

A quarterly publication for United Hospital Nurses

nursing notes



The voice of one

Marie Stuewe, RN, United MNA Co-Chair

You've done the second quarter self-study packet for nurses, and you've seen and used the new carpojects in giving medications that come in the Slim Paks. There is a story behind that change, one that involves one RN raising the concern about the difficulty in opening the Slim Pak and the long-term effects of the repetitive motions used to open it.

I work in the Emergency Department (ED) every other weekend, and on the weekend of Dec. 13, 2005, I once again noticed nurses opening the Slim Paks using a tourniquet, a glove, even their teeth. They were hard to open. The use of foam for hand hygiene can cause a build up of silicone on the hands making them slippery when trying to open the Slim Paks. Now think of nurses who have a degenerative joint disease in their fingers, hands or wrists and how painful these must be to open. How

many times a shift do you open a Slim Pak? What does that repetitive motion over time do to the joints involved? That weekend I opened at least 30 each shift. The ED is not the only unit where a lot of these medications are used; to name a few, they are also used in the Recovery Room, Post Surgical and Oncology.

The following week I talked with Pharmacy and sent an e-mail to ED Leadership, Pharmacy, and United's Safety director, Allina Employee Occupational Health, Allina ergonomist and our MNA business agent voicing my concern and observations.

On Jan. 4, 2006 I participated in a meeting with representatives from the above areas and three representatives from Hospira, manufacturer of the Slim Pak and

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summer 2007



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First Touch connection

Cynde Leas, RN, BSN, Medicine Unit 4400

Lolma Olson introduced First Touch at United in August 2006. My unit was one of the first to start implementing her three-step process, which consists of the First Hello, Retouch and Goodbye. Since that time, I have noticed changes within my own personal practice and within the department. The patients seem to know and use the names of staff much more frequently. I think this is due to the development of more personal relationships. In my own experience, I enjoy taking the extra few minutes at the beginning of my shift to connect with my patients. This reminds me to slow down and show my patients that I care about them on a personal level.

Recently we had a patient with dementia who was combative, known to throw things and very uncooperative. I heard in report that she had a difficult night. When I went in to do my First Hello, I did not know how much she would comprehend. Although she never made eye contact with me, she did answer most of my questions appropriately.

I included the patient care associate (PCA) who was working with this patient in my First Hello. I held the patient's hand, told her the PCA would be with her for the whole day one-on-one, and would be keeping her company. The PCA had not had the First Touch training, but because it is so simple and includes many of the basic things we already do I was able to explain the process to him. Our shift went very smoothly. The patient enjoyed holding hands (not mine, but the PCAs) and was very calm and cooperative for us. It is possible she was just tired from her busy night, but I took care of her for three shifts during her stay and never had any difficulties.

I went into nursing because I enjoy dealing with people, and when I use First Touch I develop a personal connection with my patients. This makes me feel better and shifts the relationship from nurse taking care of patient, to nurse and patient working together to improve health. First Touch is now just an automatic part of my nursing practice.

Passport to Excellence

Cynde Leas, RN, BSN, Medicine Unit 4400

The Passport to Nursing Excellence event during this year's National Nurses' Week celebration featured a cruise ship theme. Thirty two nurses served as tour guides for the eight "ports of call," which included:

- Nursing around the globe
- Educational advancement in nursing
- Nursing research and evidence-based practice
- Quality indicators in nursing
- Advanced practice roles in nursing
- Expanded roles in nursing
- Nurses as teachers
- Certification in specialty nursing

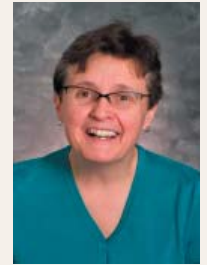
Nurses received a passport as part of the Nurses' Week gift packet to assist in developing a plan for advancing their nursing practice. More than 250 nurses attended the event and took advantage of the opportunity to network with their nursing colleagues.

The event demonstrated not only excellence in nursing but the strong commitment of United Hospital nurses to the professional development of their nursing colleagues.

Get to know...

