A new venue to the annual Quality & Safety Fair was storyboard podium presentations. Julie Glen, director of Medical Information Systems shares Achieving Meaningful Use, one of the presented quality projects.

According to the American Hospital Association, every day, America’s hospitals strive to improve the safety and quality of care they provide. Research has shown that certain kinds of health information technology (IT) – such as computerized physician order entry (CPOE), electronic health records (EHRs) and bar coding for medication administration can limit errors and improve care. Health IT can also be a tool for improving efficiency. Efforts are underway across the country in hospitals big and small, rural and urban to adopt health IT.

To move the country toward achieving these goals, the Medicare and Medicaid EHR Incentive Programs were created to provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. This is often referred to as the “Meaningful Use Program”.

The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health Information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

Simply put, “meaningful use” means providers need to show they’re using certified EHR technology, such as Epic, in ways that can be measured significantly in quality and in quantity.

- The goal of achieving widespread adoption and meaningful use of electronic health records by 2014 is established in the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), part of the American recovery and Reinvestment Act of 2009.
- The HITECH Act directs the Centers for Medicare & Medicaid Services (CMS) to administer an incentive payments program that will make available significant bonus payments to eligible health care providers who adopt and demonstrate meaningful use of certified electronic health records (EHR).
- In addition, the HITECH Act provides for leadership and support for EHR adoption and use through the Office of the National Coordinator for Health Information Technology.

There are two facets of the program. One for hospitals and one for Eligible Professionals (EP’s). The requirements are similar for both programs such as a set of core objectives must be met.
The health-care environment is changing at a faster pace. As I reflect on the changes, I am struck by how much information is given to all of us. This information includes changes in our practices to improve the patient experience, quality, patient safety, new equipment and a constant turnover of patients. I wondered how can we know what the current priorities are that need our attention? As I listed the priorities for our organization on a piece of paper, I was struck by the fact that our organizational goals reflected the Magnet Model. The new model was a framework to prioritize our goals for the year. The model describes the following characteristics of the MAGNET organization:

**Transformational Leadership** - To transform health-care organizations for the future

**Structural Empowerment** - A strategic plan, vision, structural systems, policies and processes to change the health-care system to meet the needs of our patients

**Exemplary Practice** - Understanding the role of the professional nurse, providing excellent care to patients and their families, the application of evidence-based care

**New Knowledge, Innovation and Improvement** - As professionals, we must be committed to improving care to meet the changing needs of patients through research, quality improvement and the implementation of evidence-based practices.

**Clinical Outcomes** - We must measure quality and benchmark ourselves to ensure that we are providing excellent care.

Magnet facilities must demonstrate that they are the top providers of care.

Our goals for this year will focus on culture changes through our work to improve the culture of safety, staff engagement, patient flow through our system, strengthening our shared decision-making councils, improving the patient experience and quality of care. The graphic element included in my letter is one we have devised for nursing that is a one-page story that tells us our priorities. For me, it is a map of what we need to achieve this year. When we are focused, our ability to improve grows exponentially. Use this tool to guide your practice as a professional, so we can be identified as a preferred hospital in Chicago.
The 2012 Quality & Safety Fair, “Pride in Quality: Celebrating Success and Embracing the Future” was held on September 5th, in the Stritch School of Medicine. This fair provided an opportunity for faculty and staff to celebrate quality and patient safety throughout the health system.

The fair offered an excellent opportunity for faculty and staff to:

- present project storyboards that display quality and safety improvement processes with significant outcomes
- network with colleagues to gain insights, practical knowledge and encouragement to address quality and safety issues in care and service
- gain knowledge of quality improvement strategies, Lean initiatives, safety practices, and change management techniques used by project team members
- recognize the achievements of outstanding quality improvement teams

Twenty-eight quality and patient-safety projects were on display. These projects demonstrated evidenced-based clinical practice guidelines, discussion of process flow opportunities, and identification of new initiatives to improve the patient experience throughout the health system.

An exciting new addition to this year’s fair was the Storyboard Podium Presentations. Three exemplary storyboards were presented, with follow-up questions and answers from the audience. Podium presentations included:

- Julie Glen RN, BSN, MBA, director of Medical Information Systems, who discussed “Achieving Meaningful Use.”
- Cathy Paulus, RN-BC, BSN, CIC, Infection Preventionist, presented, “Use of Infection Prevention Electronic Surveillance System to Improve Clinical Processes and Decrease HAIs”
- Elizabeth Schulwolf, MD, MA, reported on “Reducing the Rate of 30-Day Related-Cause Heart Failure Readmissions.”
- The People’s Choice Award went to Tewona Carter and the Breast Imaging Program, for their project, “How to Speed Access to Diagnostic Mammography.”

