



A Perspective on Neuroscience Nursing at UMMC

By: Judy A. Slide, MBA, RN, Director of Nursing

Neuroscience nursing as a recognized specialty began in 1968 with the founding of the American Association of Neuroscience Nurses (AANN). Nine years later the first Standards of Care for Neurosurgical Nursing and Core Competencies for Neurosurgical Nursing was completed, and in 1978, the first certified neuroscience registered nurse (CNRN) exam was offered.

Here at the Medical Center, neuroscience nursing had its beginnings in the early 1970s in the South Hospital. Neurology patients were located on 12 South, and neurosurgery patients were on 11 South. When the North hospital was finished in the mid 1970s, neurosurgery moved from 11 South to the west wing of the 12th floor. Originally, the neurosurgical ICU was a six bed unit at the end of North 12W. A 24-bed neurosurgical acute care unit was directly outside of the ICU. Across the corridor on North 12E was an acute care



unit composed of neurosurgery, neurology, and ophthalmology patients. Twelve South was still all neurology patients. The inpatient beds were on A and D wings, the 4-bed acute stroke unit was on B wing, and C wing was used for neurological and neuromuscular testing.

Neuro-critical care nursing was very different in the 1970s than it is today. The neurosurgical ICU (12 ICU) was an open unit with 2

private rooms known as the “quiet rooms”. These rooms were used primarily for pre-operative cerebral aneurysm patients and occasionally for patients who required isolation. Neurosurgical patients were recovered post operatively by the ICU nurses as they are now, but the technology would be considered “primitive” by today’s standards. There were no infusion pumps. Invasive monitoring consisted primarily of arterial lines and the occasional central venous pressure line that used a water monometer for measurement. Intraventricular pressure monitoring was in its infancy. There was no FDA approved kit. The system was assembled by the nurse using IV tubing, stopcocks, a platelet bag, and the catheter itself was a pediatric feeding tube. The entire system was hung from an IV pole, and a yardstick was used to determine the correct height for drainage.

For the first ten years of my career I worked as a staff nurse, first on 12 East, then on 12 West, and finally back on 12 ICU as a Primary Nurse III (SCNII today). As a graduate nurse on 12 East in 1978, I cared for patients recovering from post-op back surgery, patients with a variety of neurological diseases such as strokes, multiple sclerosis and Parkinson’s, and ophthalmology patients with detached retinas and post-operative cataract surgery. Most of these patients would not be considered for inpatient admission today. In 1980, I became a Primary Nurse II and transferred to 12 West. The primary patient populations there were pre and post operative neurosurgery patients, including brain tumors and cerebral aneurysms. Every summer 12 West and 12 East had an influx of cervical neck injury patients, primarily young men that were quadriplegic, some with a head injury as well.

Staffing during the late 1970s and 1980s was also very different than it is now. As a student in the ICU, I worked an eight hour night shift from 11 p.m. - 7 a.m., every other weekend with one RN and one LPN for six patients. On 12 East and 12 West, the staffing patterns at night were one RN and one nursing assistant.

By the time I became the Nurse Manager for the neurosurgical ICU in 1988, things were starting to change. The LPN role had

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Lisa Rowen's Rounds

March 18, 2010

Today, some of us had a wonderful opportunity to attend a press conference in Washington, D.C., where Michelle Obama focused on her mission to educate about and reduce childhood obesity. Nursing representatives from the Medical Center who also attended included Mary Taylor, Director of Nursing for Women's and Children's

Services; Mary Jo Simke, Nurse Manager for Pediatric Services; and Carmel McComiskey, Director of Nurse Practitioners. In addition, about ten others from the UMMC/UMB community attended, including staff, physicians and researchers who care or advocate for and/or study issues related to childhood obesity.

The press conference was held at the Newseum in Washington, D.C. The Newseum is a large museum that blends five centuries of news from around the world in an interactive experience for its visitors. Located on Pennsylvania Avenue about two blocks from the White House, it is also a site for selected press conferences.

As we approached the Newseum, we saw several bomb-sniffing dogs with their police escorts entering the building to determine if it was safe for Ms. Obama. I learned this was standard protocol for members of the President's family. Upon the exit of the dogs, the press was allowed to enter, although their camera equipment was scrutinized with great detail. We then entered by walking through metal detectors and with bag searches.

We were escorted to the Press Room where we were given heart healthy box lunches, water and healthy fruit drinks. While awaiting Ms. Obama's arrival, we had ample time to network. I met the editor of the health section of Newsweek; the CEO of Dairy Management, a company that represents the American Dairy Association and the National Dairy Council; the Vice President of Operations for the Washington YMCA; the Deputy Director of the National Institute of Child Health and Human Development; a faculty member from University of Vermont; and two National Football League players from Florida. As you can tell, it was a diverse group of individuals and agencies, but all who attended had an interest in the topic about which Ms. Obama has focused her attention.

Many Secret Service agents were in attendance, some standing facing the audience and others behind the audience. All food and beverages were removed, even if people had not yet finished. When I asked why, I was told it was standard operating procedure during these types of press conferences to ensure no food or beverage is thrown at the speaker if the message met with disapproval by the audience. Someone in the audience said "... but you haven't asked for our shoes... we could throw them!" Still, we all complied with the rules. The two options were to comply or be escorted out, so if your greater priority was to listen to the press conference, you made the decision to go thirsty and give up your water!

Ms. Obama finally entered the room. I will tell you right now – she is lovely. And tall. I was fortunate to be in the second row from the stage and one seat in from the center aisle, so I was only a few feet from Ms. Obama as she walked by and maybe 15 feet from the stage. For those of you who are fashionistas and are curious about



her attire, Ms. Obama wore a yellow, lightweight cashmere blend cardigan over a green short sleeve silk top with a green straight skirt (it was St. Patrick's Day). The sweater was belted with a clear, 4 inch acrylic belt, and she wore three inch green pumps. A single strand of pearls complimented her outfit. I heard that President Obama once said "My wife has the right to bare arms." This play on words is no exaggeration... and she uses her long arms and hands in an elegant manner as she articulates her ideas and articulate she is!

Regardless of one's politics, Ms. Obama has decided to make childhood obesity her cause, and I think she could not have made a better choice. Her interest in the growing obesity trend has shone a spotlight on this issue and hastened raising it to prominence in health policy. Ms. Obama explained the many reasons the United States is at a point where 20% of its children are overweight and/or obese. She mentioned:

- The sprawling urban and suburban aspects of our cities, making walking from one place to another a lost art
- The increase in fast food and processed food – usually lower priced but high in caloric and fat content
- The rise of sugar sweetened beverages, both in schools and in homes
- The lack of safe places for children to run and play
- The decrease or non-existence of physical education in schools
- The rise in purchasing high calorie lunches at school
- An increased number of children who are not monitored when they arrive home from school

Ms. Obama then turned her attention to some solutions. She advocated for her Let's Move! Program, explaining the solution to childhood obesity should not be legislated, but is rather something each of us can help change. She said she is communicating with and encouraging action on the parts of community, state and federal agencies like the YMCA or National Institute of Child Health; private industry like the dairy farmers; sports figures like

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- Clinical and professional nursing practice in inpatient, procedural, and ambulatory areas that is **evidence-based, innovative, and outcomes driven** (clinical, quality, and customer service)
- Inclusive of unit, divisional, departmental, and/or organizational strategic goals
- Suggested content topics
 - Evidence based practice
 - Patient safety and quality
 - Performance improvement with outcomes
 - Research
 - Relationship based patient and family care
 - Governance structure
 - Relationship with UM School of Nursing
 - Awards and recognition
 - Professional development
 - Regulatory requirements
 - Commitment to excellence
 - Community involvement
 - Patient & family education

Guidelines for Article Submission

1. Times New Roman - 12 pt black font only.
2. Length - three double spaced, typed pages maximum.
3. Include name, position title, credentials, and practice area for all writers.
4. Credentials must be provided for anyone named in the article.
5. Proofread article for spelling, grammar, and punctuation before submitting.
6. Provide photos in .jpg format.
7. Send completed articles via e-mail to anaunton@umm.edu.

