Many older adults will tell you it’s a lie – there is nothing golden about the golden years. The wear and tear of many years of work result in degenerative joint disease and osteoarthritis. Osteoporosis often leads to compression fractures. Pain becomes a constant and unwelcome companion to many senior citizens (Martire et al., 2003). In an era where great strides have been made in many areas of the health sciences, pain in the older adult population remains poorly assessed and treated. Recognition of pain in older adults is vital in order to treat it. The elderly patient may not always volunteer the information, and therefore, must be assessed on a routine basis for pain or discomfort (Blomqvist, 2003).

The presence of pain has far-reaching effects as well. In one study of chronic pain in elderly nursing home residents, pain was associated with the inability to enjoy social activities (54%), depression (32%), impaired cognition (12%), and anxiety (26%) (Teno, Weitzens, Wetle, & Mor, 2001). In another study, the number is even more startling; prevalence of pain among older adult nursing home residents has been rated as high as 75% (Blomqvist, 2003, Blomqvist & Hallberg, 1999).

**Evaluation Tools**

Pain is defined by the International Association for the Study of Pain (IASP) (2007) as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” The IASP continues to state that pain is subjective; it is an emotional experience. This explanation coincides with McCaffery and Pasero (1999), who explained that “pain is whatever the experiencing person says it is, existing whenever he says it does” (p. 17). Tools used to evaluate pain come in many different styles and formats. These tools may be utilized in a variety of settings with a wide range of patients and may look at various aspects of the pain experience.

The tools most commonly used in practice generally deal with pain intensity – how much a person hurts. One example is the Visual Analog Scale, a 10-centimeter line with word anchors at either end, such as “no pain” at one end and “the worst pain imaginable” at the other. The patient is asked...
As I write this message, the cost of gasoline is very close to $4 a gallon. I guess to make the high cost of gasoline seem more pleasant, I heard on the news that you could be paying $11.00 a gallon for gasoline if you lived in Turkey. We are definitely living in a challenging economic environment. Nurses who have not been in the workforce are temporarily returning to healthcare settings because of the declining economy, according to a recent Wall Street Journal article (Dougherty, 2008).

In a time of economic slowdown, consumers want value for their money. With annual dues remaining at $84.00, your membership in AMSN remains an excellent value. Being a member of AMSN provides you with many benefits.

The Benefits of Membership

One of AMSN’s strategic plan goals is to advance the art and science of medical-surgical nursing through research and evidence-based practice (EBP). Our publications, (Med-Surg Matters newsletter, MEDSURG Nursing journal, and Med-Surg Nursing Connection e-newsletter) provide current research findings and evidence-based practices that improve the quality of care we provide to our patients. AMSN’s Web site offers links to help you access EBP resources, position statements, and educational materials. The Research Committee, chaired by Lynne Connelly, and the AMSN Foundation, chaired by Cece Grindel, have collaborated so that a $5,000 grant will be provided to fund our first EBP project to enhance medical-surgical nursing practice. In addition, the Research Committee and MSNCB, led by Marlene Roman, are working together to research the value and impact of medical-surgical nursing certification.

Many of you are certified medical-surgical nurses, demonstrating your commitment to excellence in patient care. Membership in AMSN provides a discount for certification study materials, as well as for initial certification and recertification. Many of our members report that they receive bonuses and/or increased salaries for certification, which is beneficial in any economy.

Another goal within AMSN’s strategic plan is to enhance the professional growth of nurses. Continuing education opportunities are available at the local chapter level, through our publications, at our annual convention, and soon, online. Our Clinical Leadership Task Force, chaired by Nancy Janes, has been hard at work developing leadership modules, which will be posted on AMSN’s Web site. Watch for an announcement later this year regarding more online continuing nursing education offerings.

Professional development opportunities are also available at the chapter level. The Chapter Development Committee, chaired by Mike Frace, provides resources to assist those of you wanting to charter a new chapter. Established chapters also benefit from the guidance of the Chapter Development Committee.

Another member benefit is the opportunity to engage in volunteer activities. You can become involved at the local and national levels. We frequently place calls for volunteers to work on task forces and committees. Volunteering is rewarding and can often be helpful in your job as a means of demonstrating leadership and professionalism.

Another AMSN strategic plan goal is to address adult health care issues in educational, practice, and legislative arenas. Our Legislative Policies and Issues Committee, chaired by Cindy Ward, provides updated information on our Web site to help you make knowledge-based decisions about current legislative issues. The committee will be pro-
Dr. Mike Magee, a current member of the National Commission for Quality Long-Term Care, will be the keynote speaker at AMSN’s 17th Annual Convention in Nashville, TN. Dr. Magee is a recognized leader in the health care arena, has written a book, Home-Centered Health Care, and for five years hosted an Internet program, “Health Politics with Dr. Mike Magee,” which covered news and information related to health and health care. The goal of that program was to help viewers understand the big picture of health and how our health care system works. He continues this work at www.HealthCommentary.com

Dr. Magee is known for his thoughts and predictions about a new health care model that empowers individuals and makes the system more human (and humane) by establishing team-based approaches and home-centered health care. He is a strong advocate for the patient-physician relationship and for health care based on the principles of compassion, partnership, and understanding. He is found at the center of health care reform because of his work on creating healthy and functioning partnerships between government, industry, academia, and non-governmental organizations. In addition to these issues, he has presented on other clinical, public health, and public policy issues around the world.