Our featured speaker this year was Paul Conlon, senior vice president of Clinical Quality and Patient Safety at Trinity Health. He delivered the keynote address on Trinity Health’s patient-safety initiatives. He congratulated Loyola’s commitment to patients that aligns with Trinity’s mission of “Consistent delivery of the highest quality, safest and the most efficient care for every patient, every time.” In addition, he discussed the Unified Clinical Organization Initiatives of building a “Just Culture” that incorporates a culture of safety, patient safety initiatives, and quality and improved care processes.

We applaud all the participant’s efforts and congratulate the winners of the 2012 Quality and Safety Fair. Be sure to visit the Center for Clinical Effectiveness website at www.luhs.org/depts/cce to view all the 2012 storyboard presentations.
Kudos to Nursing

Presentations:


Presentations by Dario Ruffulo, RN DNP CCRN ACNP -BC
- September, Domestic Violence: A Sometimes Subtle Disease. Sponsored by CCDPH and Region VIII Trauma Centers. Region Trauma Conference
- April, Anemia in the ICU, Brain Death: It is not as Easy as You Think, Trauma in Developing Nations. Peoria, IL.
- April, DIC-Current Treatments and Interventions, Blood Transfusion Therapy in 2012, and Complication of Anesthesia in the ICU, Idaho.
- March, Craniofacial Trauma, and The Pregnant Trauma Victim: Two Patients, Resuscitation in 2012. Sponsored by Midwest AACN Conference. Chicago, IL
- February, Update on Nutrition in the Critically Ill Care of the Patient with Diffuse Axonal Injury. AACN, Hinsdale, IL

Publication:

Certifications:
The following nurses became certified in Acute and Critical Care Nursing Adult (CCRN):
- Camille Agpaoa Valiente, 3MICU
- Cheryl Finke, 4ICU
- Peter Gustafson, 4ICU

Lindsey Cavoto, 6 BMTU, has become a Certified Oncology Nurse (OCN).

Kelly Krause, 4 PICU, has become a certified Pediatric Nurse (CPN).

Barbara Massura, HVC, has become a certified Progressive Care Nurse (PCCN).

Susan Mazzuca, H/V, has become a certified Medical Surgical Nurse (CMSRN).

Irene Marie Ortega, 2 NE, has become a certified Medical Surgical Nurse (CMSRN).

Adrianne Salvador, OR has become a have certified Perioperative Nurse (CNOR).

Eleanor Wetzel, CV, has become a certified Progressive Care Nurse (PCCN).

Jessica Woloszyk, 2NE, has become a certified Critical Care Clinical Nurse Specialist. (CCNS)

Recertifications:
- Bessie Baldovino, Dialysis, recertified as a Certified Nephrology Nurse (CNN).
- Suzanne Elizalde, OR, recertified as a Perioperative Nurse (CNOR).
- Maria Carmen Galvan, Surgery, recertified as a Perioperative Nurse (CNOR).
- Sandra Graham, Dialysis, recertified as a Certified Nephrology Nurse (CNN).
- Katrina Hejnowski, ED, recertified as a Certified Emergency Nurse (CEN).
- Cheryl Tibbetts, Day Hospital, recertified as an oncology nurse (OCN).
- Geraldine Zingraf, Transplant, recertified as a Clinical Transplant Coordinator (CCTC).
- Joanne Zoeller, PACU, recertified as a Post Anesthesia Nurse (CPAN).

4 ICU nurses: Becky Anderson, Becky Badgero, Jessica Blank, Chante Friend, Judy King, Isabel Orona, Erin Stalley, Madeline Thompson, and Jeramie Ward have all recently completed Trauma Nurse Core Curriculum
Scenario:
A patient is tested and determined to be HIV positive. He requests that you NOT tell his wife. What are the legal and ethical responsibilities of the health care team?

Ethical Discussion:
Legal and ethical debates regarding the disclosure of HIV status to spouses and others may be at risk of infection are contentious. There is continued concern that at-risk individuals may not seek HIV testing due to fear that their test results will be disclosed. While the Centers for Disease Control and Prevention has established guidelines, there is significant variance among state laws.

Illinois laws promote “informed, voluntary, and confidential” HIV testing. (Illinois health departments also offer anonymous testing.) Therefore, generally anyone with access to an individual’s HIV test results must maintain strict confidentiality of those results and the individual’s identity. Primary legal (and, most would argue, ethical) responsibility for notifying partners rests with the infected individual. However, there are a few exceptions in which HIV status either may or must be disclosed by a physician or other health care provider.

