

### **What's with the new call lights?**

Boston Medical Center is upgrading the patient nurse call system on the inpatient units over the next year. The new nurse call system, the Rauland Responder IV, will be installed in several phases.

Phase 1 will replace the old nurse call system with the new basic nurse call system.

Phase 2 will focus on several upgrades including the ability to centrally alarm clinical equipment and will connect the nurse call system to the hospital admitting system.

Phase 3 will bring wireless technology to the hands of the RNs and the CNAs.

Several units have already completed Phase 1 and include 6 east and 6 west, 4 east and 4 west and 5 west telemetry on the Menino campus. In October, we will be working on the units on the 7<sup>th</sup> floor and then will finish the ED, the 3<sup>rd</sup> floor and the ICUs before moving to the East Newton Campus.

The nurse new call system will help to reduce the noise level on the unit and increase patient satisfaction, as it will help to improve caregiver response time through better efficiency. Once the entire system is in place, the unit coordinator will be able to answer the patient's call by name as the Admitting system will download patients name into the nurse call system and it will display on the console. The unit coordinator will then dispatch the call to the nurse's cell phone instructing her on exactly what the patient needs. At night, the system will automatically ring directly to the caregiver assigned to the patient. Other calls to the unit (lab results, physicians returning pages, family members) can also be immediately connected to the nurse's cell phone as well.

Other improved features include enhanced dome lights, duty stations and staff stations in lounge space so staff can hear unit activity in non-patient rooms and the system will also allow us to review response times and call activity for staffing purposes.

If you have any specific questions about the new nurse call system, ask the unit staff for a demonstration!

L Guy

## ***INPATIENT NURSES!!!***

### **GET YOUR FLU SHOT**

**FRIDAY, 10/29**

**6am-Noon**

**1-8pm**

**85 E. Concord, 4<sup>th</sup> floor**

**PROTECT YOURSELF.  
PROTECT YOUR PATIENTS.  
GET YOUR FLU SHOT!!!**

## **THE INPATIENT TIMES**

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[www.internal.bmc.org/medicine/it/it.html](http://www.internal.bmc.org/medicine/it/it.html)*

# **The Inpatient Times**

*All the news that makes you more fit to treat*

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### ***Mission Possible – the guide to efficient work rounds***

**Summary of the workshop for Junior Residents, July, 2004**

During a workshop in July, the junior residents were presented with the challenge of brainstorming ways to improve the efficiency and effectiveness of work rounds, aiming to complete work rounds within 2 hours (barring major disasters). Below you will find a summary of the group discussion.

“A day in the life of a ward resident”: Work rounds are a crucial part of a house officer's day, serving several important purposes. 1. Sets the tone for the day; 2. Offers learning and teaching opportunities for all of the team members; 3. Provides a plan of action for each patient; 4. Team Building.

Junior residents identified the following barriers to efficient work rounds in a brainstorming session: 1. Sick patients; 2. new patients; 3. interruptions from nurses; 4. long discussions with patients and families; 5. complex issues to address; 6. discharges; 7. “herding cats”- keeping the interns together; 8. attendings rounding with the team; printers don't work; 9. trying to teach, too!

The group then divided into Working Groups, to tackle these issues. These are their recommendations:

1. Plan your rounds before you even begin: budget your time and aim for completing rounds by 10:30 AM.
2. Identify discharged patients the night before.
3. Write a focused and SHORTER discharge summary.
4. Interns Pre-Round: Check vitals, review and record finger sticks, medications received (total amount of Valium, insulin, etc.), see and examine patients briefly, *especially* night float patients.
5. Residents should go to morning sign-out rounds, *especially* when getting new patients.
6. Use non-work rounds time to deal with complex issues, long discussions, etc. (Going back to see the patient after rounds for the detailed exam or discussion, etc).
7. Rapid teaching techniques (think out loud, quick pearls, etc).
8. Set clear expectations of the members of the team surrounding presentations, pre-rounding, etc., at the beginning of the block.
9. Round as a team: Split rounds will be rarely necessary, if work rounds are efficient.
10. Consider assigning an intern to “scribe” orders, etc, while the other presents.
11. Use the oral presentation format developed by the Department of Medicine found on the Medicine Home Page of the BMC Intranet.

#### **Summary:**

1. Plan your work rounds before you begin and set a time for rounds to end.
2. Tell your interns and students EXPLICITLY what you need from them for efficient rounds (pre-rounding, type of presentation, etc).
3. You do not need to do EVERYTHING during work rounds.