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<u>ISSUE DATE</u>	<u>ARTICLE DUE DATE</u>
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Lisa's Rounds from page 2

NFL players; health care providers and educators; and the media. Believing in integrating physical activities into schools and after-school events, Ms. Obama spoke of the work professional football players have accomplished that inspires children to move and play, burning calories and expending energy.

The press conference kicked off Ms. Obama's recent cover story on childhood obesity for Newsweek magazine. In the magazine, she pens "And let's be honest with ourselves: our kids didn't do this to themselves. Our kids don't decide what's served in the school cafeteria or whether there's time for gym class or recess. Our kids don't choose to make food products with tons of sugar and sodium in supersize portions, and then have those products marketed to them everywhere they turn. And no matter how much they beg for fast food and candy, our kids shouldn't be the ones calling the shots at dinnertime. We're in charge. We make these decisions."

The First Lady explains the solution to childhood obesity rests in the hands of parents and concerned adults, rather than legislation and executive orders, and writes "Instead, it's about what all of us can do to help our kids lead active, healthy lives; parents making healthier choices for their families; mayors and governors doing their part to build healthier cities and states; and the private sector doing its part as well—from food manufacturers offering healthier options to retailers understanding that what's good for kids and families can be good for businesses too."

At the press conference, Ms. Obama was inclusive and non-confrontational. She had an uncanny way of not pointing her finger at one particular cause of the problem, but rather tried to involve everyone in the solutions.

Our day in Washington was truly a day I will never forget. I have lived through many First Ladies, including Mamie Eisenhower, Jackie Kennedy, Lady Bird Johnson, Pat Nixon, Betty Ford, Rosalynn Carter, Nancy Reagan, Barbara Bush, Hillary Clinton, Laura Bush, and now Michelle Obama. No matter how you lean politically, to be able to hear a First Lady up close and personal is a special moment, especially when her cause is vital to the health and future of the nation.



(Left to right): Mary Jo Simke, Mary Taylor, Lisa Rowen, Ellen Beth Levitt, and Karen Warmkessel

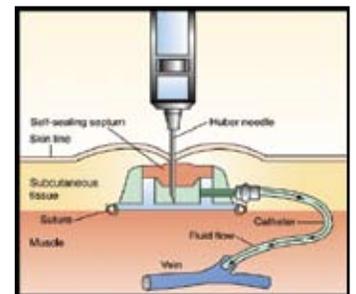
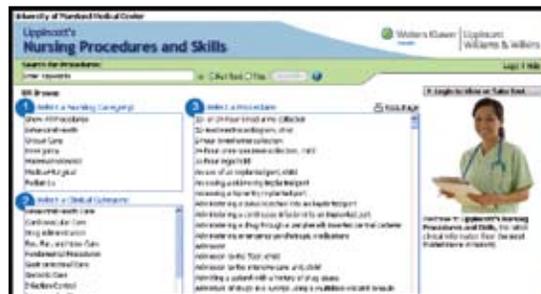
Lippincott Nursing Personal Learning System: A point-of-care reference tool for providing quality care

By: Kristy Gorman, MS, RN

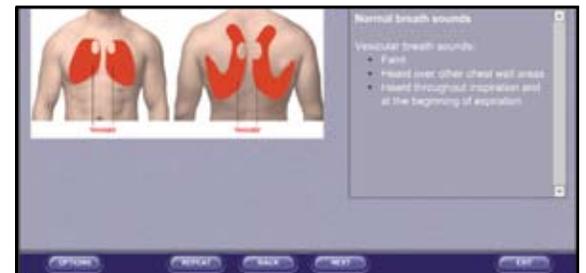
Establishing an effective competency assessment and learning program is essential to providing quality care, as well as adhering to standards of regulatory bodies. The Joint Commission HR 3.10 states “Competence to perform job responsibilities is assessed, demonstrated, and maintained.” In that regard, UMMC has implemented a variety of online nursing reference tools and resources. One such tool is the Lippincott Nursing Personal Learning System, which includes Lippincott’s Nursing Procedures and Skills, Clinical Simulations, and Competency Evaluation Modules.

Lippincott’s Nursing Procedures and Skills

LNPS is a point-of-care resource, with superior content focused on clinical competency and skill development. LNPS includes over 900 highly detailed nursing procedures with enhanced visual aids. Each procedure contains evidence-based references, which are reviewed at least annually for content currency, including adherence to current standards and guidelines required by the Joint Commission, the Intravenous Nursing Society, the American Association of Critical Care Nurses, and other respected nursing authorities. LNPS competency tests are also available options.



Clinical Simulations The Clinical Simulations are “virtual” patient clinical scenarios created by authorities such as the AACN. There are a variety of interactive case studies and tutorial programs that address every aspect of clinical nursing practice. These self-paced scenarios provide clinicians with specialty education, assessment of clinical knowledge and critical thinking skills, and knowledge testing with immediate instructive feedback. Example tutorials include AACN Nursing Care of Acute Renal Dysfunction and Heart Sounds: Basic Skills & Techniques.



Competency Evaluation Modules Training modules are available for the most critical and clinically challenging specialties in nursing. The Competency Evaluation Modules encompass a portfolio of highly interactive programs designed to thoroughly evaluate aptitude and skill sets within several distinct areas of the ER, OB, and ICU. Each module contains seven clinical scenarios with fifty multiple-choice questions embedded throughout which are designed to evaluate knowledge, proficiency, and communication abilities. Examples include Caring for Patients with Cardiovascular and Respiratory Conditions, Intensive Care Training Module, and Neonatal Resuscitation Training Module.



Lippincott’s Nursing Procedures and Skills is accessible on the UMM intranet by selecting the Nursing tab and navigating to the “Nursing Procedures and Skills” link provided under the Professional Development section.

Individual employees may self-enroll in any of the Lippincott Professional Learning System courses through HealthStream. After enrolling, the course will appear in the “My Learning” tab under the “Elective Learning” section.

For additional information about utilizing the Lippincott Nursing Personal Learning System on your unit, please contact Kristy Gorman via email at kgorman@umm.edu.

Honorable Mention

Progressive Care Unit

The Progressive Care Unit has received the prestigious Beacon Award for Progressive Care Excellence from the American Association of Critical Care Nurses (AACN). The award recognizes the top intensive care units in the country. The PCU is the first progressive care unit in Maryland to win this award. Progressive care is a transition from the higher-acuity critical care model for patients who are progressing but still need more care than on a typical acute floor.

Blood & Bone Marrow Transplant Team

The UMMC Blood & Bone Marrow Transplant (BMT) unit won first place for “Best Nursing Team” in the Maryland, Virginia and Washington, DC, region from ADVANCE for Nurses magazine.