Although patient confidentiality is a prima facie ethical obligation of all health care professionals, because due to the nature of HIV transmission, ethical consideration must also be given to at-risk, unsuspecting third parties. By Illinois law, a physician may disclose a patient’s HIV status to a spouse “provided that the physician has first sought unsuccessfully to persuade the patient to notify the spouse or that, a reasonable time after the patient has agreed to make the notification, the physician has reason to believe that the patient has not provided the notification.” (IL 410/ILCS 305/9)

In short, a physician has a legal and ethical obligation to persuade an HIV-infected patient to disclose their HIV status to their spouse. If the patient does not follow through on this, the physician, according to his or her judgment, may disclose this information to the spouse. However, this is not legally required, and there are no civil or criminal penalties either way. Many would argue that in this situation, the right of the spouse to maintain their own health overrides the index patient’s right to confidentiality, and therefore disclosure is the ethical thing to do.

Under Illinois law, non-spousal sexual and needle-sharing partners (“partners”) are treated very differently than spouses. Disclosure to such partners is illegal, and health care providers can be fined for unauthorized disclosure of a patients’ HIV status, whether that disclosure is due to negligence ($2,000 or more) or intentional ($10,000 or more).

However, health care providers do have specific ethical obligations with respect to partners; these are similar as in the case of spouses; the difference is that disclosure is legally prohibited. Any health care provider providing results of an HIV test should explain the test results and methods for preventing HIV transmission, and provide referrals for appropriate medical and psychological follow-up. Anyone testing positive should also be offered assistance in locating and referring sexual and needle-sharing partners for counseling and testing. If a patient refuses such assistance, they should be strongly encouraged to notify previous partners themselves.

In Illinois, HIV+ individuals are not legally required to notify previous sexual and needle-sharing partners of possible past exposure to HIV. However, criminal transmission of HIV is a Class 2 felony. This means that an individual knows that he or she is infected with HIV and 1) engages in intimate contact; 2) transfers, donates, or provides blood, tissue, semen, organs, or other potentially infectious body fluids for transfusion, transplantation, or other administration; or 3) dispenses, delivers, exchanges, sells, or in any other way transfers any non-sterile intravenous or intramuscular drug paraphernalia to another person (720 ILCS 5/12-16.2) Criminal transmission does not require that a person actually become infected with HIV in order to be prosecuted.

An individual’s HIV status must be disclosed by hospitals:
- to any health care provider who will be treating the patient
- to principals of HIV+ children in public schools
- to temporary caretakers of HIV+ children in protective custody
- to law enforcement officials at the request of sexual assault survivors
- to any health care provider, employee of a health care facility, EMT, paramedic, firefighter, or law enforcement officer involved in accidental direct skin or mucous membrane contact with the blood or bodily fluids of an individual that may be involved in the transmission of HIV as determined by physician judgment

Children ages 12 and older are able to consent to HIV testing without parental involvement; physicians may – but are not legally required – to notify the child’s parents of HIV status.

Nurses are legally and ethically required to maintain strict confidentiality. However, in partnership with the treating physician, nurses may be able to play an important role in encouraging HIV+ patients to notify spouses and other partners.

Resources:
People have performed surgery for thousands of years; however, it was only 150 years ago that inhalation anesthesia enabled relatively painless procedures. Even then, patients died at alarming rates from surgery, anesthesia, and postoperative infection. With the subsequent development of the germ theory and antiseptic techniques of the late 1800’s, then blood transfusion, intravenous hydration and antibiotics of the first half of the twentieth century surgery became almost commonplace.

In the early 1960’s, anesthesiologists standardized the assessment risk of patients based on general physical status and cardiac disease. Over the ensuing 30 years investigators have refined cardiac risk indices, developed new algorithms and guidelines and introduced evidence-based intervention to reduce the risk associated with surgery and anesthesia.

The development of the anesthesia clinic for assessment was recommended more than 50 years ago. The purpose of such a venue was to optimize the conditions of persons “not in the best possible state for their operation.” The Pre-Anesthesia Screening (PAS) clinic has been proven to diminish complications associated with anesthesia and surgery, diminish unnecessary consultations, laboratory test and diagnostic studies; reduce hospital costs and duration of hospital stays, reduce the risk of day-of-surgery (DOS) cancellations of cases and improve patient satisfaction.