A Jackson

### Nursing cares about pressure ulcers

Pressure ulcers occur from ischemia to tissue from localized pressure. This is a simple definition to a complicated problem as the amount of pressure that can be tolerated is affected by nutrition, age, comorbidities, and moisture to list a few. The prevention as well as the treatment requires a team approach that includes Physicians to CNA's. Pressure ulcers cause pain, increase hospital stays and delay rehabilitation.

The division of nursing at BMC cares about pressure ulcer prevention and improving skin care at BMC. We are approaching the problem from several angles:

-There is a skin care committee co-chaired by Linda Alexander MSN, CWOCN and Murray Corliss BSN, CWOCN. The members include a representative from each unit, nursing director, nursing manager, a PT and a Nutritionist. We meet monthly to discuss problems/solutions of skin care and, conduct pressure ulcer prevalence surveys.

-There is an initiative on the units to complete a daily Braden score. The Braden scale is a validated tool to assess the potential for skin breakdown.

-BMC is in the process of upgrading the inpatient beds with features to reduce or relieve pressure; the ENC should be complete this year and the MP will start in 2005. We also rent therapeutic beds or overlays. Each unit has a therapeutic bed book as well as guidelines in the bedside books.

-Prevalence surveys have been done yearly at BMC for many years. The nursing department is currently applying for ANCC Magnet status and data on pressure ulcers is required quarterly. The overall prevalence and the facility-acquired prevalence are both recorded. We define facility acquired as either insufficient data on admission or the ulcer did occur at BMC. This encourages staff to carefully assess skin and the potential for breakdown on admission and to initiate a plan of care.

In March 2004, BMC participated in an international pressure ulcer survey sponsored by Hill-Rom, a therapeutic bed company. We examined 378 patients that day for pressure ulcers. A total of 44 patients had pressure ulcers,

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22 of these were facility-acquired. Our overall prevalence was 11.6%, compared to 15.5% nationally and our facility-acquired prevalence was 5.8% compared to 7.7% nationally. Stage II ulcers are the most common and the location of sacrum/buttocks is the most frequent location.

**How can the medical team help?** Please be aware that although pressure ulcer prevalence is a nursing indicator of care there are many facets affecting the tissue tolerance.

**Nutrition** is frequently consulted on medical patients; please be aware of their recommendations. An already compromised patient is further at risk if their caloric intake is poor, or they are NPO for any length of time. Blood sugars should be controlled to optimize tissue health.

Talk to the nursing staff to work together to optimize prevention. **Familiarize yourself with the beds** and when a therapeutic rental surface is required, place the order. In general a patient with increased **moisture** (from incontinence, diaphoresis, etc) is 5x more likely to suffer skin break down and a patient with dehydration is 2.5x more likely.

RNs need **current orders** to provide wound care; multiple orders are confusing so please discontinue the old orders when the treatment changes.

**Assess the wounds on a regular basis** and remember a pressure ulcer is like real estate. Location is important, look at the entire neighborhood first (the patient and their risk factors) then the house (the periwound) then the rooms (the wound once cleansed-not before it is cleansed)

If you have any questions, feel free to call one of us! Linda Alexander (bp: 5341) or Murray Corliss (bp: 8947).

*L.Alexander  
M Corliss*

**Got an idea for an article for  
The Inpatient Times?  
Want to write a piece for next  
month's paper?  
Contact  
Jeff Greenwald**

### *I've got rhythm...*

#### Atrial fibrillation in the elderly

As our country's population ages and life expectancy continues to rise, we are facing what some editors have quipped, "the epidemic of the new millennium" - otherwise known as atrial fibrillation. It is estimated that by the year 2020, 3.3 million Americans will have atrial fibrillation. Of this group, 1/3 of our patients with atrial fibrillation will be older than 80-years of age. Are we treating the elderly properly? Have we been well educated regarding best care for these individuals?

Atrial fibrillation is a known significant risk factor for ischemic stroke, accounting for 15% of all strokes in the U.S. and 30% in patients over the age of 80. Therefore, present recommendations by the ACCP (American College of Chest Physicians) state that all patients older than 75 should receive warfarin anticoagulation (INR between 2-3). Despite these recommendations, physicians must rely on their clinical judgment as to whether this patient is a "good candidate" for anticoagulation. Recent estimates reveal that of eligible elderly patients only 1/3 of them receive anticoagulation. Are we doing the right thing?