Naomi English, RN, Float Pool

I started my nursing education at Onondaga Community College in Syracuse, NY, and finished



up at Cornell University. I moved to Minnesota to attend graduate school; I have a master of public health degree with a focus in occupational health nursing. Most of my career has been devoted to critical care nursing. I also managed an occupational health clinic as a federal occupational health nurse for several years. Research matters tremendously to me because nurses are, I believe, at the intersection of science and caring. We must provide the best care we can in a field that is continually advancing. Research enables us to keep our practice current so that our patients can have the best outcomes.

Chem dep assessments

To request a chemical dependency consult for a patient, use Excellian to order an IP Consult to Substance Abuse Counselor #207507. This order is different than the nursing order Substance Abuse Assessment. Teresa Eakman is the new chemical dependency counselor/assessor at Hospital. Contact Eakman, at 651-241-5284 or teresa.eakman@allina.com with any questions.

Patient safety: suicide prevention

Christine Fenske RN, CNS, Behavioral Health Services

The Joint Commission has a new National Patient Safety Goal. Goal 15a requires that all patients who are at risk for suicide be identified. Patients will be assessed for suicidal and self harm thoughts when they meet certain conditions.

For nurses, this means that if a patient's primary problem or complaint is emotional or behavioral, or an encounter due to a suicide attempt, the patient should be assessed for suicidal or self harm thoughts. If it is learned that a patient

may be at risk for suicide through information from family, referral sources or other care providers, for example, the patient should be assessed. Finally, if a patient voices thoughts of suicide he or she should be assessed.

A placeholder on the ED Triage Navigator and the Med Surg and ICU admission and daily flow sheets will remind nurses of the criteria and cue nurses to add the "Danger to Self" row to the flow sheet. After ensuring the patient's safety, the results of this

assessment should be communicated to the patient's physician to determine the need for a psychiatric evaluation and more intensive monitoring, such as a one-on-one attendant. The assessment should be completed each waking shift.

To document monitoring by the one-on-one attendant add the "Patient Monitoring" group and choose "1 staff: 1 patient continuous." More information is available in the current nurse learning packet. Contact me at ext. 15278 with any questions.

Guatemala trip brought cultural appreciation

Cynde Leas, RN, BSN, Medicine Unit 4400

Remember the first week in February when the temperature was below zero and the wind chill 20 below? I was enjoying the balmy weather in Guatemala with 16 other nurses from Augsburg College. We had an awesome experience immersing ourselves with the Guatemalan people, culture and traditions.

San Lucas was our home for most of our stay and this is where we met the women who shared their knowledge, expertise and patience with us about their traditional back-strap

weaving. It is back-breaking work that demands strength in your arms and hands. We worked outside, tied to trees in the most beautiful, lush, relaxing environment. Even though the women did not speak English, we formed relationships with them. After attempting to weave our own cloth, we gained a deep appreciation for the time, effort and talent required to produce some of these amazing works of art.

Throughout our stay we had a cultural guide from the Center for

Global Education who enriched our understanding of the Guatemalan way of life. We experienced so much, including a visit to a hospital, helping out at the diabetic clinic, sorting coffee beans, going on home visits, participating in a Mayan ceremony, shopping the market in Chichicastenango, exploring ancient Mayan ruins in Tikal and talking with health promoters, midwives, city officials and Guatemalan people in their homes. The poverty contrasted with the happy, smiling faces of the children. It was the trip of a lifetime.

Patient Passport now more user friendly

Linda Gfrerer, RN, MS, Education Services

The Patient Passport, the form that travels with the patient during transport from the sending unit to the procedural/ treatment area, has been revised and is now more user-friendly. The revised forms are printed on lighter blue paper with larger text, and the forms have information on front and back.

Revisions and Reminders:

- It is the responsibility of the LPN/

RN from the sending unit to complete the front side of the form. It is not within the scope of the HUC role to complete the form.

- "Verified Allergy Band on Patient" has been added with a check box on the sending unit side of the form.
- The procedural/treatment areas complete the back side of the form.
- A blank with "Procedure Completed; Not Tolerated Well"

has been added in addition to "Tolerated Well" and "Could Not Complete Procedure Well."

- The font of the form has been enlarged, and the color has been changed to a lighter color both making the form easier to use.