Here at the Maywood campus the PAS Clinic is under the medical direction of Michael O’Rourke, MD and the management of Jeanne Keane RN, BSN. There are 10 nurses and two patient care technicians caring for approximately 125 patients per week. The providers of the clinic are Advanced Practice Nurses (APN) Eun Kim RN MSN ACNP-BC and Daria Ruffolo RN DNP ACNP-BC along with a monthly rotating anesthesia resident.

The function of the PAS APNs is to assess the patient’s medical status, provide a comprehensive assessment, order and review diagnostic test as needed, and to identify and ameliorate potential risks. The goal is a review of this data and determining the need for subspecialty consultation as necessary so that there is sufficient pertinent information to optimize the surgical and anesthesia experience. All of this data is then factored in with the patient’s functional capacity and the risk stratification of the intended surgery. Using current evidence-based guidelines a final decision is arrived at to determine if the patient has been indeed optimized for their operation.

A significant element of this pre-operative visit is to increase patient confidence in how to prepare for, what to expect and what they will physically encounter during their surgical stay and how that may affect their care after surgery. During this visit there is a discussion about the risks and benefits of different types of anesthesia as well as current evidence-based modalities for pain control such as nerve blocks and regional anesthetics. This visit offers an opportunity for the nurses and APNs to review the patient’s medications and many teachable moments regarding post-operative care, such as pain management, deep vein thrombosis prevention and pulmonary hygiene.

Patients leave the clinic with a comprehensive discharge instruction sheet as well and their provider’s contact data and ideally with a sense that this visit has been deemed helpful in the provision of safer and more personalized care.
My name is Fr. Joel Medina, S.J. and I commenced my mission as a chaplain at the LUHS on August 20. I am serving on 2ICU, HTU/CCU, 5 Tower, and the ED. I have been a Jesuit for ten years and I am a member of the Chicago-Detroit Province; I was ordained last year. I was missioned in my first year as a chaplain part time at the John H. Stroger Hospital and as a priest at St. Procopius parish in the Pilsen area of Chicago.

I attended the Boston College School of Theology and Ministry and graduated last year; I participated in a Clinical Pastoral Education (CPE) practicum in the summer of 2010 at the Northeast Health System in Beverly, MA and I enjoyed this opportunity. I will continue my formal training as a hospital chaplain in our Pastoral Care Department.

I worked as a registered nurse in hospital settings for 25 years prior to entering the Society of Jesus; my last formal position was at the University of Michigan Health System in Vascular Access Services as a PICC nurse. Working as a nurse provided me with many clinical opportunities to be of service to people. Yet, I had a desire for more from life and concurrently I felt called by God to discern a vocation to the Society of Jesus.

I stand in awe at how God has led me in my life and as Jesuit while in formation. In January of 2003 as a Jesuit novice, I made the twentieth annotation of the Spiritual Exercises of St. Ignatius of Loyola. An insight I had was that, just as Jesus constantly prayed to his Father, I also am to continually pray to him and ask him to sustain me at all times.

In 2007 while visiting the Holy Land, I became much more aware of how Jesus spread the Kingdom of God with much energy and visited many places. I also wish to spread and promote the Kingdom and tell people that God loves us and to tell of his great mercy. One of my favorite scripture passages is Luke 24:13-35 when the disciples are on the road to Emmaus. Jesus comes to them on the road and accompanies them. Our Lord meets us where we are and he invites us to tell him what is on our mind. In reflecting on the disciples on the road to Emmaus, I am reminded that at times, we will turn away from following him, and that we are sinners. As a Jesuit priest, I wish to encourage people on their faith journey. I will invite my brothers and sisters to listen to God and rest in him. I do believe that our Lord provides us with the graces to return to him and he encourages us on our faith journey.

The disciples on the road to Emmaus came to recognize Jesus in the breaking of the bread. I wish to accompany my brothers and sisters in their joys and sorrows of life, and wherever they are in their faith life. I wish to promote the Eucharist to my brothers and sisters so that we may be reminded of what our Lord has done for us and also so that we may be nourished by him. At the end of the Emmaus story, the disciples return to their companions to spread the Good News to others that our Lord had risen; we also are all invited to proclaim the Good News in our various vocations.

I look forward to serving the patients, their families, and the staff of the LUHS.

Sincerely, Fr. Joel, SJ

Spiritual Corner

Reflections of a Nurse

Barb Pudelek RN, MSN, ACNP
Manager, 3 MICU

It’s hard to believe that I have been a nurse at Loyola since 1982. So many things have changed. New buildings have been added, the famous Pub and bowling alley are gone and we actually have parking garages. Technology has changed the way we communicate – no more hand written green order sheets, no more midnight audits, no more blue addressograph cards and “LUCI” has been replaced with EPIC.