Dr. Magee’s book, The New Face of Aging, and his role as a national spokesman for the Senior Olympics, show his passion and advocacy for healthy aging. Other books that Dr. Magee has written are The Best Medicine, The Book of Choices, and Health Politics: Power, Populism and Health.

Join us on October 2, 2008, in Nashville, TN, when Dr. Magee will describe his vision of home-centered health care that will transform the health care team into providing care, education, monitoring, and prevention. He will discuss the mega issues driving the future of health care and share his thoughts on how our professions will evolve over time to meet the changing health care market. This is a session that will make you think, get you excited, and give you hope for our future!
The preceptor is a key influence on reducing the turnover of nurses in their first year of hire. Preceptors who are satisfied and properly trained may improve the orientation experience, leading to a decrease in first-year turnover. Many organizations select nurses to act as preceptors simply because the nurse is working the same shift as the preceptee. Preceptors are often selected based solely on clinical skills without regard for the preceptor’s ability or desire to teach.

**Preceptor Training Needs**

Organizations with successful preceptor programs provide preceptors with training, education, and support to prepare them to meet the role responsibilities needed to effectively guide the preceptee through the orientation process. Research in this area has identified subject matter needed by the preceptor to be effective. One topic includes the understanding of teaching and learning styles. Preceptors need to be able to identify and adapt their own teaching and learning styles in order to cope with the preceptee’s learning styles. Different people learn in different ways, and the preceptor needs to be able to change teaching styles to accommodate the needs of the learner.

Schumacher (2007) identified six caring behaviors of preceptors that led to an improved orientation experience for new nurses. These are “advocating, welcoming (including autonomy with appropriate preceptor presence), making human connections, and clear, non-punitive feedback” (p. 188). Four negative behaviors were also identified, including “unwelcoming, autonomy with no preceptor presence, no autonomy with preceptor overpresence, and feedback that was not clear and timely” (p. 188). Preceptor training should include these concepts to assure positive behaviors are used and negative behaviors are avoided.

To assure that preceptors can function optimally, the preceptor program needs to provide preceptors with a structure to track the progress of students and their own performance. Santucci (2004) suggests “tools for guiding and tracking learning and performance provide consistency among preceptors, document progress and goals, and can clarify learning needs” (p. 277).

The preceptor role includes “regular interaction, explicit sharing of ideas, clarity of expectations, and a focus on areas of strength, as well as those areas requiring improvement” (Myrick & Yonge, 2005, p. 5). The training program for preceptors should not only include information regarding basics of adult learning, but also principles of teaching and role modeling, communication skills, caring behaviors, how to provide constructive feedback (positive and negative), how to socialize a new employee into a unit, and how to deal with conflict. Documenting and reporting progress of the orientee, creating a learning environment, and goal setting should also be included in the curriculum. Finally, specific unit-based skills need to be reviewed with the preceptor in order to assure the preceptor is able to correctly train the preceptee.

Selection criteria for the preceptor are important. Experience, willingness to share nursing knowledge with others, certification, and overall attitude are important selection criteria. Bashford (2002) describes additional qualifications for the preceptor as a nurse who has “completed all aspects of the unit orientation, exceeds minimum criteria on performance evaluation, is proficient in all items of the unit-specific skills and emergency preparedness, has fulfilled all mandatory educational requirements, demonstrates leadership by participating on an agency committee or project, and assumes charge responsibilities as needed” (para. 16). By selecting preceptors who are passionate about providing a good orientation to new nurses, giving preceptors the skills and knowledge they need to provide this orientation, and establishing consistency between departments, an organization can improve new nurse orientation and will decrease new nurse turnover.

**Consistency with Research**

Significant research has been done in the areas of preceptorship and orientation. A review of the literature reveals that the first year of nursing is often the most difficult because the new nurse is bridging the gap between didactic learning and practical application of knowledge in the patient care setting. The use of well-trained preceptors is recognized as a strong influence on the new nurse to be successful in that crucial first year. Nicol and Young (2007) explain that “an empathetic preceptor who is aware of the graduate’s needs can make the difference between the graduate nurse enjoying his or her professional role, surviving the first year, and leaving the profession” (p. 298). In a study of intensive care unit (ICU) orientation practices across the nation, Thomason (2006) reports that 80% of the organizations participating in the study “provided a formalized preceptor training program that lasted between 4 and 12 hours, with an average of 6 hours of classroom instruction” (p. 243). A cost analysis of preceptor training determined that “over time, investment in preceptor development is also expected to impact new hire retention, thereby clearly demonstrating preceptor influence on this equation” (Baggot, Hensinger, Parry, Valdes, & Zaim, 2005, p. 145).
Support for Preceptor Training

Research strongly supports promoting programs to enhance preceptor training. A review of the literature reveals many research studies and analyses of studies, conclusively demonstrating the need for formalized training for preceptors. In addition to generalized analysis, specific studies are cited here to provide research support for the preceptor training program proposal.