A 2001 pooled analysis of the initial five randomized trials regarding atrial fibrillation revealed that patients older than 65 have a 3.5-8.1% risk of stroke if untreated. This was reduced to 1-1.5% with anticoagulation. In contrast, the rate of major hemorrhage within the anticoagulated patient was estimated to be only 0.2% higher than those untreated. Therefore, why are there not more elderly patients being anticoagulated to reduce their risk from stroke with atrial fibrillation.

Most practitioners fear that older patients have: too many comorbid diseases which risk medication interactions; cognitive impairment (including dementia) which could make handling an anticoagulation regimen difficult; and finally, the age old trumpeted risk of mechanical falls. Regarding these fears - anticoagulation clinics and other ancillary services are facilitating effective management

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of anticoagulation and further, recent studies reveal that practitioners, as a whole, significantly overestimate risk of falls.

As our older population grows, we will soon need to continue wrestling with difficult decisions and playing the odds in hopes of benefiting our patients. While the fear of a devastating intracranial hemorrhage paralyzes many physicians, one must counter with the remembering the impact of stroke. I've provided just a sampling of recent data which can be used to inform your decisions - are you choosing correctly for your older patient?

*J Wallace*

### **How would you like to get *less* exercise? BMC is looking into team-patient collocation for Medicine**

There have been many gripes about the new Care Management system and the need to touch base with different Care Managers on each floor on which your team has patients. This system is not very efficient for the house officers and does not promote good communications as desired.

To attempt to reduce the pandemonium, Boston Medical Center is looking into the possibility of collocating patients by team. For example, (solely for illustrative purposes...nothing is even remotely set...) perhaps the B firm patients might all end up at Menino 6-west with a few spilling over to 7-east and A firm patients might collocate on 6-east with spill over going also to 7-east, etc.

The advantage of the new Care Manager system would be obvious here and doctors, nurses, Care Managers, and Social Workers really would have closer communications facilitated by the new system.

Before you shout "YIPPEE," hold your horses. You can only imagine the complexity of such a system will take a long time to establish. This is not going to happen tomorrow and will take the input of a lot of folks on whom this will have a major impact. It will not happen tomorrow.

But, you should know that Boston Medical Center is concerned about the extra steps required under the new system to maintain communications on the Medicine service and is taking actions to improve the situation.

*J Greenwald*

### **Care pathways available at Boston Medical Center**

Many of you are aware that Boston Medical Center has developed nationally renowned care pathways for numerous cardiology diagnoses. You may not be aware that many of these have been revamped recently.

In addition, a brand new updated and reformatted Adult Community Acquired Pneumonia pathway is being released this week and by next week will be on every Medicine floor at Boston Medical Center. It includes an online (SCM) order set as well as a printed fold-out page of guidelines to help you with management at each stage of the hospitalization (Emergency Department, ICU, Medical ward, and Discharge), a patient pathway which educates the patient about what is happening and what to anticipate will his/her illness, and a nursing education form.

Like all pathways, you may initiate the Community Acquired Pneumonia pathway in any phase – not just in the ED. To initiate the pathway, the orderset can be found in SCM by simply clicking on the initial “Admit/Transfer/Discharge” tab in the orders section and it lives in that list.

In addition to the CAP pathway, as mentioned, Boston Medical Center has numerous cardiology pathways including:

1. Acute Coronary Syndrome
2. ST Elevation MI
3. Chest Pain
4. Heart Failure

To access these pathways, go to SCM’s order text box. On the top left orders table, click “Cardiology” and then click “Admit” and you can scroll down to the orderset you want.

An additional pathway you should be aware of is the Comfort Measures Only pathway which is very useful for caring for patients who are “CMO.” This pathway may be ordered in SCM by typing CMO on the order line.

Other pathways in development include Asthma and Insulin management. Please contact Jeff Greenwald with questions about CAP, Deborah Whalen with questions about cardiology pathways, and Jennifer Hughes with CMO pathway questions.

*J Greenwald*

### **Case Management becomes Care Management**

BMC has begun the transition into a new model of Case Management...now called Care Management. This change comes as part of a hospital redesign effort to improve through- put in a system that has maximized its geographic bed capacity. This initiative also recognizes the increasing needs of our patients and has significantly increased the inpatient Social Work supports.

The new model offers a unit based approach to care that includes a team of one Nurse Care Manager and one Clinical Social Worker to each patient care unit. This team will be responsible for the safe, timely and efficient disposition of our patients.