Most of my nursing career has been in the ICU and I am amazed at the advancement in technology. Remember the old Bear ventilators or how we had to keep a roll of tin foil at the nurses’ station to wrap Nipride drips to protect the bag and tubing from light? Many things have changed over the years but the one constant is the people. Countless people have come and gone from Loyola but there are still many coworkers that I remember from orientation and it’s always fun to share stories of the “old days”.

But more importantly, there is a certain “feeling” to Loyola that has always remained and truly captures what it means to work at Loyola. Loyola feels like family. It may be because many of us actually have sisters or brothers, husbands or wives, even parents and their children working at Loyola. Or maybe the Loyola feeling comes from using the Magis values to guide patient care. My parents receive their health care here and they constantly tell me everyone is always friendly and smiling. The lab tech talks with them instead of simply drawing their blood. The nurses truly care that my parents are comfortable during my mom’s treatment. Their physicians take the time to listen to their concerns. This is what makes Loyola different. I am honored to witness the care we provide every day.

Over the last 30 years, I have worked in many different departments but patient centered care remains a priority and focus in everything we do. Yes, many things have changed and we all have the occasional bad day, but I can’t imagine working anywhere else because Loyola feels like home.
A conference between the staff nurse and the manager should take place to verify that all Level 1 and Level 2 criteria is met. They should agree that the staff nurse has obtained a level 2 performance at which time the manager will complete an EIF to transfer the RN to level 2.

An eligible RN may advance to Level 3 once they have functioned in the role of staff nurse for 24-36 months. This may include work in a staff nurse position outside of LUHS. In addition to required criteria the applicant must demonstrate a minimum of 20 points in weighted criteria from at least 3 areas. Advancement from Level 3 to Level 4 an applicant must demonstrate along with required criteria 40 points from 4 areas with a minimum of 15 points from Level 4 criteria.

Important to note:
- Registered nurses must remain in each level for a minimum of 1 year prior to seeking advancement.
- A NEW application must be submitted when applying for Level 3 and Level 4 or when an application has been returned and more than 1 quarter has passed since return. A New application includes: Completed application form, In-service education for past 12 months, current resume, manager letter, paragraph demonstrating critical thinking, 3 peer review forms OR 360 feedback, clinical log reflecting 8 of 12 previous months activities and weighted criteria documentation.

The clinical ladder was established to provide nurses’ for career advancement while remaining in clinical settings. As ambassadors we want to help our peers meet their goals for advancement and be recognized for the dedicated professionals they are.

Go Green Tip

Nancy Madsen, BSN, RN-BC

Don’t forget Loyola recycles - all non HPI paper, magazines, cardboard, styrofoam, all clean plastic including plastic bags (unless labeled hazardous) are recyclable in the blue or brown recycle bins. Also the cafeteria has recycle bins which can be used for clean plastic (like the covers for your food), cans, water bottles and styrofoam. If you have questions, call Madsen

Hoyne continued from page 4:


Hobbies/Activities: Traveling, Cross country skiing, snow shoeing, hiking, gardening, bowling, bicycling, fishing, gourmet cooking, reading, board games, and dancing at least every 2 weeks with her favorite dance partner her husband Ray.

4ICU will host a Retirement party, November 28. She will be missed and we wish her well.
Certification Corner

Pediatric Certification - Certified Pediatric Nurse

Certification is an objective, measurable way of determining a nurse's competency that verifies the achievement of specialty knowledge beyond basic nursing preparation.

The Certified Pediatric Nurse exam is for the nurse who has extensive experience in pediatric practice and who demonstrates knowledge and abilities related to pediatric nursing beyond basic RN licensure.

An RN who passes this exam is called a Certified Pediatric Nurse and earns the CPN® credential, which they are entitled to use as long as they actively maintain their certification.

The Certified Pediatric Nurse exam is administered by the Pediatric Nursing Certification Board (PNCB) which is governed by a multidisciplinary board made up of pediatric nurses, pediatric nurse practitioners, and pediatricians. Representatives from the Society of Pediatric Nurses, the Association of Faculties of Pediatric Nurse Practitioners, the National Association of Pediatric Nurse Practitioners, and the American Academy of Pediatrics are present on the board.