Smith and Chalker (2005) studied the effect of continuity of preceptor assignments on new graduate nurses using a descriptive, retrospective review. The sampling included 93 new nurses, 53 of whom had randomly assigned multiple preceptors, while 35 had a single assigned preceptor. The researchers state that one limitation of this study was its small sample size. The major threat to external validity was that all members of the study were members of the military on active duty. Results indicated that using a single preceptor helped the new graduate nurse make the transition to staff nurse, building confidence and competence to manage a team of patients individually. Multiple preceptors helped the new graduate hone clinical skills by experiencing a variety of practice and leadership styles. Tailoring the orientation program to meet the “unique needs of the new graduate” (Smith & Chalker, 2005, p. 52) is significant.

Thomason (2006) studied preceptor development in the ICU setting. This researcher explains that “an important step in the orientation improvement process centers on the selection, preparation, development, and empowerment of the preceptor nurse” (p. 238). The study was conducted using a random survey from a broad sample of hospitals across the U.S. The initial contact was a telephonic standardized interview with the person in each hospital responsible for the unit-based ICU orientation program. This was followed with an e-mailed survey to clinical nurse specialists working in the adult critical care environment. The surveys revealed that 80% of the responding hospitals provided formalized preceptor training. External validity is challenged by the small sample size and by only mailing the surveys to clinical nurse specialists who were members of a professional organization. The researcher acknowledges that the results of this survey cannot be globalized to all hospitals, yet the results of the survey highlight the need for preceptor training to enhance new graduate orientation.

A phenomenological study by Shumacher (2007) explored caring behaviors of preceptors. Set in a large Midwestern medical center with two hospitals and a clinic, this study identified six caring and four non-caring behaviors. Ten newly graduated participants maintained reflective journals. In addition, in-depth interviews were conducted with each participant. The study provided specific examples of behaviors to be taught to preceptors to enhance the orientation process and promote nurse retention.

Yonge and Myrick (2004) conducted a study of undergraduate students and their preceptors to determine the role of training in preceptor performance. A survey was conducted with all members of the fourth-year nursing program and their assigned preceptors at a Canadian university. A limitation of the study included no access to the students’ addresses by the researchers, so preceptor surveys were distributed by preceptors. However, the findings of this study demonstrated the need for training for preceptors prior to the precepting experience.

Hautala, Saylor, and O’Leary-Kelley (2007) conducted a study of preceptor stressors. A descriptive exploratory study using questionnaires was given to a convenience sample of 65 registered nurses in the San Francisco area. Limitations of the study included the small convenience sample, voluntary participation (indicating that nurses who choose to participate may have had increased stress and perceived less support), and the possibility that the two hospitals surveyed may not completely represent all hospitals. Findings indicate the need for preceptor training, support, and recognition.

Conclusion

A wide base of literature exists to support implementation of preceptor training programs. Minimal financial risk is involved, and organizations may realize significant savings if a training program is successfully implemented. Consistently trained preceptors who are satisfied and feel supported in their efforts will improve the retention of newly hired nurses.

Diana E. Anderson, BSN, RN, CMSRN, is the Assistant Director, Med Surg Summit Healthcare Regional Medical Center, Show Low, AZ, and Editor, Med Surg Matters.

Note: A related article entitled, “Positive Precepting Can Reduce the Stress,” can be found in the June 2008 issue of MEDSurg NURSING, The Journal of Adult Health, the official journal of the Academy of Medical-Surgical Nurses.

References


Med-Surg Nurses Recognized at New England Hospital During National Nurses Week Celebration

Fairview Hospital is a 25-bed critical access hospital located in the beautiful Berkshire Hills of western Massachusetts. What we lack in size and numbers, we certainly make up for, and exceed, in spirit!

The theme of 2008 National Nurses Week was Nurses: Making a Difference Everyday. This theme represents what it means to be a nurse everyday – making a difference in the lives of patients and in our community. Nurses at Fairview Hospital are known for our caring attitudes, our understanding of patients, and our high level of competence in providing patient care.

The nurses on the medical-surgical unit were the hosts of this year’s celebration. Multiple activities were planned by the six-member Nurses Week Committee for approximately 95 nurses and all employees, as well as our family members and members of our community. This was our chance to celebrate the critical role that nurses play in health, well-being, and education.

A large bulletin board in the lobby reflected this theme with a scene of a night sky and a shooting star, with nurses pictured as the tail of the star. Surrounding the star, many nurses wrote how they make a difference. Some of the entries included, “Showing our patients courtesy and caring is important to me,” “I function as a preceptor to new staff and assist them to be successful in their nursing career,” and “What greater gift than to make a difference by giving part of yourself to help another in such a caring and nurturing way, no matter how small it may be.”

The theme of Fairview’s medical-surgical unit is butterflies, which symbolize transformation and new beginnings. As the kick-off to the celebration, we baked and decorated 30 butterfly cakes in addition to a dozen cupcakes, and delivered a cake or cupcake to every department within the hospital. We titled this activity “Wind Beneath Our Wings.” A card was delivered with each cake that read:

“We would like to take this opportunity to honor YOU – our valued healthcare team members. We could not be successful in our work without you. You truly are “The Wind Beneath Our Wings!” Thank you for all that you do!”