Audits on use of the Patient Passport will take place July through September 2007.

Tips on searching for best evidence

Pamela Barnard, MSLS, AHIP-Senior Knowledge Consultant, Allina Library Services

Conducting a search for the best evidence to answer a specific nursing care question or verify a current practice can be tricky. Knowing the best search strategy and the best databases to use, as well as how far to go if you are not finding the answers to your questions, can all take time and persistence that may be in short supply in the busy patient care environment.

Strategies and resources are available to limit searches quickly to best practices. One special feature is called Clinical Queries in the PubMed/MEDLINE database. You can access this feature at www.pubmed.gov. Under the left

hand navigation, choose “Clinical Queries.”

From this page, you can limit a search by the Clinical Study category, Systematic Reviews or more. These apply a predeveloped search strategy called a “hedge” against your subject in order to pull up the strongest evidence (often a study using a randomized controlled trial methodology) on your question. Hedges work best for broad questions and not as well for specific nursing intervention questions. Since they are in PubMed/MEDLINE and not the CINAHL (nursing) database, they will work with more clinical medicine topics. Although there are

no clinical queries as in PubMed, several limits in CINAHL can help get to best practices. Examples:

- Publication Type = Systematic Reviews
- Publication Type = Practice Guidelines
- Special Interest = Evidence-based Practice

These options may be accessed under the Refine Search tab in EBSCO/CINAHL. Call or e-mail Allina Library Services for more information at 612-863-4312 or library.services@allina.com.

Spotlight on enterostomal therapy

Anita Carteaux, RN, WOC Clinician

The nursing specialty of enterostomal therapy (ET) has undergone substantive change since its beginnings in the 1950s. Its focus has expanded from management of people with ostomies and fistulas to include caring for people with incontinence, pressure ulcers and all types of wounds.

The world's first enterostomal therapist was a patient, Ohio native Norma Gill, who had an ostomy performed at The Cleveland Clinic by surgeon Rupert Turnbull Jr., MD, in the early 1950s. After she recovered, Gill expressed an interest in caring for patients with ostomies and fistulae.

Working with Turnbull, she laid the foundation for enterostomal nursing and set her goals to provide empathic care to patients with stomas and fistulae, to develop ideas for more effective and efficient ostomy products and to educate

patients and other health care professionals on managing ostomies and fistulas. Most of all she wanted to assure patients that they could live full lives with an ostomy.

The first school of enterostomal therapy started in 1961 at The Cleveland Clinic. Today, there are seven programs located across the United States, including St. Paul. The three-to-six month programs are for nurses who have completed a four-year baccalaureate program. Credits may be earned toward a master's degree.

There are approximately 4,000 nurse professionals practicing WOC Nursing (wound, ostomy, continence) worldwide.

A typical day for a WOC nurse at United is unpredictable. In addition to being clinical practitioners, we are educators for staff, patients and their families. We are called upon to

identify and match conditions and treatments. We work in consultation with physicians and nurses to develop individualized care plans, obtain and apply the best products for each patient situation and assist in the transition from acute care to home care or another care center.

Satisfaction is guaranteed as a WOC nurse...

- Colleagues look to us for additional nursing expertise in situations that can be difficult
- Patients and their families have often experienced multiple medical crises and are grateful for the added resources of specialty nurses
- Outcomes are easily measured
- We always have a network of partners in our pursuit of improved quality of life for patients.

Management of venous access devices

Linda Phalen, RN, ACM, IV Resource

Venous access devices come in different sizes, lengths, number of lumens, power versus not powered, location, flushes and more. This article shares information about commonly asked questions.

An IV is referred to as a central line when the tip lies in the superior vena cava (SVC) or the right atrium. When listening to the X-ray report, you may hear the radiologist refer to the tip location in the SVC, RA or junction of the SVC/RA; all are considered acceptable locations. The SVC is approximately 2 to 3 inches long and the blood flow through this vein is approximately 2000ml/minute. The subclavian, brachialcephalic or innominate veins are not considered to be central line locations. The blood flow is less than that within the SVC, and due to the curvature of these vessels they carry a high risk of thrombus formation. Therefore these locations are not considered acceptable tip placements without contacting the ordering physician.