What are the requirements to take the CPN exam?
- RN
- 1800 hours of pediatric clinical nursing practice as an RN in a pediatric nursing specialty within 24 month period prior to application

How do I obtain an application?
- Go to www.pnbc.org
- Go to the Certify tab, choose Pediatric Nurse and apply online
- The cost of taking the exam is $295, which includes a $100 nonrefundable registration fee

Where do I take the test?
- A computer based testing site through Prometric Testing Center

What should I review for the test?
- The CPN® computer-based exam contains 175 multiple-choice items. Of these, 150 questions are pre-selected as scored questions and 25 are non-scored pre-test questions. Total testing time for the exam is 3 hours.
- Exam questions are related to pediatric nursing content in the following areas: Assessment, Health Promotion, Management, and Professional Role

The PNCB offers the following resources for nurses preparing to take the exam, go to www.pnbc.org:
- CPN Exam Content Outline
- CPN Certification Reference List
- Sample Questions
- Exam Tips
- CPN Exam Prep
- Test-taking Strategies

Loyola offers Free Review classes

Once I am certified, how often do I have to renew?
- Recertification enrollment happens each year from October 1 to December 31. During this open enrollment period, you will visit the PNCB website and complete a brief online application to select a Recertification option that shows how you are maintaining competency in your practice. Recertification is guided by two basic principles:
- Each year, you'll document 15 contact hours of accepted activity.
- During each 7-year Recert tracking cycle, you'll complete the PNCB Pediatric Updates requirements for your certification type.

The cost of each yearly recertification is $50

How does Loyola support certification?
- Loyola reimburses cost up to $300 for obtaining certification or re-certification; go to the Loyola nursing website for more information on the Education Stipend
- Salary increases linked to clinical ladder: certification is weighted 3 points for level 3 and is required for level 4.

How can you get started?
- Find more information at www.pnbc.org
- Contact a Certification Liaison: Josey Pudwill, jcavazo@lumc.edu

Other available pediatric-specific certifications:
- CCRN-Critical Care Registered Nurse, Pediatric (www.aacn.org)
- CPHON-Certified Pediatric Hematology Oncology Nurse (www.oncc.org)
- CPEN-Certified Pediatric Emergency Nurse (www.pnbc.org)

What are you waiting for? You know it, Now show it!
Blood components are safer than they have been at any point in history. Donors are carefully screened for illness and travel that could potentially transmit illness to the recipient. The blood itself undergoes more than a dozen different tests to screen for transmissible viruses.

So why are we still talking about transfusion safety? Because transfusion is a process that goes from "Vein-to-Vein". Safety on the donor side isn’t enough! Safety on the recipient side is at least as important when we talk about "Transfusion Safety". And on the recipient side transfusion safety starts well before you have a blood component in hand ready to transfuse. Safety starts with patient identification when the blood bank sample is collected ~ remember those 5 Rights ~ we start with the right patient! If the patient is not properly identified at the time the sample is collected all of the other checks & balances are subject to error. Acute Hemolytic Transfusion reaction from ABO incompatibility accounts for 10% of transfusion associated fatalities reported to the FDA annually (although the number is low ~ there were 3 in FY11) In the past 5 years, 22 patients died from Acute Hemolytic Transfusion reaction due to ABO incompatibility. Patient identification errors account for most of those fatalities.

In October I was privileged to present a half-day workshop at the annual AABB meeting with two other TSOs and a Transfusion Medicine physician. Working with these other Transfusion Safety professionals was personally rewarding but more than that it gave me access to lots of new resources to share with you through NurseLink! In the next few issues I’ll be sharing some of the educational resources available from the Puget Sound Blood Center, Dartmouth-Hitchcock Medical Center and the Ontario Regional Blood Coordinating Network.

Other Transfusion Safety News

- The blood bank has been working diligently on inventory management in order to provide you with Pre-Storage Leukocyte Reduced blood components to meet your patient’s needs. Before you pull out a LR filter check the label on your blood product ~ it might be just what you need!

- Transfusion Safety Officers across the country are getting more organized ~ there is now a TSO Subsection of the Transfusion Medicine Section of the AABB. This will give us access to lots more “good ideas” for transfusion safety.

- The AABB has published a draft “Best Practices for a Patient Blood Management Program.” Blood Management & Transfusion Safety are moving forward!

Loyola’s Online RN to BSN degree completion program—One Year Later

By: Monique Ridosh, MSN, RN Director, RN to BSN Program

One year later Loyola’s fully online degree completion RN to BSN program has tripled enrollment! Over 100 RNs from across the country and locally are enjoying the flexibility of obtaining their BSN degree online. Using Blackboard education platform enhanced by our new instructional designer, Stacey Zurek and three new full time faculty with experience in online learning best practices and advanced practice nursing, RN students are being groomed for leadership positions in nursing’s future.