Nursing Spectrum Excellence Awards

Kristin Seidl, PhD, RN, Director of Outcomes for Nursing and Patient Care Services, and **Melissa Custer**, BSN, RN, Senior Clinical Nurse I in the Surgical Intensive Care Unit, have been named regional finalists in the 2010 Nursing Spectrum Excellence Awards.

Seidl is a finalist in the category “Advancing and Leading the Profession.” Custer is a finalist for the “Clinical Care” category. As finalists, Seidl and Custer are among 30 nurses from Maryland, Virginia and Washington DC who were honored at the annual Nursing Excellence Awards Banquet.

Lisa Rowen Receives AONE Grant

Lisa Rowen DNSc, RN, FAAN, Chief Nursing Officer and Sr. VP Nursing and Patient Care Services, received a research grant from the American Organization of Nurse Executives (AONE) for her proposal, “A Comparison Study of Leadership Development Interventions: Effects on Nurse and Patient Outcomes”. Lisa was awarded the grant at the American Organization of Nurse Executives Annual Meeting and Exposition in Indianapolis, Indiana on April 9, 2010.

A landmark report from the Institute of Medicine (2000) highlighted the problems of errors and adverse events that occur in hospitalized patients in the United States. In a later report, (IOM, 2004) recommendations were made to change nursing work environments to improve patient safety. These recommendations included the development of “transformational leaders” and “strong nursing leadership” to implement effective management practices that would create cultures of safety and improve patient outcomes.

Research examining the relationship between nursing leadership and patient outcomes is relatively recent, with most studies published in the past five years. These studies provide evidence to support a positive relationship between transformational nursing leadership and improved patient outcomes that are mediated by the influence of staff nurse performance. However, there are few studies that have examined the most effective method to develop transformational nurse leaders. A clearer understanding of the mechanisms by which leadership practices contribute to positive changes in staff performance, work environments and patient outcomes is needed.

The purpose of this study is to explore the effect of different interventions of leadership development for unit managers and clinical leaders on patient and nurse outcomes over time. Other members of the research team include Karen Doyle, MBA, MS, RN, NEA-BC, Vice President for Nursing and Operations, Karen Johnson, PhD, RN, Director of Nursing, Research, and Evidence-based Practice, and Kristin Seidl, PhD, RN, Director for Nursing and Patient Outcomes.

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been eliminated, and the technology was becoming more sophisticated. The first pre-assembled intraventricular catheter kits were being marketed by Codman. The acute stroke unit on 12 South had moved to North 11 West and was renamed the neurological critical care unit (NCCU). The 12th floor of the South Hospital was converted to office space, and 12 East became the neurology acute care unit. Patients with multiple sclerosis, Parkinson’s disease, and most of the ophthalmology diagnoses were now being treated as outpatients. On 12 West, a four bed intermediate care unit opened up to decompress 12 ICU. The nursing staff from 12 West were competency trained to provide care for patients on monitors and ventilators.

In the early 1990s, planning for the Homer Gudelsky Building began, and in 1991 my role expanded to include the NCCU. The Gudelsky Building opened in 1995 with a large black tie reception attended by then Governor Schaffer and a variety of VIPs. The first units to move into the Gudelsky Building were the newly created NeuroCare ICU on 4 West, the NeuroCare IMC on 4 East, and the NeuroCare Acute Care unit on Gudelsky 5. For the first time, neurosurgery and neurology patients were located on the same units. The ICU on 4 West was intended to be a 19-bed unit, but we never opened beyond 11 beds. The IMC on 4 East was much as it is today; ten IMC level beds and four epilepsy monitoring beds; and Gudelsky 5 encompassed all 32 beds.

Despite all of these changes, the core of what it means to be a “neuro-nurse” has remained constant. The nurse’s assessment skills are still the most effective tool in caring for the neurologically impaired patient. It isn’t about the vital signs or the ICP monitor, although they are important. It’s really about knowing the patient’s baseline and then being able to identify subtle changes over time. The patient may still be alert and oriented to person, place and time, but are the answers a little more hesitant? Is the speech a little slurred or is there a slight pronator drift this time that wasn’t there before? It’s also about knowing the anatomy and physiology of the brain so well that you can anticipate what will happen next if your patient deteriorates. As any neurocare nurse will tell you, by the time the vital signs change, it’s too late and you’ve missed something.

Neurologically impaired patients and their families, whether the diagnosis is a brain tumor, a stroke, or a traumatic injury, are one of the most vulnerable populations in hospitals today. Neurological diagnoses are often life threatening, and almost always life altering. These patients and their families are left with cognitive and/or motor deficits that will change the way they function, work, and interact with others for the rest of their lives. As a neuroscience nurse you have the potential and the responsibility to mitigate those deficits whenever possible. Being a neuroscience nurse can be physically demanding and emotionally draining, but it is also incredibly rewarding from a professional perspective and quite possibly the most fulfilling experience you will ever have as a nurse.

Interpretation and Translation Services

By: Diane Gregg, LCSW-C, MSSA, Director, Social Work & Human Services

Roxana Del Barco, MA, UMMC Medical Interpretation Coordinator

By federal mandate (Title VI of the Civil Rights Act, 1964; Americans with Disability Act, 1990; Office of Minority Health CLAS standards, 2001) all government-funded programs, including healthcare programs, have the legal responsibility to provide language access for Limited English Proficient (LEP) and hearing impaired individuals. The Joint Commission also requires that accredited hospitals provide interpretation and translation services to patients and families, as necessary. Recently, regulatory focus has expanded to include language access for safety reasons. Effective communication between healthcare providers and patients is critical to the delivery of safe quality care. With LEP and hearing impaired patients, this involves the provision of language assistance tools and services, including the use of interpreters.

Many of our bi-lingual patients may have limited English proficiency when it comes to medical and health terms. So, for these patients, it is important to ask “What language do you prefer to use when talking to your doctor or about your health?”

Remember that communication is directly related to patient safety. The rate of adverse events involving severe harm or death is two times higher for LEP patients. If you cannot communicate with your patient, your patient is not safe!

Accurate interpretation requires a trained professional. Self-reported “bilingual” skills of staff may be insufficient for gathering and giving correct medical information. Ad-hoc interpreters frequently omit or misinterpret information. In emergency situations, adult family members may be utilized until a trained interpreter is available. Never use minor children for interpretation.

As a guide, remember to arrange interpretation services in the following circumstances.

- Obtaining patient’s medical history;
- Informed consent;
- Physician or health team rounds;
- Preoperative information;
- Postoperative information;
- Discharge planning;
- Discharge education; and
- Family meetings.

At the University of Maryland Medical Center, we offer medical interpretation services 24/7 for the hearing impaired, as well as for LEP patients and families. Foreign language interpretation is offered in over 250 languages through on-site and telephonic interpreters. For hearing impaired patients, we offer on-site and video-conferencing for American Sign Language.

All UMMC Spanish interpreters are qualified and trained and

- Must pass language proficiency test;
- Must pass medical interpreting skills assessment; and
- Must comply with professional Code of Ethics/Standards of Practice.

All vendors who provide interpretation through video-conferencing (sign language), the Language Line telephone (foreign language), or come on-site (sign and foreign language) are certified and HIPPA compliant.