The new model also expands team coverage to all inpatient areas of the hospital including the Emergency Departments, Pediatrics, and Maternity and Obstetrical Services.

The Care Management Department is overseen by Maureen Colton and Lisa O’Connor, with day-to-day supervision of staff by Monica Ferraro and a Social Work Supervisor who has not yet been hired. The Department reports into Kathy Davidson, the Vice-President for Nursing.

The Care Management Department will be instrumental in BMC achieving the goals it has set forth for the coming and future years. Such goals include but are not limited to improving Clinical Pathway compliance, development of new Clinical Pathways, reducing lost days, decreasing the length of stay, increasing discharges, moving average discharge time up and decreasing the number of patients discharged from BMC with LOS > 30 days. One of the most important goals in the new design is to improve communication at the unit level and ensure that the team is always aware of the overall plan of care and that the approach is coordinated.

The Department will roll out its changes gradually over the next 90 days. If questions arise, please contact Lisa O’Connor or Maureen Colton.

*L O’Connor*

### **What is the American College of Physicians?**

The American College of Physicians, (ACP), founded in 1915, is the largest medical organization in the US. Membership is comprised of more than 115,000 Internal Medicine physicians, fellows, residents and medical students. The ACP serves as a forum to enable internists to enhance the quality and effectiveness of health care by fostering excellence and professionalism in medicine. The agenda of the ACP encompasses a wide spectrum of issues. It includes advocacy at both the grassroots and legislative levels and for both practitioner and patient. The ACP provides a powerful voice regarding patient safety, electronic medicine prescribing, graduate medical education and a multitude of key public health issues including bioterrorism, liability, managed care, minority health, HIPAA, etc.

It is well known that members of the ACP receive the Annals of Internal Medicine, the MKSAPs at a discounted rate and multiple CME opportunities. The ACP also offers clinical decision support via the Physicians' Information and Education Resource (PIER) which is an evidence-based medical resource available on-line and downloadable to PDA. It is an expanding set of modules covering medical, legal and ethical issues, procedures and drug resources. The website topics within the categories of diseases, screening and prevention, complimentary/alternative ([www.acponline.org](http://www.acponline.org)) also provides guidelines/algorithms for cardiology, general internal medicine, endocrine and metabolism, infectious disease and pulmonary, in addition to immunizations, bioterrorism, screening practices, diagnosis, treatment, and medical technology. Practicing internists can also obtain information on practice management, medical informatics, liability/group insurance, and license renewal requirements.

The ACP provides many opportunities for medical students/residents and fellows to be a part of a vibrant medical community while helping to plan for the future. *Continued →*

ACP provides a career resource center as well as classifieds for practitioners of all levels. There are many ways to become directly involved in the ACP as a resident at BMC. The most immediate way is to submit a clinical vignette or research abstract to both the state and national meetings. The national meeting is in San Francisco, CA on April 14-16, 2005 and the state meeting will be in Waltham, MA on November 13, 2004. Deadline for submission for the state meeting has passed but the national meeting submission date is October 1, 2004. Cash prizes are awarded to oral presenters as well as poster winners. Those invited by the ACP to present their work in San Francisco will receive travel and meeting expenses support from our residency program.

I encourage all ACP associate members to attend the Massachusetts chapter meeting in November. This event includes poster presentations, oral presentations and medical jeopardy. The meeting will include everyone from medical students to private practice clinicians and is an amazing forum to learn more about clinical updates, view scientific/research presentations, find out more about ACP programs and initiate networking opportunities.

In addition, panels will be held on reimbursement reform and electronic health record in office-based practice. The Mass chapter representatives are also currently working on various programs including fellowship meetings, and a day of lobbying on Beacon Hill where we can address issues surrounding access to healthcare, residency issues and support for primary care specialties among other things. I encourage all BMC house staff to give an associate membership to the ACP consideration, as it is a vast resource of clinical information as well as both our voice within the medical and public communities.

*A Rosenzweig*

**Mass ACP Meeting  
November 13, 2004 – Waltham, Mass**

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**National ACP Meeting  
April 14-16, 2005 – San Francisco, CA**

## Direct admissions to Medicine:

### Friend or foe?

You are in your clinic and are your typical 30 minutes behind schedule. Your patient, a 62 year old diabetic finally shows up for a long overdue appointment with a shallow ulcer on his left ankle with some green goo dripping from it and a small area of surrounding cellulitis. You decide to admit the patient and wonder what a few hours in the Emergency Department will add to this patient's care. Little, you decide, and so you direct admit the patient to your firm. How do you do this? Simple!