Triple lumens are central lines inserted by an MD or MDA. They are placed in the subclavian or jugular veins with the tip in the SVC/RA. They are flushed with 100 units of heparin every 24 hours and after intermittent use.

Peripherally inserted central catheters (PICC) are inserted into a peripheral vein by a trained RN and advanced to the SVC. The tip must be in the SVC or SVC/RA junction to be a central catheter and referred to as a PICC. (If the tip location is in the subclavian or brachialcephalic it is not a central line but a peripheral IV that is a midclavicular. TPN solutions and chemotherapy intended for central line infusions may not be delivered through a midclavicular catheter. PICCs may be used to draw labs, but always flush with 20 ml of normal saline following any blood draws and 200 units of heparin to prevent clotting. It is important to secure all IV tubing with PICC lines to prevent pulling on the catheter and accidental removal of the line.

PICCs can be open-ended or closed-ended. Open-ended PICCs are inserted at United by both IV Resource and Interventional Radiology. Closed-ended PICCs are the Groshongs, which have a valve at the distal end that prevents the backflow of blood into the catheter. Groshongs do not require a clamp or heparin flushes, only saline flushes every 24 hours. Groshongs are not CT compatible. Open-ended PICCs are flushed every 12 hours with normal saline and heparin.

Midlines, peripheral IVs inserted into an antecubital vein by IV Resource or CMT, extend just distal of the shoulder. The purpose of the midline is to provide a bridge in Critical Care Units until a central line can be placed or for the patients on the sepsis protocol for fluid resuscitation in noncritical care units. The duration for the midline is 48 hours. These are preferred over standard peripheral IVs because the length and insertion technique makes them more stable with less risk of infiltration. A blood return must be present to use a midline. It is identified by a bright green sticker at the insertion site that reads MIDLINE. Midlines may not be used for TPN, chemo or lab draws. Midlines are flushed with 100 units of heparin if not in use.

If unsure what line the patient has, refer to the DOC Flowsheet. If the patient has a PICC catheter, always know where your tip is located. Refer to the chest X-ray reports to verify tip placement. Patients admitted with PICC catheters require a chest X-ray to have a record of tip location. Notify IV Resource about the admission so that these patients can be followed for BioPatch dressing changes.

IV Resource is available to assist you with concerns or question that you may have concerning IV lines.

Professional development fair held June 13

Susan Loushin, RN, MA, and Linda Gfrerer, RN, MS

United Hospital Education Services sponsored a fair for RNs to talk to college representatives about advanced nursing degrees and to colleagues about specialty nursing certifications. During panel discussions, RNs shared stories about their journeys toward specialty certification and advanced nursing degrees. Panel members included:

Specialty Nursing Certification

- Christie Frid, RN, OCN
 - Kathy Forbes, BS, RN, C
 - Sarah Gustafson, RN, C
 - M.J. Lee-Vanhouten, LSW, RN, C, CDE
 - Cheri Talsness, BS, RN, CIC
- ### Advanced Nursing Degrees
- Ann Berndtson, MA, RN, ONC
 - Naomi English, BS, RN, MPH

- Katie Krisko-Hagel, MS, RN
- Donna Schumacher, RN, CRNA

If you were unable to attend and would like information contact:

Advanced Nursing Degrees:

- Linda Gfrerer, MS, RN, ext. 18227
- Specialty Nursing Certification:

- Susan Loushin, MA, RN, ext. 18240

Diabetes update and reminders

Lisa Schipp, RN, Diabetes Resource Team

Admission screening

As you may or may not know, almost half of United patients have diabetes. When using the admission screening tool to assess if a diabetes consult is needed, remember that just having diabetes is not a qualifying criteria. In Excellian, the diabetes education activity needs to be activated upon admission.

To perform this process:

- click (add title)
- search for template 433-diabetes
- select appropriate topics for your patient (e.g., insulin or oral agents)
- click accept

Please use this activity to teach and assess patients' diabetes educational needs. Consults are done through the order entry activity. It is very helpful if the reason the patient needs to be seen is written in the comments section. Please do not complete the order as this does not allow the order to print to our office or show up on our list as a consult.