We also provided each nurse with a small gift bag filled with treats, a meal ticket to the cafeteria, makeup samples, and pens.

Several staff members, both nursing and non-nursing, participated in a “sock swap.” Prior to Nurses Week, participating staff chose another participant’s name from a basket, and during Nurses Week, presented a fun pair of socks to their chosen co-worker. It was a great way to get to know staff from other departments and disciplines!

Each nursing department was also asked to assemble a gift basket with a specific theme of their choice – and the “Battle of the Baskets” had begun! Eight gorgeous baskets were on display in the lobby throughout the week, and staff and visitors were able to take chances to win them. The baskets included gardening, entertainment, relaxation, heart-healthy food and beverages, sports, and Mother’s Day. Money raised from these baskets was placed into a fund to provide scholarships to local students interested in nursing. The raffle was a great success, and over $2,600 was raised from this event.

Another event was a “Health and Wellness Fair” for staff and community, at which nurses and staff from other disciplines performed checks, including blood pressure, finger-stick glucose, oxygen saturation levels, pulmonary function tests, and hand washing with “glow germ” (Glo Germ™). We also educated them about tobacco, the importance of CPR and defibrillation, how to have a “healthy meal plate,” stress management, and MRSA. The Berkshire Health Systems Community Outreach Van provided cholesterol checks and insurance information.

In addition to caring for our patients, our co-workers, our nursing community, and our general surrounding public, we also cared for ourselves! A Reiki therapist performed Reiki treatments for nurses and an aesthetician provided nurses with complimentary facials – both of which were extremely relaxing. A makeup consultant was available for all staff to enjoy, and a uniform company visited for a day and sold fantastic scrubs and shoes. The nursing administration served a special and delicious breakfast, lunch, and dinner in our conference room, complete with white linen table cloths, fresh flowers, and soft background music, to all nurses on one day.

The two highlights of the week were activities for all staff to enjoy. On Friday night, “Too Live Nurse,” a musical comedy group for health care professionals (one of our CCU staff nurses is the founder), performed at a local theater and had the crowd laughing throughout the entire show. On Saturday, we held a softball game and carnival for all staff and their families, complete with a professional magician. Staff from all departments played ball – including physicians and even our hospital CEO!

We thoroughly enjoyed planning the celebration, and were delighted that everyone enjoyed the week and were very appreciative of our efforts. It was a busy but fun-filled Nurses Week!

Jo-Ann Buffoni, BS, RN, is a Nurse at Fairview Hospital, Great Barrington, MA.

Editor’s Note: Do you have a story to share about your unit from National Nurses Week? Let’s hear from you! Send your Nurses Week stories and photos to Diana Anderson, Editor, at danderson@summithealthcare.net
Welcome New Chapters!

North Central New Jersey Chapter #101
A group of medical surgical nurses from Morristown Memorial Hospital (MMH) has established a local chapter, North Central New Jersey Chapter #101, which began meeting in February and received its charter in April 2008.

Our goal is to promote the image of the medical-surgical nursing and the professional growth of individual medical-surgical nurses through leadership, advocacy, research, networking, and educational programs. Our first evidence-based symposium, entitled “Innovations in Medical-Surgical Nursing,” was held in Malcolm Forbes Theater at MMH on June 6, 2008. Topics pertaining to the latest trends in med-surg included advanced technology and Robert Wood Johnson Foundation’s new initiative to improve and transform care at bedside. Other topics, such as stroke, pleural effusions, and wound care in the 21st Century, were carefully selected to meet the needs of the specialty nurses. NCNJ aims to inspire excellence and build camaraderie among members. If you are interested in finding more information about joining the chapter, please e-mail janet.munoz@atlantichealth.org or call 973-971-8246.

Jennifer Jaromahum, RN-BC
Morristown Memorial Hospital
Morristown, NJ

Richmond Metro Chapter #232
Congratulations to the Richmond Metro Chapter #232, which earned its charter in April 2008. Based in the area surrounding Williamsburg, Richmond, and Mechanicsville, VA, the chapter has appointed the following officers:

President: . . . . . . . . . .Renee C. McKeel
President-Elect: . . . . . . .Deborah R. Denmark
Secretary: . . . . . . . . . .Beverly Reed-Burbage
Treasurer: . . . . . . . . . .Kathy B. Harman

Goals of the chapter are to:
• Promote medical-surgical nursing as a professional speciality.
• Provide education and networking for Richmond-Metro nurses.
• Maintain effective communication with and serve as a resource to the community.

Educational plans include a membership drive with speaker on the topic of “Professional Growth.” CNE contact hours will be offered. Other educational offerings are stroke treatments and education, wound/ostomy care and teaching, DVT prevention, and MRSA education and treatment. Chapter dues will be $10.00 per year, and two fund-raising events are planned for the first quarter.