1. During the day while clinics are open, begin by requesting that your stable patient go to the lab and have initial blood work (cultures also if needed) be done. Also, if possible, have someone place an iv.
2. While your patient is in the lab, call admitting and request a bed. (Note, patients requiring telemetry -- e.g. for chest pain -- may not be directly admitted as they are considered too unstable not to be on telemetry while awaiting a bed and thus require a trip to the Emergency Department.)
3. The Admitting Department is committed to facilitating direct admits and prioritizes them *over* patients in the Emergency Department. This was done to encourage appropriate direct admit patients from clogging up the ED. Admitting will notify you in (hopefully) short order of who the admitting team/attending will be.
4. If you do not have a bed after an hour or so, the Admitting office should notify you with an bed status update. If you choose not to wait longer or your clinic is closing, you should send your patient to the ED.
5. Once a team and attending is assigned, you must contact the inpatient attending and see if he/she will accept your patient for direct admission to the team.
6. Once accepted by the attending, you should contact admitting to notify them that the patient has been accepted and then you can arrange transport to the appropriate bed.

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It is then the responsibility of the inpatient team attending to tell his/her house officers about the incoming patient.

Remember as the inpatient house officer, if a directly admitted patient arrives to the floor without labs, xrays, ivs, etc, it is because one of your colleagues felt they were not urgent or were unable to obtain them for whatever reason in the clinic setting. Get them done on the floor when the patient arrives. There is rarely an emergency about the situation. If you feel there is an emergency about the situation discuss it with your attending.

Finally, please also remember, it is the responsibility of the inpatient team to contact the PCP who referred the patient in within 24 hours of admission. Talk with them about your plans for the patient and solicit their ideas about their goals for this admission as well.

Yes, direct admissions may not be as "buffed" when they arrive on the floor as our patients from the ED. This is a reality however. Please work with these patients as compassionately and patiently as you do those who arrive from the ED.

*J Greenwald*

**DOES YOUR PATIENT HAVE  
A PCP AT  
BOSTON MEDICAL CENTER  
BUT CAN'T GET A POST-  
DISCHARGE FOLLOW-UP  
APPOINTMENT FOR MONTHS?**

**IF YOUR PATIENT HAS A  
DISCREET PROBLEM FROM THE  
INPATIENT STAY REQUIRING  
QUICK FOLLOW-UP,  
SEND HIM/HER TO THE  
*POST DISCHARGE CLINIC***

**THE PATIENT CAN BE SEEN  
TYPICALLY WITHIN 7 DAYS.  
CALL 638-7970 TO REQUEST A  
POST DISCHARGE CLINIC  
APPOINTMENT.**

### The flu shot debacle

On October 5, 2004, the CDC was notified by Chiron that their manufacturing process had revealed contaminants in the factory where Fluvirin® influenza injection was being processed. In August, problems were discovered with sterility in the processing plant. Originally they thought only 4 million doses were effected. Now, it seems that all 48 million doses will not be shipped. The Department of Public Health and Human Services anticipates that the United States will only be receiving approximately half of our expected influenza doses for the 2004-2005 season. The remaining supply of 54 million is from Aventis, under the trade name Fluzone®. In addition, 1.1 - 1.5 million doses of the inhaled live attenuated vaccine called FluMist® is available from MedImmune.

Therefore, BMC has echoed the CDC's recommendations issued on October 7, 2004, to vaccinate the High Priority individuals as highlighted below:

- Children 6-23 months
- Adults 65 and older
- People 2- 65 years of age with chronic medical conditions such as diabetes, renal dysfunction, hemoglobinopathies, immunosuppression (including immunosuppression from drugs or HIV)
- Healthcare workers with direct patient care
- All women who will be pregnant during the influenza season
- Residents of nursing homes and long term care facilities
- Out-of-home caregivers and contacts of children < 6 months
- Children 6mos-18 years on chronic aspirin therapy

With the shortages pressing hard, individuals may want to consider if they qualify for the inhaled live attenuated influenza vaccine FluMist®. Candidates for this vaccine

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are health individuals 5-49 years of age who are not pregnant, working with severely immunocompromised patients (i.e. Bone Marrow Transplant) or children < 6 months old.<sup>1</sup>

Healthcare workers should continue to take care of themselves during these upcoming winter months including frequent hand washing and masking if contagious.