Staff can arrange for telephonic foreign language interpretation 24/7 by using the Language Line telephone on the patient unit.

Arrangements for on-site or video-conferencing interpretation are made 24/7 through the paging system, 8-BEEP (TALK) ID#8255. Please provide the following information.

- Patient’s name and location;
- Contact person and telephone or pager number;
- Reason for on-site interpretation services;
- Dates and times needed; and
- Wait for confirmation of interpreter availability.

The following UMMC sites are included for interpretation services.

- UMMC;
- Outpatient Clinics at 16 South Eutaw Street;
- Transplant Services at 29 South Greene Street; and
- Psychiatric Services at 701 Pratt Street

The Patient Advocacy Department, in addition to other duties, arranges for interpretation services through 8-BEEP (TALK) ID#8255. For questions or to arrange a staff in-service, contact Odetta James-Harlee, Supervisor, Patient Advocacy Department, ext. 8-8777.

Announcing NEW Feed and Flush Sets For The Kangaroo ePump

The new feed and flush sets allow for programmed flushing intervals, eliminating the need to manually flush enteral feeding devices. The pre-programmed flushing intervals allow for uninterrupted nursing care while providing accurate results. The DEHP-Free sets will be stocked in all ICU, IMC, and high volume user units. For additional information check out the website: www.KangarooPumpTraining.com



Great Catch Award

By: Fe Nieves-Khouw MSN, RN Director, Quality Improvement and Patient Safety Officer

Some adverse events result from unavoidable complications of medical care, but others result from medical errors. We have numerous policies and systems in place to prevent medical errors, but sometimes communication problems, limits of human memory or attention, or other issues allow an error to slip past despite our best attempts to prevent them. Seemingly “minor” errors, such as a practitioner forgetting to wash his/her hands or not identifying a patient prior to a diagnostic study may have “major” adverse consequences for a patient. Sometimes all that stands between a patient and an adverse event is an alert employee who takes action to avert a potential disaster; an employee who makes a “great catch.”

UMMC has consistently encouraged reporting of concerns impacting safety and quality. The “Great Catch” award is an extension of this commitment and is designed to improve identification and reporting of near misses or close calls by recognizing and rewarding those individuals who identify or “catch” an error prior to its reaching the patient.

What is a Near Miss or Close Call?

In a survey conducted by the Institute for Safe Medication Practices (ISMP) in 2009, 88% of respondents defined “near miss” as an “error that happened but did not reach the patient”. However, 3% of respondents defined near miss as “an error that reached the patient but did not result in harm”. Because of potential confusion, respondents to the same survey suggested that the term “**close call**” might be more easily understood in healthcare.

ISMP defines “close call” as an “event, situation, or error that took place but was captured before reaching the patient. An example would be a medication ordered for a patient who is allergic to the drug, the pharmacist was alerted to the allergy during computer order entry, the prescriber was called, and the medication was not dispensed or administered to the patient. Another example is the wrong drug was dispensed by Pharmacy, and a nurse caught the error before it was administered to the patient”.

Another definition comes from the Agency for Healthcare Research and Quality (AHRQ). AHRQ defines “close call” as an event or situation that did not produce patient injury, but only because of chance. This good fortune might reflect robustness of the patient (e.g., a patient with penicillin allergy receives penicillin but no reaction) or a fortuitous, timely intervention (e.g., a nurse happens to realize the physician wrote an order in the wrong chart).

Informed by definitions from these two highly regarded agencies, UMMC considers an event a “close call” when a situation potentially harmful to the patient is discovered prior to reaching the patient, or when an error reached a patient but did not cause harm.

The “Great Catch” Award

UMMC has instituted the “Great Catch” award to increase our focus on timely recognition and intervention to protect a patient from potential harm. Themes or patterns learned from these reports will provide another source of evidence for quality or process improvement.

The “Great Catch” Nominating Process

1. Any UMMC employee may nominate him or herself or another for a “Great Catch Award” by submitting a story describing an occurrence involving the care of the patient where harm or potential harm was prevented or averted.
2. Submit a concise but complete story containing the following information:
 - a. Date of occurrence.
 - b. Date when report was written.
 - c. A description of the occurrence including action taken and potential harm to the patient. The action should be beyond the normal, expected job responsibilities.
 - d. The name, title, department, contact information, and name of the individual who made the catch, their supervisor, and the nominating individual.
3. Use the “Great Catch” form posted on the Intranet for easy access by any UMMC staff.
4. Fax or e-mail the “Great Catch” report to the Department of Quality and Safety no later than the **first Monday of each month**. Use Fax # 8- 8258 (attn: Fe Nieves-Khouw) or email the report to fnieves@umm.edu.
5. Selected “Great Catch” awardees will be presented and recognized at the UMMC Manager’s meeting.

Reward and Recognition:

“Great Catch” awardees will receive:

1. A “Great Catch” certificate of recognition;
2. Monetary reward;
3. Special Thank You and posting of the “Great Catch” report on UMMC Intranet; and
4. Publication of “Great Catch” stories in [News and Views](#) and [UMMC Connections](#).

Follow Up

UMMC leadership will review all “Great Catch” reports to identify common themes and/or common causes and determine follow up actions.

see **Great Catch** on page 10

Chain of Command and Rapid Response ... Keeping

There is a UMMC policy called “Chain of Command”, COP-031 on the UMMC Intranet in the hospital policy and procedure manual. It addresses steps that should be taken should concerns arise regarding the patient’s medical plan of care not being adequately addressed in the opinion of the healthcare provider.

The intent of this policy is to guide UMMC staff on how to proceed to a higher authority if there is a concern with the patient’s medical plan of care. The medical staff chain of command shall be used anytime a healthcare provider determines that there is a need to proceed to a higher authority for discussion or decisions regarding patient care or safety. If the patient meets criteria for **rapid response**, the escalation process described later in this article shall be followed. The Nursing and Medical Chains of Command are depicted below and discussed in the Chain of Command policy.

The Nursing Chain of Command

Patient Care Technician directs concerns to the assigned nurse who will make the decision to progress up the chain of command.



Assigned nurse refers to the Charge Nurse, Clinical Nurse Specialist or a more senior nurse as appropriate if he/she needs support or consultation at any step of the process or if he/she is unable to reach or resolve the concern utilizing the Chain of Command policy.



Charge Nurse refers to the Nursing Coordinator (as indicated for support or consultation) and should continue to seek consultation regarding the medical plan of care until (a) the patient’s clinical management is clarified; and/or (b) the health care provider judges the plan of care is appropriate.

The Medical Chain of Command (from lowest to highest position)

Interns, Junior Resident, NP, PA, Nurse Midwives



Senior Resident or Specialty Fellow (if applicable)



Attending Physician



Medical Director (if applicable)



Division Chief or Program Director (if applicable)



Department Chair/Designee



Senior Vice President of Medical Affairs/Chief Medical Officer

The healthcare provider shall continue up the chain of command if unable to resolve the concern. Steps may be skipped as necessary based on the urgency of the patient care situation.

our Patients Safe Every Day, Every Time

Rapid Response

Rapid Response is a policy recently approved to address the Patient Safety Goal that requires all hospitals to **Improve Recognition and Response to Changes in a Patient's Condition**. Our approach to improving recognition and response to changes in a patient's condition is to support nurses in initiating a **rapid response process**.