Greater Lehigh Valley Chapter #117
Congratulations to the Greater Lehigh Valley Chapter #117, which earned its charter in April 2008. Based in Allentown, PA, the chapter has appointed the following officers:

President: . . . . . . . . . .Tracie Lynn Heckman
President-Elect: . . . . . . .Denise M. Pisciotta
Secretary: . . . . . . . . . .Debra A. Peter
Treasurer: . . . . . . . . . .April L. Gheller

Goals of the chapter are:
• Hold at least two educational opportunities during 2008.
• Enhance the image of the professional medical-surgical nurse.
• Recognize medical-surgical nursing as a speciality.

Annual dues are set at $20.00 per year. The fund-raising committee is discussing options for the next year, including bake sales, cook book, and basket raffles. The education committee will be contacting local educational programs that are currently offering contact hours. Representatives from companies that provide educational opportunities will be contacted. In addition, nursing resources will also be contacted regarding additional educational opportunities. Local chapter meetings will be held four times a year.

Greater Berks Chapter #116
Congratulations to the Greater Berks Chapter #116, which earned its charter in April 2008. Based in Reading, PA, the chapter has appointed the following officers:

President: . . . . . . . . . .Andrea Pichter
President-Elect: . . . . . . .Sarah L. Keller
Secretary: . . . . . . . . . .Marguerite Windle
Treasurer: . . . . . . . . . .Kersten Berger Reider

Goals of the chapter are to:
• Enhance the image of the professional medical-surgical nurse.
• Facilitate communication and collaboration among medical-surgical nurses in the Greater Berks area.
• Enhance professional growth and networking of chapter members through educational program offerings.

Annual member dues are $15.00. Fund-raising efforts and meeting schedules are under discussion.
Despite a temporary lull in the country’s nursing shortage, data point to a gathering storm that will be “like a Category Three hurricane, but one that hits the entire nation,” according to Peter Buerhaus, PhD, RN, FAAN, a leading work force analyst.

Buerhaus, a Vanderbilt University professor, and his colleagues released the latest data from three studies on the nursing industry during a May 6 press conference at the National Press Club in Washington, DC. They predicted dire numbers for the shortage; however, the research was more positive regarding the high public regard of the nursing profession. Also, researchers went to the source—nurses themselves—and asked for their opinions on the upcoming presidential election, their views on U.S. health care policy, and how they feel about their own profession.

The current nursing shortage began in 1998, Buerhaus said, and according to his latest data, could spike to 500,000 by 2025. Colliding forces, including an aging nursing work force and a surge in demand for health care as 78 million baby boomers reach age 65, do not bode well for the future.

“A shortage that size could incapacitate the health care system,” Buerhaus said. “Low nurse staffing affects the quality of care. There is a clear impact on patients: more infections, falls, cardiac arrests, and medication errors.”

At the press conference, Buerhaus and Karen Donelan, ScD, senior scientist at the Institute for Health Policy, Massachusetts General Hospital, outlined the major points of their article, “Public Perceptions of Nursing Careers: The Influence of the Media and Nursing Shortages,” published in the May/June issue of Nursing Economic$ journal. Beth Ulrich, EdD, RN, FACHE, FAAN, senior vice president of Professional & Consulting Services for Nursing Spectrum/NurseWeek, announced results of the latest national survey of registered nurses, which included RNs’ views of health policy issues and solutions, and the upcoming elections.

Key findings from the three studies included the following:

- In that same survey, RNs said the most important health care problem the government needs to tackle is access to care/lack of insurance (34%), with health care costs a close second (28%).
- The third survey of 1,600 Americans regarding their perceptions of the nursing profession showed 70% of the public view a nursing career as positive or very positive, second only to teaching (74%). In addition, 63% said they would recommend nursing as a career to a high school or college student.
- In the public survey, 61% of Americans were aware of a nursing shortage.
- The public feels that RNs are underpaid (53%) and should get better benefits, factors that feed the shortage. According to Donelan, who spearheaded the public survey, Americans hold nurses in high regard, an opinion that is bolstered by positive news reports and television shows that portray nurses as knowledgeable, respected professionals.

The analysts pointed out that it was difficult finding explicit information from the presidential candidates on the nursing shortage.

“This is a concern because the impact will go beyond the health care industry and affect the entire economy,” Buerhaus said. “Suppliers of health care goods and services, pharmaceuticals, workers needing jobs, and many others will suffer.”

For Ulrich, the answers to many of the health care industry’s woes can be found by talking with the nurses themselves.

“If anyone understands the health care system, it’s nurses,” she said. The survey of nurses, which was sponsored by the Johnson & Johnson Campaign for Nursing’s
Future and Nursing Spectrum/NurseWeek, and conducted by Harris Interactive, was particularly significant, Ulrich said, because it gives a voice to the single largest group of health care professionals in the country. (Approximately 2.5 million RNs practice in the United States today, according to the U.S. Department of Labor, Bureau of Labor Statistics.)

The researchers recommended a multi-pronged approach to combat the shortage. Buerhaus said a comprehensive national strategy must be developed to recruit and retain nurses. Programs to encourage other groups, such as men and Hispanics, to enter the profession would help. In addition, there needs to be additional funding for nursing education programs, as a shortfall in faculty is contributing to the shortage.