In closing, the Inpatient Influenza Vaccine Initiative is still ongoing. We have planned to vaccinate 700 of our high-risk patients, as defined by the CDC, for the 2004-2005 season. This is still achievable since we average 75 discharges each day. That means in this entire hospital we only need to find 6 patients each day that meet the CDC's guidelines. I am sure they are still within our doors.

*C Williams*

1. CDC Press Office. (2004) Press Release. Interim Influenza Vaccination Recommendations: 2004-05

**Flu Shots for  
HOUSE OFFICERS  
will be available**

**Wednesday 10/27  
3-8pm  
Menino 5 Conference Room**

**Friday 10/29  
6am-Noon  
1-8pm  
85 E. Concord, 4<sup>th</sup> Floor**

**PLEASE PROTECT  
YOURSELF AND YOUR  
PATIENTS.  
GET A FLU SHOT!!!**

## **Tying down the elderly vs. restraint-free care**

It is one o'clock in the morning and you are admitting your 10<sup>th</sup> admission. Another patient is crashing and the nursing staff is calling you to request an evaluation on a little old lady who is now wandering around the floor. You wish you could order the nursing staff to tie the patient to her bed and move on with other problems. Well, you'd better think twice before you do it. Restraints are not good solutions. In fact, **"a physical restraint, which is meant to protect, has no known therapeutic value and can actually be hazardous for the patient."**

*Definition of Restraints:* Restraints are defined as any device that inhibits purposeful, self-initiated movement. It is to be used only when less restrictive interventions have been determined to be ineffective.

*Disadvantages of restraints:* **There are 100 deaths from strangulation due to restraints reported to the FDA annually.** Restraints do not prevent patients from falling because they decrease balance and mobility. There also have been a number of studies proving that restraints are associated with an **increased rate of mortality and serious fall-related injuries** such as a higher incidence of fracture, strangulation and asphyxia. Restraints limit patient independence and decrease ADL performance, which leads to poor physical and psychological functioning, i.e. deconditioning, muscle wasting, increased aspiration, urinary incontinence, pressure ulcers, depression, agitation, fear, withdrawal and demoralization.

*Criteria for restraining patients:*

1. Patient does not respond to alternative interventions
2. Exhibits confusion and/or disorientation of severity so as to compromise safety
3. Danger to self/others

You can order restraints in two main situations according to the BMC procedure protocol:

- 1 To promote acute medical/surgical care
- 2 To provide behavioral management e.g., acute psychiatric disorder
- 3 Routine or PRN use of restraints is prohibited.

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*Types of restraints:* Restraints come in different flavors at BMC, eg. soft limb restraint, hand mitts restraint, vest restraint, 4-side rails restraint, vail bed with side rails, etc.

*What usually happens when you order a restraint for the patient?* Every 15 minutes, staff must enter the patient's room and observe the patient and environment to ascertain that the patient is free from immediate risk of harm. Observation includes skin check, body alignment, safe environment/equipment location and general location of the patient. The RN also has to provide written documentation every 2 hours. This is not an easy job considering the number of patients and routine paper work for each shift.

*Restraint Free Care* suggests that "each person be cared for as a separate and unique individual; that people's rights be respected; that care be directed toward the **maintenance of dignity, autonomy, self-esteem and physical well-being**; and that all persons be assured the highest quality of life." There are several methods that can help to avoid restraint orders. Try these methods *before* you order restraints.

- Camouflage tubes and IVs and discontinue when possible
- Convert IV to Heplock and place IV pole out of patient's view
- Provide distractive activities and ambulation
- Have family/staff observe
- Continue with normal sleep pattern
- Avoid unnecessary medications
- Keep environment safe and clear of clutter
- Reduce stimulation. Use a calm and non-threatening approach.
- Maintain enough light.
- Keep patient in a visible location and meet basic physical needs of the patient, e.g. toileting, hydration and nutrition. *O Krairit*

References:

1. Evans LK, Strump NE. Tying down the elderly: a Review of the literature on physical restraints. J Am Geriatr Soc 1989; 36:65-74
2. Tinetti ME, Liu WL, Ginter SF. Mechanical restraint use and fall-related injuries among residents of skilled nursing facilities. Ann Intern Med 1992; 116:369-374
3. Evans LK, Strump NE. A clinical trial to reduce restraints in nursing homes. J Am Geriatr Soc 1997; 45:675-681

## **Improving patient satisfaction:**

### **Just tell 'em your name!**

Fact: Patients encounter numerous caregivers during their inpatient stay at Boston Medical Center.