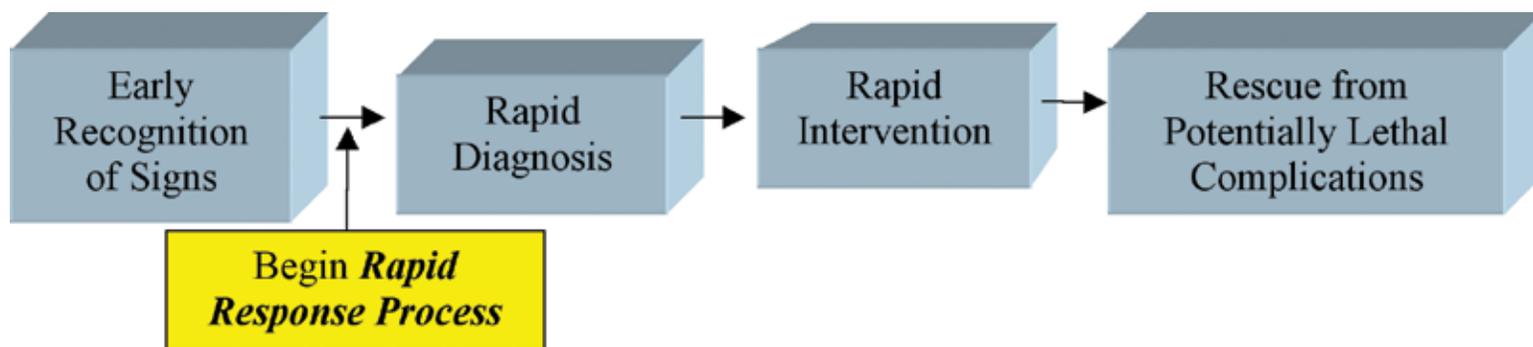
Having a rapid response process means that we have a way that nurses can

- Quickly identify “at risk” patients;
- Alert the provider to the problem and **expect** immediate assistance, and
- Escalate their concerns to a higher level when a provider does not respond within the expected time.

The bottom-line is that we now have a **rapid response process** that can improve our ability to **save a patient's life**. Early identification of patient deterioration and timely activation of a rapid response could prevent or improve the outcome of cardiopulmonary arrests. In many cases, clinical deterioration may occur for a duration as long as 6-8 hours prior to a critical event or arrest.

The use of a Trigger Tool or Early Warning Signs has been shown to help prevent underestimation of a patient's clinical deterioration. Trigger Tools have been developed for the following patient populations: Adult, Newborn, Pediatrics, Mother-baby, Perioperative Services, and Ambulatory. These tools, along with the **Rapid Response policy**, may be found on the UMMC Intranet in the hospital policy and procedure manual (COP-023). These Trigger Tools contain early warning signs for the various populations. Nurses need to use the tool (appropriate for the patient population) to identify patient deterioration early. Early response to such warning signs greatly improves the chances of preventing arrest and saving lives. Critical and emergency care units have immediate access to providers and can activate the rapid response process internally. Other areas will activate the process described in the policy (COP-023).

Any team member can recognize instability, but **nurses are at the bedside most consistently and frequently**, and they typically are the first caregiver to recognize signs of clinical deterioration. Equally important to rapid assessment is the need for an informed nurse to **rapidly** and **effectively** communicate these symptoms to the team caring for the patient. The following diagram depicts the steps of the rapid response process.



Step 1: Validate assessment with another nurse, preferably a more experienced or senior clinical nurse.

Step 2: Call or send a text message to the assigned, covering, or on call physician or other provider (NP or PA). Also notify the charge nurse (if not already involved), nursing coordinator and the Patient Placement Center.

Text message or STAT page: (basic)

“(Unit) initiating the rapid response system for (patient name); he/she is (criteria met from list). Please come to (Unit and room #)”.

- Response Expectation: Face to face evaluation of the patient within 15 minutes of initiating the rapid response process.
- If unable to come within 15 minutes: “Please identify another provider on your team that I can contact immediately”.

Here is an expanded example from Trauma using SBAR.

“This is 4STA initiating the rapid response process for John Doe in room 6A. He has an oxygen saturation of less than 90% despite oxygen administration. The patient is a 28 year old male admitted on 8/22 after a motor vehicle accident with bilateral rib fracture, and history of asthma and smoking. Patient presents now with increased RR 24-30, using accessory muscles. He went from 95% oxygen saturation on room air to 89% on 4 L NC. My recommendations are that we do an ABG, get respiratory consult, possible nebulizer and a chest x-ray. Are you available to come to the patient's room within the next 15 minutes per the process guidelines? If not, please identify another provider on your team that I can contact per the guidelines.”

Step 3: If a provider is unable to be present on the unit within 15 minutes, escalate to Senior Resident or fellow using the same text/script.

Step 4: If a senior resident/fellow is unable to respond within 15 minutes, escalate to the **attending physician** using the same text/script

see **Rapid Response** on page 12

Enhancements to the Professional Advancement Model

By: Luiza Lima, MS, RN, Professional Development Coordinator

Greg Raymond, MBA, RN, Director, NeuroCare & Behavioral Health Services

The Professional Advancement Model will complete its 2nd anniversary in August. Yes, time goes by very fast!

After the implementation of PAM in 2008 and with every cycle since, UMMC and PAM leadership have continuously sought input from nurses, managers, and directors regarding how to facilitate the application process. Multiple enhancements have already been incorporated into the process during these past 20 months, but the portfolio template remained the same. This was one element that needed revision.

Good News!! A curriculum vitae (CV) will be incorporated into the portfolio of applicants applying for promotion in the July 1-15 cycle. A CV template with guidelines is available on the UMM intranet, and a copy is provided on page 11. These resources are located by clicking on the Professional Advancement Model link within the Nursing page under Departments.

The CV compiles and narrates one's work performance and contributions to self, others, unit, department, organization, community, and to the profession of nursing. The CV explains how an applicant meets requirements related to a promotional role. For instance, if an area of focus is Service, Safety & Quality, the CV must have content demonstrating how the nurse meets the requirements under this area.

Evidence to support the CV content will still be required. Self, peer, and manager evaluations are also required in the same fashion as before.

Applicants should submit a CV and all evidence in a soft binder, including the evaluations mentioned above to the Clinical Practice & Professional Development Office at the Paca/Pratt building, 2nd floor during the application submission cycle (every three months – dates available on the Intranet). Additionally, optional resources to facilitate application submission are accessible through the UMM intranet.

The process for evaluation of applications and respective recommendations has not changed. The Advancement Model Review Team will review all applications and forward recommendations to managers as before.

Senior Clinical Nurses not applying for promotion should provide a CV to their managers using the same CV template for use as part of their annual performance evaluation process. There is no requirement for providing a portfolio.

Current department peer evaluation elements should continue to be used. We recommend that the new CV be incorporated into the existing departmental peer review process. A new and standardized peer review process is under development through the Professional Development Council and will be introduced in the near future.

If you have questions, please contact Luiza Lima via email at llima@umm.edu ext. 8-7699 or Greg Raymond via email at graymond@umm.edu ext. 8-8567.

Great Catch from page 7

Great Catch Awardees

Numerous submissions for the Great Catch award are received each month. Many nominations are indeed "great catches" and have prevented situations that could have harmed our patients. The first two awardees for the month of February are both from the Medical Intensive Care Unit. Raylyn Miller BSN, RN made a significant observation regarding medication administration. Thea Epple BSN, RN prevented potential spread of infection by reinforcing proper handwashing technique for a patient with C Difficile colitis.