According to Nursing Economic$ Editor Donna Nickitas, PhD, RN, CNAA, BC, who moderated the press conference, the journal will be publishing additional articles about the research in upcoming issues. More information can be found on the Nursing Economic$ Web site, www.nursingeconomics.net.

The press conference was sponsored by Nursing Economic$ and Nursing Spectrum/NurseWeek.

Certification in Medical-Surgical Nursing Strategies and Test-Taking Tips

Certified Medical-Surgical Registered Nurse (CMSRN) is the earned credential that recognizes that the highest standards of medical-surgical nursing practice have been achieved. Certification is the way to show that you have taken that extra step to validate your knowledge and skills. It builds your confidence as a professional and demonstrates that you meet nationally recognized standards in the specialty of medical-surgical nursing.

Test-Taking Strategies for the Certification Examination

- Answer only the questions you are sure of first. When you are finished with the test, only re-look at those that you did not answer the first time through.
- Read each item carefully. Read the stem first and make sure you understand it. Try to answer the item before looking at the options. Then read each option carefully before determining the correct answer. Underline key words and do not read anything more into the item than what is there.
- If you skip an item, make sure you skip the corresponding item on your answer sheet as well. If there are items for which you are unsure of the correct answer, mark them so that you can return to them later. Be sure to erase those marks on your answer sheet.
- Periodically review your answer sheet. Compare the number on your answer sheet with the number of the test item you are answering so that you don’t misnumber your responses.

Test-Taking Tips

- When you’re not sure of the answer to a question, use logic to weed out those options that could be correct versus those that are definitely incorrect. If in doubt, make an educated guess.
- Attempt to answer every item. There is no penalty for guessing because each of the items is weighted equally. Do not leave any questions blank.
- If the answer is a priority question, and you don’t know the answer, look for one that assesses or one with “airway.” The nursing process always starts with assess, so remember your ABCs.
- Changing your answer. Testing recommendations used to discourage changing answers because the first answer was usually correct, and some studies still support this. Other research tells us this is not true. Therefore, when reviewing the test, change any answers that you feel you should, but take care not to read information into the question that has not been given.

Other Tips

- If two or more options express the same idea, they will both be wrong.
- If two answers seem to be correct, choose the option that causes the other to occur.
- Select options that relate to a common need or the medical-surgical population in general.
- Select options that reflect nursing judgment.
- Select options that are correct without exception.
- Avoid options that are true statements but do not answer the question.
- Be sure to time yourself so that you don’t find you still have half the test to take in one hour. The proctor will call out “one hour left” and “30 minutes left.” Make sure you bring a watch with you and glance at it every once in awhile to be sure that you are moving along without having to worry about the need to speed up.

After the examination, congratulate yourself on the many answers that you knew. Refrain from agonizing over the items you considered difficult and reward yourself.

For more information on the certification examination or to apply online, visit medsurgnurse.org and click on the “Certification” tab at the left of the page. You may also contact us via e-mail at mcnb@ajj.com or via telephone at 866-877-2676. To request an application by mail, the address is MSNCB, East Holly Ave. box 56, Pitman, NJ 08071.

Deirdre G. Bauer RN, CMSRN, is a Clinical Coordinator on the Medical-Cardiac Unit, Memorial North Hospital, Colorado Springs, CO, and Treasurer, Medical-Surgical Nursing Certification Board (MSNCB).
to make a mark along the line to represent pain intensity. Another tool is the Numeric Rating Scale, in which the patient is asked to rate pain from 0 to 10, with 0 equaling no pain and 10 indicating the worst pain.

Tools used by researchers and practitioners for thorough pain assessment attempt to assess “some aspects of suffering” (McCaffery & Pasero, 1999, p. 59). These assessment tools – the McGill Pain Questionnaire (Melzack, 1987) and the Brief Pain Inventory – are directed at “the effect of pain on various aspects of living in an attempt to assess the extent to which the person suffers with pain” (McCaffery & Pasero, 1999, p. 59).

Problems with the Assessment and Treatment of Pain

The fact that pain is prevalent in older adults is not in question. Problems do exist, however, in the assessment and treatment of pain. The reasons for this are two-fold. First, untreated pain can lead to a host of problems that impair the overall health of older adults. Sleep may be disrupted, increasing the risk of confusion. This altered sleep-wake cycle may be the manifestation of pain itself or other chronic conditions. Depression may occur as well (Closs, 1996), which can have an impact on the assessment and treatment of pain. Speech difficulties and a decrease in cognition and motor function may also hinder or prevent reporting or expressing pain. Second, the assessment of an older adult patient may not be as complete as it could be. Possible reasons may be generational in nature. Older adults are not used to demanding care, “leading to less willingness to report pain to staff. Resignation to the presence of pain or a wish to not bother others is also common among older adults” (Blomqvist & Hallberg, 1999, p. 160).