Fact: Many patients are unable to identify who is actually responsible for their care.

Fact: Patient satisfaction surveys have repeatedly identified the issue of patient's inability to identify who their caregivers are as a significant contributor to their lack of satisfaction with the care they receive at Boston Medical Center.

No doubt, you always walk into a room and introduce yourself and wear your BMC identification badge and name tag in plain site. Yet we still have this theme arising on our patient satisfaction surveys repeatedly.

The point is that patients still cannot always remember you or your name or your role in their care after the first time you introduce yourself.

Here are some easy steps to begin to address this issue:

1. Make sure you really are wearing your BMC ID and name tag in plain site.
2. Always introduce yourself upon first meeting with a patient, a family member, or another visitor.
3. Periodically remind the patient who you are and which team you represent in simple terms like "I'm part of the team which will be taking care of your general health" or "I'm from the team looking into your heart failure" etc.
4. For HO's and students, identify for the patient not only who you are and that you are a trainee, but who you work for (ie. your attending).
5. Ward attendings should make very clear to the patient that they are the "boss" or "head of the team" or whatever words

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you like to convey your leadership position. Patients need to know this role and be able to identify you as the responsible leader.

If this seems trivial, it's not. Repeated surveys here and elsewhere find that patients' satisfaction with their care is partially due to knowing who is providing that care. There are few problems in a hospital system as complex as ours that can so easily be addressed. This is one of them. Please, remember to identify yourself, your team, and your role to patients when you see them and periodically thereafter to reinforce the knowledge.

*J Greenwald*

**WHEN DISCHARGING A PATIENT  
REMEMBER TO PUT  
ALL DISCHARGE MEDICATIONS  
IN LOGICIAN!**

**VERY SOON,  
NO HANDWRITTEN  
PRESCRIPTIONS WILL BE  
ACCEPTED BY  
BOSTON MEDICAL CENTER'S  
PHARMACY  
(UNLESS THE COMPUTER SYSTEM  
IS DOWN FOR REPAIR).  
ONLY LOGICIAN PRINTED  
PRESCRIPTIONS WILL BE  
ACCEPTED.**

**THIS SYSTEM WILL INSURE THAT  
OUTPATIENT PHYSICIANS  
CAN SEE WHAT MEDICATIONS  
THEIR PATIENTS  
WERE SENT HOME ON.**

### Diagnosing the flu

No doubt by now you are aware that flu shots are here both on the inpatient service and the outpatient clinics. No doubt, also, you are aware that there is a nationwide shortage of flu vaccine this season. What you may not be aware of is how to diagnose influenza (or the flu) should you suspect its presence in one of your patients.

What follows is information provided by Dr. Don Schwartz of microbiology and Dr. Dan Shapiro (formerly BMC ID Division).

Boston Medical Center uses a rapid influenza A&B assay. The results of this assay are available on the computer within one hour of the sample **arriving in the lab**. The test is run 7 days/week from 6am to 11pm. The sensitivity and specificity of the test depends on the type/source of the specimen sent.

Specimen	Sensitivity	Specificity
Nasal Aspirate	88%	69%
Nasopharyngeal Swab	83%	76%
Throat Swab	62%	79%
Sputum	81%	51%

**Nasal aspirates:** Insert a depressed bulb syringe deeply into either nare and suction while withdrawing. Expel collected specimen into a sterile cup.

**Nasopharyngeal Swabs:** Insert a Dacron® nasopharyngeal swab beneath the inferior turbinate of either nare and vigorously rub and roll against the mucosal surface. Remove swab from nose and insert, tip down, into paper wrapper.

**Throat Swabs:** Vigorously rub a rayon throat swab on both tonsillar surfaces and the posterior pharynx. Remove swab from mouth and insert, tip down, into paper wrapper.

**Sputum:** Obtain sputum by deep cough either spontaneously or following mechanical induction using a throat swab. Collect in a sterile cup.

NOTE: Unacceptable swabs include those with wooden shafts, calcium alginate or cotton tips, or the Culturette® EZ™ system. Please only send the lab the appropriate type of swab so the sample can be processed.

