such as this one provided by Nancy Perdomo, RN.

PESTO 3-BEAN SALAD

Ingredients:

1/3 lb. fresh green beans, cut into 2-inch pieces
1 can (15 ounce) cannellini beans, rinsed and drained
1 can (15 ounce) garbanzo beans, rinsed and drained
1 cup basil leaves
1/2 cup fresh mint leaves
1/4 cup pine nuts, lightly toasted
1/4-1/3 cup extra virgin olive oil
1-2 garlic cloves
1/2 cup grated Parmigiano-Reggiano cheese

Fill a small skillet with about 1 inch of water and bring to a boil. Add salt to the boiling water and then add green beans and cook for about one minute; drain and cool under cold running water and reserve.

Place basil, garlic and mint in a food processor with the nuts. Add salt and pepper to taste and turn processor on. Stream in the olive oil to form a thick, pasty sauce. Transfer the sauce to a bowl. Stir in the grated cheese. Add the cooled green beans and the canned beans to the bowl and stir to combine. Adjust seasonings as needed. Can be served room temperature or chilled.

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