Literature Review

The literature clearly identifies that pain is a common factor in the lives of older adults and that there are problems associated with aging that can make the assessment and treatment of pain more difficult. All studies recognized that treatment of pain is complex and should be multidimensional, utilizing both pharmacological and non-pharmacological means of treatment. All studies generally agreed that a precondition for pain management includes awareness by the health care worker that pain does exist, which requires structured and regular assessments (Blomqvist, 2003). One of the main themes expressed throughout the various studies indicated stressors and the individual’s ability to cope effectively with these stressors are major factors in pain management for older adult patients with orthopedic pain.

Stressors identified in these studies include having to cope with pain (chronic and acute), immobility, loss of independence, and financial burdens (Blomqvist, 2003; Bergh, Jakobsen, Sjostrom, & Steen, 2005; Griffiths & Jordan, 1998; Keefe et al., 1987; Martire et al., 2003). Stressors associated with pain and/or injury can have far-reaching physiological and psychological effects (such as impairment of the immune system), excessive release of hormones (such as adrenocorticotropic hormone [ACTH], cortisol, and antidiuretic hormone [ADH]), decreases in release of hormones (such as insulin and testosterone), cardiovascular effects (including hypertension, hypercoagulation, and increased myocardial oxygen consumption), and a decrease in cognitive function (including depression and mental confusion) (McCaffery & Pasero, 1999). These effects “impair the individual’s ability to cope with further stressors” (Griffiths & Jordan, 1998, p. 1277).

Once identified, it is possible to decrease stressors and enhance coping mechanisms by initially increasing attention paid to the technical aspects of pain management, namely decreasing and controlling pain through medication and education (Griffiths & Jordan, 1998). After pain has reached a moderate level of control, it is possible to effectively teach coping mechanisms. Coping strategies include distraction, gentle physical therapy, re-interpretation of pain sensations, prayer, positive self-statements, and concentrating on positive aspects (Blomqvist, 2003; Griffiths & Jordan, 1998; Keefe et al., 1987; Martire et al., 2003). Once these individuals are able to use effective coping strategies, it is found that they have lower pain ratings than the individual who is unable or unwilling to master these techniques, and as a result, will need less medication to control pain (Bergh et al., 2005; Griffiths & Jordan, 1998; Keefe et al., 1987). By decreasing the pain level through the use of medication, it is possible to teach the individual effective coping strategies to decrease the amount of pain medication needed (Griffiths & Jordan, 1998; Keefe et al., 1987).

Evaluation of stressors was accomplished using the Coping Strategies Questionnaire (CSQ) in the study completed by Keefe et al. (1987). The CSQ looked at areas that allowed older adults to handle stressors. Methods included diverting attention, re-interpretation of the pain sensation, ignoring the pain sensation, coping self-statements, praying, or hoping and catastrophizing. All studies reviewed dealt with at least one of these coping strategies, and many dealt with more than one (Bergh, et al., 2005; Blomqvist, 2003; Griffiths & Jordan, 1998; Keefe et al., 1987; Martire et al., 2003).

Active participation by the patient is vital to the success of any health care plan. Decreasing or managing pain in the older adult patient is no different. Keefe et al. (1987) found that individuals who use effective coping strategies have lower pain ratings than those who do not. This, along with increased self-efficacy, has been found to be significant in cases where family members (such as a spouse) also participated in the treatment plan and education (Martire et al., 2003). This study found that couples intervention is more successful in addressing emotional aspects (coping mechanisms) as a couple than in addressing practical aspects.

Another important factor in the development and utilization of these coping skills is the role of the health care provider. Older adults have many ways of describing pain; health care providers must be attuned in order to provide adequate pain control (Bergh, et al., 2005). Descriptive words and pictures are often used to describe pain. Health care providers must develop competency in this area if they are to educate older adult patients effectively. Health care providers’ perceptions of patients’ pain varies widely. In addition, the interpersonal relationship that develops between a patient and the health care provider also influences the provider’s perception of pain (Blomqvist, 2003). These factors can inhibit teaching of the coping strategies necessary to allow the older adult patient a decrease in pain and a more productive and satisfying life.
A troubling item found within one study (Blomqvist, 2003) was that “rather than viewing it (distraction as a coping mechanism) as a natural process, it seemed to reverse them (health care providers) and made them doubt the presence or intensity of the pain” (p. 582). The study goes on to say that “the findings may imply that the care of older people might be improved if the staff created distracting milieus for older people” (p. 582). It is vitally important that health care providers receive the education and training with regard to utilization and benefits of coping mechanisms in order to provide these relief measures.

**Conclusion**

Strong evidence supports the incorporation of teaching coping strategies to older adults experiencing orthopedic pain. Further, it is not adequate to simply address the intensity of pain, but “it is of the utmost importance in health care to take the patient’s descriptions of suffering as the point of departure” (Bergh et al., 2005). In clinical practice, pain assessment is often equated with obtaining a pain intensity level. Other aspects of the pain experience, such as talking about and describing pain, are allowed little attention or completely ignored. Nevertheless, Melzack (as cited by Bergh et al., 2005) stated, “to describe pain solely in terms of intensity is like specifying the visual world only in terms of light flux without regard to pattern, color, texture, and the many other dimensions of the visual experience” (p. 358).