RN to BSN graduates are already demonstrating their new leadership skills. Laurie Berg, RN BSN summer ’12 is in Loyola’s MSN program on her way to becoming an emergency nurse practitioner. Mary Smith, RN BSN summer ’12 now oversees staff in an OB/Gyn Outpatient Center while she serves as a charge nurse in an inpatient birthing unit. The RN students’ course, Spirituality in Nursing, provides an opportunity for students to better understand that the world’s people and societies are interrelated and interdependent. This global awareness can be experienced through a faculty guided service learning trip to Lourdes, France every spring. Other Loyola nursing international experiences available to students include Rome, Belize or Vietnam.

Loyola values the experience students bring to the classroom. Our philosophy is to build on what you already know and strengthen leadership skills. We honor prior learning by awarding up to 25 semester hours of credit for your professional nursing portfolio. Applicants must have a current RN license and may be admitted year round.

For the most up-to-date application information, visit LUC.edu/nursing/rnbsn.
**Magnet Council Updates**

### Magnet Ambassador Council

**MAC contacts:**
- Erin Fruth RN-BC
- Linda Flemm, MSN, APN, AOCNS
- Theresa Pavone, DNP, RN
- Nora Primiano, RN

The committee has collaborated to:
- Update Magnet Ambassador roles and responsibilities
- Revise membership handouts for new members
- Educate the revised Magnet Components
- Develop plan for annual Hope for the Holidays. Any ideas can be shared with Jennifer Johnson RN at jennjohn@lumc.edu. She is leading this annual fundraising event.

### APN Council

**APN council contacts:**
- Pat Hummel, RNC, MA, NNP, PNP

- The APN committee continues to work on credentialing and recredentialing. Competency assessment by TJC requirements continues to be refined.

### Education and Professional Development

**EPC contacts:**
- Barb Hering RNC, MSN APN/CNSD
- Diane Stace RN, MSN, APN, CCRN, CCNS

- The education council has been working on creating a Toolkit for our certification campaign.
  
  "You Know It, Now Show It……Get Certified!!!!
  
- Take a look within the nursing website under Certification to get an updated version of “A How-to-Guide for Certification”. Also, take some time to review the certification information sheets for your area.

### New Certification

In an effort to promote certification, the Nursing Education and Professional Development Council has provided the following information.

The link below requires Microsoft PowerPoint to open and view.

[New A How-to-Guide for Certification](#)

Certification Information Sheets:
- CCRN 382 KB
- CNOR 356 KB
- CPN 331 KB
- PCRN 355 KB
- PNP 538 KB

To access the Magnet list of approved certifications please click on ANCC website and click on the link titled "Selected Examples of National Certification for Submission on DB"

### Nursing Professional Practice Council

**NPPC contacts:**
- Erin Podgorny BSN,RN,CCRN-CMC
- Renee Niznik BSN, RN

- Continue to coordinate monthly grand rounds and offer continuing educational credits
- Discussed presenting a repeated grand round on the Saturday of Nurses’ week 2013
- Developed Bowel Program, pilot to begin on 2 ICU and Neuro units
- Developed a policy pertaining to Pediatric Pain Management during Procedures. Looking for a primary investigator to assist this lead
- Encouraging council membership and recruitment for co-chairs
Magnet Council Updates

Nursing Quality and Safety Council

- A fall-related Root Cause Analysis was presented by Risk Management. Inconsistency with bed alarm wall connection ports and alarm messages were identified. Education has now been done, house-wide.
- Falls Gap Analysis/Survey, a Trinity Directive was discussed in detail. Trinity's 2013 Goal: Reduce falls by 50%. EPIC is working on incorporating flags to alert pharmacists of patients at mode rate-high risk for falls. Collaboration with Rehab, PT and OT on using chair alarms is underway. The "Bee Safe" tool from John Hopkins is in process of update in 2012.
- Current practices with donning sterile gloves, gown and mask during procedures was discussed. Trinity PER Council is looking to adopt a standard practice in all Ministry Organizations.
- Baxter infusion pumps and the Medication Bar Coding Pilot were discussed.
- Restraint updates and skin ulcer prevention will be a strong focus in 2013.
- Five Loyola Representatives were sent to Duke University to obtain certification in Culture of Safety, a 3-day workshop. Inpatient and Outpatient Culture of Safety surveys will be addressed by work groups that will be formed as a result of this workshop in the coming months.