March awardees are also both nurses. Marni Edelman from General Pediatrics identified a discrepancy with discharge medications. Jean Filletti from the Trauma Resuscitation Unit reported a hazardous condition on the helipad that prevented a potential injury.

References:

Institute of Safe Medication Practices, ISMP survey helps define near miss and close call. <http://www.ismp.org/newsletters/acutecare/articles/20090924.asp> accessed on 2/3/2010

Agency for Healthcare Research and Quality, AHRQ patient safety network-glossary, p. 6. <http://www.psnnet.ahrq.gov/glossary.aspx> accessed 2/3/2010



Raylyn Miller, BSN, RN



Thea Epple, BSN, RN

Curriculum Vitae (Template)



(Name & Credentials)

(Place of work)

(Current role: CN II, SCN...)

(Contact Information: address, phone #s, email, etc)

Directions: Complete each section thoroughly without abbreviations. Do not include any personal information and experience. Delete sections when not applicable.

1. **Education** (chronological): Include all formal accredited education – month/year, degree, program, and institution, even if currently attending. Indicate with an * when currently in school and anticipated degree/graduation date.
2. **Experience** (most recent first): Include month/year (from – to), position(s) held, and organization. Specify any leadership roles, such as Charge Nurse, Nurse Educator, etc. Include description of responsibilities up to 100 words or less.
3. **Professional certification** information (list available on the Intranet – ANCC/Magnet recognition): Certification name and credentials, name of nationally or internationally recognized certifying organization, initial certification date, and expiration date. Do not include techniques, such as ACLS, PALS, NRP, CPR, etc.
4. **Current professional organization or academic societies membership(s)**: Include membership date, name of organization, and list any leadership position or role.
5. **Research/EBP/PI continuum:**
 - 5.1. **Process Improvement:** Include title of the project, baseline data/anecdotal explanation, brief list of interventions, and outcome(s)/impact or where in the process. Include your role (participant, leader, etc) and indicate if unit-based and/or organizational.
 - 5.2. **EBP:** Include question, recommendation(s), translation to practice, and outcome/impact. Indicate if unit-based, divisional, or organizational. Include your role (participant, leader, etc).
 - 5.3. **Research and grants:** Principal investigator's name, purpose(s), research question(s), and design. Include your role on the project (collected data, principal investigator, collaborated with the design, etc) unit/division/organization or where in the process and indicate if unit-based and/or organizational.
6. **Publication(s)** internal (News & Views, Connections, patient handouts materials, policies you helped develop, competencies, procedures, etc) and/or external (letters to the editor, journals, book chapters, etc). If applicable, include complete reference in APA. Include your role (contributor, first/second author, etc).
 - 6.1. **External publications:**
 - 6.2. **Internal Publications:**
7. **Presentation(s)** given on professional forums (internal and/or external): include date of presentation, title, sponsor (or forum?), format (lecture, poster, etc), and month/year. Include your role.
 - 7.1. **Teaching:** Title and/or topic, sponsor, format (inservices, lectures, poster sessions, case studies, competency marathons, etc.), intended audience, month/year. Include your role (instructor, professor, speaker, etc).
 - 7.2. **Formal mentorship, preceptorship, and/or coaching** (e.g., mentor of sr. student on scholar program, mentor/coach employee on performance improvement plan, coach as super user on a variety of situations, etc): Describe responsibilities briefly, including dates.
8. **Committee appointment**, such as nursing governance involvement, unit-based, task force, etc.: Include name of group, chair's name, group purpose, your role (chair, co-chair, participant, etc.) and dates of appointment.
9. **Honors and awards:** Internal and external, name of the award, organization granting award, and date.
10. **Community service:** Include name of organization, type of activity, if voluntary or part of work, and dates.
11. Include a page with the required yearly **continuing education hours** for your current role (CN II – 5 hours, SCN I – 10 hours, SCN II – 15 hours). College credits count for half of the total hours. The remaining hours must be met by some other means.

We Discover

Congratulations to the following UMMC Nurses who presented oral or poster presentations at state and national professional conferences from January - March 2010.

Mylene de Vera, BSN, RN, OCN	Effect of Oral Cryotherapy on Mucositis-Related Pain and Patient Functioning in Hematopoietic Stem Cell Transplant Patients Receiving High Dose Melphalan. Poster Presentation. American Society for Blood and Marrow Transplant/Oncology Nursing Society. Orlando, FL.
Serena Twu, BSN, RN Cindy Rew, BSN, RN Greg Raymond, MBA, BSN, RN	Establishing a Turning Program in the SICU: Striving for Quality Outcomes. Poster Presentation. 6th Annual Maryland Patient Safety Conference. Baltimore.
Karen Kaiser, PhD, RN-BC, AOCN, CHPN Megan Rushe, PharmD Trisha Fronczek, MS, RN-BC, CCRN Michele Bennett, BSN, RN	Disposable Pain Pumps: Safe Dispensing and Administration. Poster Presentation. 6th Annual Maryland Patient Safety Conference. Baltimore.
Mary Ann Bautista, BSN, RN, CNRN Brigid Blader, MS, RN Sheree Chase-Carter, MS, RN, MBA	Using Simulation to Train Neuro ICU Staff Nurses How to Respond to Inadvertent Tracheostomy Decannulation. Poster Presentation. Excellence in Teaching in Nursing Conference. Baltimore.
Linda Byrne, BSN, RN Jane Aumick, RN, CCRN Lynn Armstrong, BSN, RN Karen McQuillan, MS, RN, CCRN, CNRN Deborah Stein, MD, MPH, FACS	Improved Patient/Family Satisfaction After Implementation of Family Rounds. Poster Presentation. Nursing Practice Based on Evidence: Quality Care at Risk. Baltimore and the 42nd Annual Conference of the American Association of Neuroscience Nurses. Baltimore.

Rapid Response from page 9

Documentation: Enter brief note in progress note section of the patient's medical record.

Date/Time: "Rapid response process initiated. Patient's (criteria met as listed on early warning signs list). Dr. _____ on unit. (describe interventions taken)

OR (after 15 minutes)

Physician not yet on unit, call placed to/paged Dr. _____`

Monitoring: Requirements of this standard include monitoring the impact of having a rapid response system on several indicators such as:

1. Avoidance of cardiopulmonary arrest as indicated by impact on frequency of codes;
2. Avoidance of escalation to a higher level of care as indicated by patient transfers to an ICU;
3. Patient rescue as indicated by mortality rate; and
4. Additionally, UMMC tracks the most frequent reasons for activating the rapid response process

The Nurse/Assigned staff should complete the Monitoring form which aims to evaluate the effectiveness of the rapid response process. The monitoring tool includes the questions below.

1. Reason for initiating the rapid response process.
2. Response time within 15 minutes (yes/no).
3. Escalation needed (yes/no).
4. To what level (senior resident, fellow, attending physician).
5. Patient Outcome: code called (after initiating rapid response), transferred to ICU; stayed on unit.

For more information, contact Fe Nieves-Khouw, fnieves@umm.edu, 8-7575 or Carla Middleton, cmiddleton@umm.edu, 8-0909.