D Schwartz  
J Greenwald

**ARE YOU REGISTERED  
TO VOTE  
NOVEMBER 2<sup>ND</sup>?  
PLEASE VOTE!  
YOUR VOTE MATTERS.**

### Need clothes for patients to go home?

As Blanche DuBois said, thanks to the “kindness of strangers,” Boston Medical Center has had donations of clothing over the last year that are intended to be used by our patient. The Care Management Department (particularly the Social Workers) has access to the supplies. Please talk with them if you need clothing for a patient.

J Greenwald

### **Remember to contact your patient’s PCP:**

- On admission
- On discharge

**-- With any significant change in your patient’s status (e.g. the patient goes to the ICU), is transferred to another service, or dies**

### **Remember to contact your attending:**

- If a patient dies
- If a patient’s condition changes significantly
- If a patient leaves or threatens to leave AMA
- If you are concerned or have questions about a patient’s condition
- If you are having difficulty with another service

### **We need YOU (more specifically, your patients) for our study!**

*Staphylococcus aureus* bacteremia and Infective Endocarditis (IE) are associated with significant morbidity and mortality despite prompt treatment. Historically, such infections were treated with methicillin; the emergence of methicillin-resistant *Staphylococcus aureus* (MRSA) has prompted clinicians to use Vancomycin as primary antibiotic therapy. However, the emergence of resistant organisms in the form of Vancomycin-intermediate susceptible *Staphylococcus aureus* (VISA) and more recently, Vancomycin-resistant *Staphylococcus aureus* (VRSA), has forced clinicians to search for safe and effective alternative antibiotic therapies.

In this setting, daptomycin is considered to be an acceptable antibiotic alternative to Vancomycin. Currently, the FDA has approved this antibiotic for the treatment of complicated skin and skin structure infections caused by susceptible strains such as MRSA. Given this indication, the effectiveness of daptomycin in its ability to treat *S. aureus* bacteremia and IE has yet to be assessed.

Daptomycin is a lipopeptide antibiotic derived from the fermentation of *Streptomyces roseosporus*. Daptomycin’s mode of action is by disrupting the bacterial plasma membrane, affecting peptidoglycan synthesis, lipoteichoic acid synthesis, and bacterial membrane potential.

The primary goal of this research study is to demonstrate that daptomycin is not inferior to conventional intravenous therapy in the treatment of *S. aureus* bacteremia and IE. Conventional therapy includes semi-synthetic penicillin (nafcillin, oxacillin, cloxacillin, or flucloxacillin) and Vancomycin. *Continued* →

**Got a patient with  
Staph aureus bacteremia  
or endocarditis?  
Contact Ellen Klein (bp: 5772)  
or Dr. John Po (bp: 1303)**

Subjects may be randomized and study medication begun on the basis of a single positive peripheral blood culture for *S. aureus*. **This is where we need your help.** If you have a patient that has a positive blood culture result of *S. aureus* within 2 days of the draw, please contact Ellen Klein (5772) She will evaluate the patient for possible inclusion in the Daptomycin study. Alternatively, as the investigative group gets flagged for all *S. aureus* positive blood cultures, please expect a call from Ellen Klein, Dr. John Leander Po. or Dr. Shalini Patel. *J Po*

### **CD4 and HIV viral load: No consent required, right?**

The patient is a 37 year old male with a history of multiple sexual partners and needle sharing for his heroin habit. He presents with thrush, pneumonia, and generalized lymphadenopathy. Diligently, you ask the patient about whether he’d be willing to have an HIV test. He says no. You know your attending will want an HIV test so you figure, “I’ll just get a CD4 count” or maybe, “I’ll just order a HIV viral load.” They don’t require me to fill out the consent form for the lab, right?

If this is your line of thinking, my friend, you are incorrect. It is true that the lab does not require a faxed consent form for CD4 and viral load testing. However, to use these tests to diagnose HIV in lieu of the appropriate standard testing methods is not only clinically unsound but completely unethical and potentially illegal.

The HIV viral load is not a screening test for HIV as occasionally background “noise” in the test can lead to a detectable viral load in an uninfected patient. The CD4 count may be reduced in the setting of acute illness, sometimes markedly so. As such, neither can reliably be used for the diagnosis of HIV infection.

Ethically, the purpose of getting informed consent is not specific to whether you perform an EIA/Western (standard blood test) or rapid test, it’s specific to the process of learning whether a patient has HIV. Going through a loophole in the system to find out a patient’s status without proper consent is just plain wrong. *J Greenwald*