Nursing Research Council

- Are you interested in Nursing Research but don't know where to start? The Nursing Research Council is accepting applications for the 3rd Nursing Research Fellowship. The fellowship program has been redesigned to assist the novice nurse in conducting a research project from formulating the research question to collecting and analyzing data. The fellowship program provides 96 hours of paid time to attend class and work on your research project with the guidance of experienced nurse researchers. Past participants have presented their research through posters and podium presentations at both local and national conferences. This is a great opportunity to answer those curious questions about nursing and patient care. To apply for the Nursing Research Fellowship go to Nursing Department website http://www.luhs.org/internal/depts/nursing_int/index.htm to download more information and an application. The deadline to submit an application is: November 16th.

Nursing Research e-Journal Club

- The current e-journal club article explores the use of call lights by patients and families. Participating in the e-journal club is a great way to learn about current nursing research and receive contact hours.
- The Nursing Research and Evidence Based Practice Council is excited to provide you with an opportunity to work with a council member to select and critique a research article for an upcoming Nursing Research e-Journal Club. This activity provides Level 4 credit and is weighted as 5 points. Please contact Pam Clementi or Barb Pudelek if you are interested in this opportunity.

Nursing Research Conference

- The Nursing Research Conference has been postponed until early 2013. Watch for an announcement of the new date.
The Art of Nursing: Loyola Nurse

T is for teacher and team. Loyola nurses are noted for our patients care planning and education.

H is for hallmark quality care and concern we show to our patients.

E is for embrace. We are active in embracing our outside community in volunteering and donating time, money to those less fortunate.

L is for loyalty. We are devoted to our career, patient care and their families.

O is for the opportunity to become the best thru continuous education and quality improvement.

Y is for yodel. We sing the praises of our community we have to Loyola and its family.

O is for our obligation to be morally, socially, and legally conscious of out duties.

L is for leadership. We have leaders in all aspects-from Paula Hindle, CNE, down to our staff nurses.

A is for autonomy. We are expected to practice autonomously in our licensed in our field. Loyola nurses have access to many resources on the internet to facilitate professional growth.

N is for the Loyola nurse-nurturing, universal, respectful, safety conscious, empowered, has style.

U is for unit. We work together with staff as a team.

R is for respect, responsibility. We take great pride in our values and practice commitment.

S is for style and structure. We pride ourselves in our organizational structure and management style.

E is for enrichment. By our values of respect, concern, cooperation and care we not only enrich our lives but our co-workers and patients’ life as well.

Calling all bakers!!!

Earlier this week, Trinity announced that it will continue to support the LUHS Holiday Assistance Program. This terrific news allows us to lend support to our fellow employees by contributing to the holiday assistance fund.

The Magnet Ambassador Council will host a bake sale November 19, 20, and 21 between 11:00 am and 2:00 pm. There are three ways to help!

Bake, bake, bake!!! We need all sorts of baked goods to sell- cookies, cakes, breads, candies, or any delicious treats you may create.

Volunteer one hour (11-12, 12-1, 1-2) on any of the sale days. We would like to one to two volunteers at each location (LOC and LHV).

Spread the word! Please let your coworkers know about the upcoming sale. Please contact Jennifer Johnson (jennjohn@lumc.edu or ext 72883) or Erica Dixon (edixon@lumc.edu or ext 72082) to volunteer. Thank you for your efforts! We hope to make this a great success!

NURSE LINK
Educational Offerings

**Nursing Department:**
- Preceptor Workshop
  - Saturday, December 1
  - (1/2 day program)
- Organ Transplant
  - Saturday, December 8
  - (full-day program)

**Management Staff:**
- Coaching for Development and Improvement
  - 11/07/2012
  - 9:00 AM - 11:00 AM
  - CEU Credits: 2

**Organization Development:**
- **General Staff:**
  - Employee Information Exchange
    - 11/15/2012 10:30 AM - 11:30 AM
    - 12/20/2012 10:30 AM - 11:30 AM
    - 01/17/2013 10:30 AM - 11:30 AM
    - 02/21/2013 10:30 AM - 11:30 AM
    - 03/21/2013 10:30 AM - 11:30 AM
    - 04/19/2013 10:30 AM - 11:30 AM
    - 05/18/2013 10:30 AM - 11:30 AM
    - 06/20/2013 10:30 AM - 11:30 AM

- **Management Staff:**
  - Hire to Fit
    - 11/21/2012 9:00 AM - 12:00 PM

**Management Staff:**
- Coaching for Development and Improvement
  - 11/07/2012
  - 9:00 AM - 11:00 AM
  - CEU Credits: 2

**NurseLink Staff**

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  - Linda Flemm