Tip sheets are available to help with this process. Request them from any diabetes educator or call 18780.

Newly diagnosed patients

When patients are new to diabetes, please request a diabetes educator consult. Patients who are being missed are those who are diagnosed in the hospital or their treatment (i.e., steroids) requires home management of their blood sugars. If you are unsure about the situation, diabetes educators are happy to help sort out problems or questions.

Insulin pumps

To find your needed forms/orders through Excellian, go to order sets and select #33038 continuous self-administered SQ Insulin pump. Go to links on the header and then select Allina protocols, custom document. This will give you the worksheet that the patient fills out everyday and the agreement. These items are signed by the patient and the nurse and put in the paper chart for scanning after discharge. The remainder of the process remains the same. You still need to obtain the information on basal rates and bolus information and the physician must write the orders. These patients need to bring in their own supplies. Remember to obtain a blood sugar two hours after a site change (to ensure insulin flow and

accurate pump function). A consult must be sent to us through the nursing screening order.

IV insulin drips

Five type of insulin drips may be ordered:

- DKA
- ICU
- Medial
- Surgical
- Cardiothoracic surgery

DKA orders are now an Excellian order set. All others are on the AKN under Allina drug protocols, United protocols. Copy and paste these protocols into a note and enter orders appropriately. Please remember to obtain the order for, and give long-acting insulin (such as Lantus), at least one hour before discontinuing insulin drip.

Equipment reminders

As insulin drip use increases, there is an increased need for IV insulin boluses. Luer lock insulin syringes are available through Materials Management. Purple lancing devices are a much kinder option for patients, especially for frequent bolus sugar checks.

The voice of one

Marie Stuewe, RN, United MNA Co-Chair

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carproject systems. After explaining my concerns and observations there was a commitment to look at the issue with short-term and long-term solutions. Short-term, United would have Kelly clamps at the Pyxis machines to use in opening the Slim Paks. Hospira would take the issue back to their engineers to review.

When I shared the story with Jim McGlade, United Human Resources director and co-chair partner of the MNA Health & Safety Committee, he

looked at the Slim Pak and noticed that the tamper-proof hash marks did not line up with the opening. I relayed this to the Hospira representative. In the meantime, United engineers developed the white Corian® blocks that are near the Pyxis machines to use instead of Kelly clamps.

Notification came from Hospira that they would need to re-tool the machines at the manufacturing plant to make a more ergonomically correct system and that it may take some

time. The new carprojects started to arrive here in late December 2006.

The voice of one and persistence do pay off. I had raised this issue with Hospira in 2004 and spoke with their Product Quality Analyst who "thanked me for bringing this to their attention, that it would be investigated and included in their product compliant analysis program." Nothing changed. Fast forward to December 2006.

Evidence-based guidelines on BP

Nursing Research Council of United Hospital

Over the past year, questions have been raised across nursing units and departments at United Hospital about some blood pressure practices. Questions voiced by many included, “Is it safe to take a BP on the same side of mastectomy surgery, and if so, how many years after surgery is this practice acceptable?” “What is the evidence around BP assessment in patients with arteriovenous fistulas?”

The Nursing Research Council began searching for evidence to answer these questions. Interestingly, no primary studies were found that investigated the safety of taking BP on an extremity with an arteriovenous fistula or on the same side of a mastectomy surgery. Furthermore, no studies were found that demonstrate taking BP on the surgical side leads to the development or exacerbation of lymphedema. More than likely, these studies do not exist because it would not be ethical to subject some patients to this practice and not others (the only way to detect if it is truly safe) if an appreciable level of harm was anticipated. Instead, the evidence that exists comes from

theoretical physiology principles, as well as published statements from national organizations. This evidence is referred to as “expert opinion” in the world of evidence-based practice — a form of evidence, but the lowest form of evidence because it has not been empirically tested in the real world.