Radiology Nursing and the CRN

By: Maureen Hanold, BSN, RN, CCRN, SCNI, Interventional Radiology

Nursing care in the Radiology Department at University of Maryland continues to expand as we perform more complex procedures on increasing numbers of patients. There are two nurses who care for pediatric patients requiring sedation for diagnostic and interventional procedures in Ultrasound, CT, MRI, Radiation Oncology, and Interventional Radiology. During the 12 years I have worked in Interventional Radiology, I have seen the adult care nursing staff numbers double, as we provide care for 5-6 procedure rooms and a busy 10 bed prep and recovery area.

Radiology encompasses a variety of modalities, and many procedures are offered for a wide array of medical conditions. The range of patient populations we care for spans the spectrum of mildly ill through acutely and critically ill. In the course of a single shift, a nurse could provide care for a young woman who is 30 weeks pregnant with kidney stones, a 78 year old patient with an intracranial hemorrhage with increasing intracranial pressure, a 54 year old motor vehicle trauma patient with a splenic bleed, a 34 year old, newly diagnosed oncology patient who needs a mediport for chemotherapy, a 66 year old female with a vertebral fracture who requires a vertebroplasty, a 16 year old who requires an LP for pressure relief secondary to Pseudotumor Cerebri, a 42 year old female undergoing a uterine fibroid embolization, and a 37 year old patient recovering from an ultrasound guided liver biopsy.

The professional organization for radiology nursing is the Association for Radiologic and Imaging Nursing (ARIN). The goal of this organization is to “provide, promote, and maintain continuity of quality patient care” in diagnostic, therapeutic, and interventional imaging environments. The *Journal of Radiology Nursing* is ARIN’s official publication and includes articles on education, patient care, research, and case studies.

The Certification for Radiology Nursing (CRN) is administered by a subsidiary of ARIN. There are a number of reasons that nurses seek CRN certification. They include recognition from peers and employers for achieving a higher level of competency in this nursing specialty, validation of clinical expertise according to a professional organization, promotion of current practice standards in the specialty of radiology nursing, and demonstration of the knowledge, skills and abilities required to attain the CRN.

The candidate for the CRN exam needs to hold an active RN license and have practiced as a licensed RN with a minimum

of 2,000 hours in radiology nursing within the past three years. This can be direct patient care or direct clinical management, supervision, education, or direction of other persons to achieve or help achieve patient/client goals for the stated number of hours. Candidates must complete 30 contact hours of continuing education applicable to nursing care of radiology patients within the last two years, and 15 of the 30 hours must be specifically related to radiological nursing.

The cost of the exam is \$300 for ARIN members and can be paid for with the educational benefit we receive from UMMC. There are a few hurdles to overcome to attain this certification and they include a limited number of testing sites (only one in Maryland); the test is offered only three times a year; and the test is a paper and pencil format so the final score is not available right away.

The exam is 4 hours in duration and includes 250 multiple choice questions. The content of the exam includes questions weighted as 40% Patient Care Conditions, 35% Imaging, Interventional, and Therapeutic Environments, 15% Safety Concerns, and 10% Professional Issues. The variety of imaging environments covered on the exam include CT, Diagnostic Radiology, MRI/MRA, Ultrasound, Nuclear Medicine, Breast Health, and PET. Therapeutic areas include Radiation Therapy and Nuclear Medicine. Interventional areas include Interventional Radiology, Biopsy in Ultrasound and CT, Device Insertion, and Lithotripsy.

One of the resources used in Interventional Radiology to help educate staff and to prepare for the CRN examine includes a bulletin board with a “CRN Questions of the Week” contest. All staff may participate. The 5 questions often generate discussion and a review of current practice. Answers are posted the following week. A quarterly drawing is held for a gift certificate to two local restaurants for all staff who participate. The *Core Curriculum for Radiologic and Imaging Nursing* is on the unit and available for staff to review. This book is a great study guide for the CRN certification exam. We are fortunate to have physicians that are motivated to educate the nursing staff and answer questions. Some nursing staff attend the yearly Society for Interventional Radiology Conference (SIRS), which includes Nurses, Radiology Technologists, and Interventional/Neuro-Interventional Radiology Physicians meeting in one location with a variety of workshops and educational sessions.

CPPD Implementing New Course Registration Process

Effective July 1, 2010, most courses offered by Clinical Practice & Professional Development will be available for registration on line through HealthStream. The online option will provide staff with immediate access to course content, date, time, location, availability, and registration. The only courses that will not be available for registration through HealthStream will be annual conferences or any courses that require registration fees or deposits from UMMC employees, such as ACLS and ONS Biotherapy/Chemotherapy.

Registration for all conferences and courses will still be available via phone, email, or walk-in at either the main CPPD office or in our Satellite Office, located in the Gudelsky Lobby. The use of HealthStream as an online registration source will provide staff greater flexibility in accessing educational resources through the CPPD office. We invite any suggestions, comments, or concerns about this new service. Please contact Margaret Mickens, Office Supervisor at ext. 8-6257 or mmickens@umm.edu

Clinical Practice & Safety Topics

Safety Flash: Elevator Labels

Issue: Employees who did not normally transport patients had difficulty identifying which elevators to take for transporting patients with different types of equipment.

Solution: Labels with pictures of the largest piece of equipment that an elevator can accommodate are posted on the frame outside of each elevator.



The largest piece of equipment this elevator can accommodate is a **WHEELCHAIR**.



The largest piece of equipment this elevator can accommodate is a **STRETCHER**.



The largest piece of equipment this elevator can accommodate is a regular size **BED**.



This elevator can accommodate a specialty bed plus additional equipment. These are the largest elevators in the hospital.

Elevator Safety Tips

- When transporting patients, know your route and which elevators will accommodate you, your patient, and their equipment.
- Patient transportation has priority. Patients with a ventilator or monitor have priority over non-ventilated/monitored patients. You may be asked to step off the elevator for a patient transport. If that's the case, please step off and get the next elevator.
- To prevent injury, elevator doors are equipped with light curtains that will detect the presence of an object and reopen the door unless:
 - The elevator has timed out. When this happens, the elevator will alarm and the doors will attempt to close. To keep the doors open, you must press and hold the Door Open button or use a transport key.
IMPORTANT: When the elevator times out and the doors begin to close, they will not reopen. You cannot stop them unless you press the DOOR OPEN button.
 - The fire service feature has been activated (by the Fire Department).
- If you have to hold the door open, either have a staff member hold the Door Open button or use a transport key.
- In case of emergency, each elevator is equipped with a phone. Press the call button and be prepared to describe your emergency to the operator that answers.
- Please contact Safety & Environmental Health ext. 8-6001 or SOSC ext. 8-5174 if you have concerns about elevator safety.
- Report elevator emergencies to ext. 8-8711.

Safety Flash Contact: Laura Wickersham, MS, Safety & Environmental Health Assistant at 8-6491 or lwickersham@umm.edu

Farmers Market Season Here

By: Denise Choiniere, MS, RN, Sustainability Manager

The University of Maryland Medical Center's Green Team, University of Maryland Baltimore, and the Downtown Market Center, are proud to announce the re-opening of the University Farmers Market. This will be the second season for the market, which takes place in Plaza Park, across the street from the hospital's main entrance, along Paca Street. The market is open every Tuesday from 10:30 am until 2:30 pm, and will run weekly from May through November, 2010.

