continuation of an ongoing organizational effort to efficiently manage data and information in our complex healthcare environment. The goals of the electronic documentation program are to utilize technology to increase the efficiency of care delivery, increase compliance with regulatory requirements, obtain outcome data for evidence based nursing research, facilitate access to patient data for process improvements, and contribute to patient safety.

**Methods, Intervention, & Analysis:** RNs attended a four hour training session that provided didactic and computer simulation. Unit based super users received additional training and supported the implementation for the first 2 weeks. Daily issues meetings addressed requests for enhancements and troubleshooting. Structured notes were created to capture initial admission assessment, ongoing assessment, patient education documentation and nursing event notes. Flow sheets were created to document vital signs, intake and output, individualized care plans, focused frequent assessments and interventions. These electronic documents combined provide a complete and thorough record of the patient's clinical data, associated outcomes and daily nursing workflow.

**Findings & Interpretation:** Clinical reports are utilized to ensure that complete and accurate documentation is achieved. A clinical summary tab allows for interdisciplinary access to nursing clinical assessments, interventions, and outcomes in the context of the complex healthcare needs experienced in the bone marrow transplant patient population.

**Discussion & Implications:** Technology, thoughtfully applied, has the potential to transform the nursing process for the benefit of patients and nurses. Nursing can fully realize the benefits that technology can provide to deliver high quality, safe, and efficient care. Data can be used to improve patient safety outcomes, drive performance improvement, contribute to nursing research and evidence based practice.

**490**

**Beep, Beep, Beep: Rescuing patients and nurses from pump alarms on an Inpatient Bone Marrow Transplant Unit**

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**Topic Significance & Study Purpose/Background/Rationale:** The Bone Marrow Transplant unit of this NCI designated comprehensive cancer center successfully implemented practice changes which substantially reduced air in line alarms. Our journey began with the implementation of bedside handoff. Data collection post implementation highlighted a decrease in patient calls except for calls related to beeping pumps. Analysis revealed air in line alarm as the primary cause and a major frustration for patients and staff. Etoposide had the highest incidence of air in line alarms. Safety concerns also guided our initiative to address the cacophony of pump alarms. Pump alarms are a safety tool communicating information to the RN. Air in line can potentially pose a safety risk, delay treatment, cause medication errors, and contribute to patient falls. The barrage of noise is an unintended hazard of pump technology, desensitizing the RN, delaying response time, and impeding recovery. A task force identified the incidence, causes, and interventions that could minimize alarms.

**Methods, Intervention, & Analysis:** Collaboration with the pump manufacturer identified areas for improvement. Staff received retraining on alarm management and troubleshooting, and reinforcing proper device use. Air detector settings were adjusted to reflect the manufacturer’s recommendations. IV tubing was changed from low sorbing to standard infusion sets. The pilot program assessed the effectiveness of an anti-siphon valve for Etoposide infusions.

**Findings & Interpretation:** Data collection following collaboration with the manufacturer resulted in a 66% decrease in air in line alarms, however, Etoposide continued to alarm. Data collection post implementation of the anti siphon valve with Etoposide infusions demonstrated a 98% reduction in alarms.

**Discussion & Implications:** The implementation of this multipronged problem solving approach resulted in a significant decrease in the incidence of pump alarms. A quieter environment improves relationships with patients, fosters a sense of safety and trust and enhances patient satisfaction. The implementation of the anti siphon valve will be evaluated for further clinical use.

**491**

**Utilizing the Timed Up and Go (TUG) Assessment to Evaluate Physical Functioning and Fall Risk in an Adult HCT Population**

*Jennifer Peterson, Peggy Burhenn, Mary Perrin, Beatriz Avila, Lisa McManus. City of Hope, Duarte, California*

**Topic Significance & Study Purpose/Background/Rationale:** Reasons for falls in the HCT patient are multi-factorial. We analyzed falls on an inpatient HCT unit at a comprehensive cancer center in California. Our data revealed patient falls were related to patients over estimating their abilities or altered balance and gait. We wanted to assess physical functioning to predict fall risk on an inpatient HCT unit. The Timed Up and Go (TUG) measure is a tool used to assess motor function. The data on TUG has focused on the elderly population. The aim of our project was to teach nurses to perform a TUG assessment and to determine patient motor abilities and fall risk. We measured patient TUG scores, fall rates and nurses’ feedback.

**Methods, Intervention, & Analysis:** The project and the training were developed and conducted jointly with the Rehabilitation and Nursing Departments. We rolled out the process at staff meetings, during huddles, and training sessions. Support was provided throughout the pilot by nursing and rehabilitation staff. We developed an informational poster for the staff outlining the rationale and procedure for TUG. Staff training was done daily for one week prior to implementation. We informed patients about the TUG. Staff performed TUG daily on all patients that were able to complete the test. The pilot was conducted for one month.

**Findings & Interpretation:** Nurses were surveyed post pilot (n=25). Reported benefits of TUG included encouraged patients to ambulate and prompted the opportunity to discuss and educate patients about physical functioning and falls. Obstacles included patient refusals or unable to walk 10 feet. Abnormal scores were recorded for 58% of patients. One fall was experienced in the pilot month as compared to 3 falls on the adjacent unit with the same patient population.

**Discussion & Implications:** A longer trial period would be required to determine the efficacy of the tool with decreasing falls.

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**Intravenous Immunoglobulin Administration**

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**Topic Significance & Study Purpose/Background/Rationale:** After bone marrow transplant, serum immunoglobulin