In the case of arteriovenous fistulas, basic physiology suggests the constriction imposed by a BP cuff would severely impede vascular flow and thus, destroy the integrity of the fistula. Similarly, while no research evidence exists, expert opinion errs on the conservative side and advises health care providers from taking BPs on the same side of mastectomy surgery (despite the fact that the risk of lymphedema is based on the extent of surgery). Disrupting lymphatic distribution with the removal of lymph nodes during radical mastectomies is what increases a woman’s risk of lymphedema should constriction occur in the affected arm. Today, modified surgeries such as sentinel node dissection carry a low risk of lymphedema. Nonetheless, since there is no evidence to show that

taking a BP in these patients is safe, expert organizations such as the National Lymphedema Network advise against this practice. Therefore, health care providers should continue to take the BP on the unaffected extremity and include this warning in patient teaching. If needed, the leg may be used to assess the BP if the patient underwent a bilateral mastectomy or has a device (VAD, AV shunt, etc.) on the opposite side of surgery.

For a more detailed account of this information, refer to our Evidence-Based Practice Guideline on the AKN, “BP Assessment in Selected Populations,” under Nursing Practices, Resources & Information.

[Members of the Nursing Research Council of United Hospital:](#) Margo Halm & Naomi English (Co-Chairs), Deb Axmacher, Becky Braden, Minda Demira, Norbert Erben, Debra Freund, Kelly Gannon, Jen Gerlach, Mary Goering, Barb Jacobs, Katie Krisko-Hagel, Dave Larson, Stephanie Leininger, Anna McFarlane, Kris Lindell-Madsen, Rozann Reyerson, Julie Sabo, Kathy Schowalter, Bette Sisler, Deb Steele, Linda Strom and

Celebrations

ONC certifications

- Christie Frid, RN, 4500 recently received her ONC certification.

Orthopedics

- Ann Caliguire, RN, Neuro/Epilepsy, has completed her second certification. She is now certified in both neurology and orthopedics.

Educational advancement BSN

- Angela Ikera, RN, 8940 received her BSN from Bethel College.

Honors

- Margo Halm, RN, PhD. director of Nursing Research & Quality, was recently selected as a Geriatric Research Scholar at New York University. She will attend a week-long research intensive in New York to advance her research on the impact of coronary artery bypass surgery on caregiving and quality of life.

Professional appointments

- Heather Lundberg, RN, was named clinical leader of The Breast Center and Infusion Center.

This spring, because of the impact of preparing for Excellian, we were only able to accommodate five nursing student preceptorships. Four of the students were from Inver Hills/Century College and the fifth was a student from the Wisconsin Indianhead Technical College (ADN program).

Congratulations on Excellian implementation

Barb Knudtson, RN, Excellian and Patient Care Informatics director

Thank you to all United Hospital nurses for your preparation and enthusiastic attitude in implementing the Excellian electronic medical record. Your work has been outstanding, and I am proud of the dedication United nurses have to providing exceptional care to patients and their families.

Now that we have been live with Excellian for more than two months, it is important to know that there are still many methods of support available to you. Department Lead Super Users and Super Users are very knowledgeable about the system and are able to bring items forward for discussion through the United Patient Care Excellian Workgroup (PCEW), co-chaired

by Lisa Waytulonis, RN, and MNA representative Glenda Cartney, RN. PCEW supports workflow planning, practice and training. PCEW is directly accountable to United Nursing Practice Care Delivery, which reviews and approves final nursing practice decisions. Current chairs of United Nursing Practice Care Delivery are Sue Penque, RN, vice president of Patient Care and Operations, and Linda Slattengren, RN, United MNA co-chair and current president of the MNA.

Several RNs represent United Hospital on various Allina Excellian user groups, including Surgical Services (OpTime), Emergency Services (ASAP/Epic ED) and Epic Care Inpatient Team. The

representatives participate and contribute to these teams and report information back to United PCEW to ensure communication continuity.

If you have any questions or concerns about Excellian, please talk to your department leader, Lead Super User and Super Users, or the Allina Technology Support Center at ext. 21900. You may also contact one of United's Excellian nursing leaders:

- Barb Knudtson, RN, at ext. 18775 or barbara.knudtson@allina.com
- Liz Hoelscher, RN, workflow analyst, at ext. 18788 or elizabeth.hoelscher@allina.com
- Lisa Waytulonis, RN, nursing coordinator, at ext. 18453 or lisa.waytulonis@allina.com

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