By hosting a farmers market, UMMC and its partners are helping to improve the availability of fresh, locally grown, and prepared food to its' employees, patients, visitors, and area residents and businesses. Purchasing food from local farmers and vendors not only supports the local agricultural community and the local economy, but it also decreases "food miles." Food travels on average 1500 miles from farm to plate. However, when purchased "locally", food travels an average of 60 miles. This significant decrease in the distance traveled cuts down on fuel consumption, greenhouse gases, air pollution, and the likelihood of related diseases, including asthma, lung disease, lung cancer, and heart disease. It also cuts down on the use of plastics used in packaging, and allows farmers to pick their food when it's ripe, maximizing the nutrient content in the food and providing fresher food that tastes better.

As health care workers, it is important for us to model healthy eating and be environmental stewards that support public health. Buying local food fulfills several of these healthy lifestyle choices. Plus, this market will host many farmers that use environmentally sustainable practices, including fewer pesticides, no antibiotics or growth hormones, and their animals are raised outside on pasture.

What's in Season:

The peak growing season for Maryland is not until the summer months, but some crops will be sprouting up sooner. Expect to find strawberries, asparagus, broccoli, cauliflower, salad greens, and spinach within the first few weeks of the market. To find out what is in season from month to month, visit http://marylandsbest.net/in_season.php



The University Farmers Market Is Proud To Feature The Following Farmers & Vendors

(*Designates first year with the University Farmers Market)

Charm City Farms* – located right here in Baltimore City. Charm City Farms offer a wide variety of vegetables, herbs, and flowers all grown without the use of pesticides.

Edible Favors – offering homemade desserts and fresh frozen ice, made with Maryland grown fruit.

Eula's Savory Soups – offering fresh, homemade, healthy bean soups, all made with Maryland grown vegetables.

Ferguson Family Farm – located in Baltimore County, MD offering naturally raised Berkshire pork using sustainable agricultural practices, such as rotating pastures and not using growth hormones or antibiotics. Learn more at: www.fergusonfamilyfarm.com

Gary's Savory Sauces – offering a variety of savory sauces for your meats, seafood, and vegetables...great for grilling! We are happy to announce that Gary will be firing up his grill this season to offer his signature turkey burgers.

Havana Road* - offering a variety of natural, wholesome, artisanal Cuban foods such as salsa, mojo, red beans, and rice ensalada. Complete list of offerings at www.havanaroad.com

Infused Spreads – offering a wide variety of creative jellies, jams, and marmalades, made with Maryland grown fruit.

Kilby Cream - located in Cecil County, MD offering farm fresh homemade ice cream, using milk from their own Cecil County dairy, free of synthetic hormones. Visit www.kilbycream.com

Mallow Munchies – Not your grandmother's crispy rice snack. Mallow Munchies are a twist on the standard treat we all know and love. It has graduated from the three ingredient treat most are familiar with. Instead, their marshmallow is made from scratch using all natural ingredients. Learn more at: www.mallowmunchies.com

Max's Empanadas - offering fresh, authentic Argentine empanadas, pastries, salads, and desserts. Learn more at: www.maxempanadas.com

Stone Mill Bakery – offering a wide variety of breads, pastries, and desserts. Known for their quality and freshness, they strive to use organic, additive free, naturally raised ingredients whenever possible. Learn more at: www.stonemillbakery.com

Ruben's Crepes – hot, freshly made crepes with a large variety of delicious fillings.

Stoecker Farms* - a family run farm for over 100 years, Stoecker Farms is located in Baltimore County and offers a wide variety of fruits and vegetables.

Tuckey's Mountain Grown Berries, Fruits, and Vegetables - located just 15 miles north west of historic Gettysburg, PA, offering a full line of berries, fruits, vegetables, cut flowers, jams, and jellies, and fresh fruit pies. Tuckey's also offers a Community Supported Agriculture (CSA) program. Learn more at: www.localharvest.org/farms/M23019

Two Oceans True Foods, Inc (Formerly Carriage House Farms) - located in Baltimore County, MD offering chicken, turkey and eggs from animals raised outdoors on pasture without synthetic hormones or antibiotics. Also offering frozen and portioned sustainable seafood. Learn more at: <http://www.localharvest.org/farms/M18351>

Winspear Farms – located in Baltimore County, offering a unique variety of produce, including triple sweet corn, heirloom purple tomatoes, and Minnesota midget melons.

Thank you to all who supported the market last year. We look forward to seeing you again this year. Be sure to bring a friend and spread the word!



Clinical Practice Reminders

Health care providers are exposed to occupational hazards such as splashes and needle sticks every day unnecessarily. You can protect yourself by doing simple things like wearing gloves, goggles, masks, and any other necessary personal protective equipment (PPE).

Facts About Occupational Exposure

- The number one blood/body fluid exposure for employees has been caused by a splash.
- 80% of the employees exposed were not wearing eye or face protection at the time of the splash.
- 100% of the employees exposed were performing tasks that had an increased risk of resulting in a splash.
- The number one response after a splash has been “I should have been wearing my goggles.” Splash exposures pose a risk of HIV, Hepatitis B, and Hepatitis C transmission.
- The top five procedures involving a splash
 - Pulling an arterial line
 - Emptying a drain
 - Stimulating a cough while suctioning a patient
 - Irrigating a wound
 - Flushing medications through an IV line.
- After a needle stick or body fluid exposure, wash the area with soap and water. For mucous membrane exposure, irrigate the affected area with saline. Call the Exposure Hotline immediately at 8-BEEP ID # STIK (7845) and contact your supervisor.
- An MSDS (Material Safety Data Sheet) can be found on the Internet. Search for the product common name or manufacturer name.
 - Materials Management can provide a copy of an MSDS for any product they distribute.
 - Environmental Services has an inventory of chemicals they actively use.

Infection Control

Hand washing is the single most important procedure for the prevention of healthcare associated infections. Alcohol-based hand rubs may be used if hands are not visibly soiled. Do not use these

for patients with *Clostridium difficile* (C-diff). Use antimicrobial (chlorhexidine) soap and water and wash for 15 seconds if hands are visibly soiled and after using the restroom. Be familiar with your unit’s hand hygiene performance. The goal is 100%.

Other Infection Control Reminders

- Food and beverages are only allowed in areas designated by the nurse manager where it is not anticipated that occupational exposure to blood or bodily fluids will occur.
- If the nursing assessment reveals that the patient may have a communicable disease (e.g. diarrhea of unknown etiology, signs and symptoms of a viral respiratory illness), the nurse can initiate presumptive isolation precautions and follow-up with the physician/prescriber for an order.
- Isolation attire is not to be worn outside the patient room unless the staff are transporting a patient on isolation precautions.
- An isolation cart is acceptable in the hallway only if the patient has a visible isolation sign.
- Isolation signage must comply with hospital policy. Handwritten signs are not acceptable.

Respirators

- Employees must be medically cleared prior to wearing any respirator. Loose fitting PAPRs do not require fit testing.
- Units that have patients on Airborne Isolation Precautions: Make sure PAPRs are charged, and that flow testers, hoods, and hoses are available.
- Disposable N95s or Reusable Respirators: Only wear what you have been fit tested for within the past year.
- To obtain a PAPR, call Customer Connect at 8-5174. Follow the instructions to perform an air flow check. This check must be done prior to each use.

Contact Sandra Pitman, RN, Employee Health via email spitman@umm.edu or ext. 8-0958.