Older adults are at increased risk of suffering from untreated pain. In order to provide adequate nursing care, pain assessment is vital. The assessment should include evaluation of the intensity as well as the quality of the pain and the coping measures in place to help the older adult patient. Furthermore, older adults need to be encouraged to report pain, and it is essential for health care providers to act upon these reports. Further research in this area would prove beneficial to identify which complementary methods of pain management are most effective in alleviating pain in the elderly.

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**References**


The use of non-invasive ventilation in the hospital has saved a multitude of patients from tracheal intubation to support respiratory effort. In the medical-surgical area, Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP) is commonly used for patients at night who have been diagnosed with obstructive sleep apnea. However, as medical-surgical nurses care for more critical patients, BiPAP is used more often as a rescue measure before sending patients to the intensive care unit; BiPAP is also used to support these patients on medical-surgical units. This article will review both of these supplementary respiratory modalities as well as look into the physiology behind each modality and their effects on the body. It will also review the indication of use for each modality as well as the contraindications for use.

The Original Noninvasive Ventilator: The Iron Lung

Remember learning about the days when patients were put in the “iron lung” to support their respiration? This was a form of non-invasive ventilation because a tube was not inserted into patients’ lungs to help them breathe. However, nurses did rely on negative pressure with the iron lung to support respirations.

The patient was placed in an airtight chamber, and pressure was regulated around the patient. When the air pressure in the chamber was lower than the air pressure in the patient’s lungs, the air would move into the patient’s lungs. When the pressure was changed in the chamber so it was higher than the patient’s lungs, the air would passively move out of the lungs. The chamber’s purpose was to act on the intrathoracic pressure of the patient through external pressure surrounding the body. This method simulates what human beings do naturally with respiration muscles and is referred to as negative pressure.

Introducing Positive Pressure

The concept of positive pressure originated around the 1500s when an anatomist and physician named Andreas Vesalius theorized that a person could blow air down the trachea of an animal with a reed to mechanically ventilate the creature (Chamberlain, 2003). It would be quite a few years before Vesalius’ theory became mechanical. Positive pressure devices were limited to use in operating rooms prior to the 1950s, at which time there was a shortage of iron lungs resulting from an outbreak of polio in Denmark. Some of the positive pressure ventilators were brought outside of the operating room setting and were used in the polio wards. Physicians noticed that patients on the positive pressure ventilation had better survival rates than those on the negative pressure of the iron lung (Deis, Abramo, & Crawley, 2008). Positive pressure occurs when air is “forced” into the lungs, thus creating positive pressure in the airway. Positive pressure is used when the trachea is intubated and the patient is placed on a ventilator, or when CPAP and BiPAP is applied to patients. CPAP and BiPAP help support a patient who has respiratory effort, and it is considered an intrusive but not invasive therapy.

When Would Non-Invasive Ventilation Be Used?

The two main goals of non-invasive ventilation are to improve respiratory gas exchange and to decrease the work of breathing (Deis et al., 2008). The main benefit of CPAP is to keep the alveoli open, but it is also used to help support the respiratory muscles and facilitate respiratory compliance (Stoltzfus, 2006). CPAP is used on medical-surgical units typically at night for patients with sleep apnea. The benefit of BiPAP is its effectiveness in reducing muscle workload and more rapidly improving oxygenation (Stoltzfus, 2006). BiPAP is used more as an alternative to endotracheal intubation in the urgent treatment of patients who are in respiratory distress. BiPAP decreases the respiratory workload of patients and improves exchange of respiratory gases. BiPAP is used for patients with acute congestive heart failure (CHF) as well as for patients with sleep apnea.

Positive Pressure and Physiology

The introduction of positive pressure into the lungs helps support patients from at least four perspectives: decreases the work of breathing, improves ventilation, maintains airway patency, and affects the cardiac output (Deis et al., 2008). In this article, the mechanism of action for each will be reviewed and the concepts will be applied.
Work of breathing. When patients are in respiratory distress, they are using their respiratory muscles and their accessory muscles to help them breathe. The introduction of positive pressure from CPAP or BiPAP provides pressure to the patient to help support ventilation, therefore decreasing the work of breathing. The goal is to help with ventilation so the body does not need to expend so much energy on breathing. The patient can only work at breathing for so long before all energy reserves are exhausted, and the patient will stop breathing.

Improves ventilation effort. The positive pressure will help patients who have ventilatory effort, yet who are not breathing enough. BiPAP helps improve the amount of air delivered to patients through positive pressure as well as the volume of air patients receive over a period of time.

Airway patency. The positive pressure delivered through CPAP and BiPAP will help keep the airway and the alveoli open.

Cardiac output. When positive pressure is introduced into the lungs, it increases the entire pressure in the chest, which then decreases venous blood return, preload, and cardiac output. The afterload is the load the patient must eject blood against and preload is the pressure stretching the ventricle after the atrium has contracted. Deis et al. (2008) suggest that the decreased ventricular afterload will actually improve cardiac output with non-invasive ventilation.

Breaking Down the Concepts of CPAP And BiPAP

CPAP is a respiratory modality that provides one continuous amount of pressure to the airways. The pressure is typically set at 4 to 10 cm H2O. The same concept is true with positive end expiratory pressure (PEEP), and CPAP and PEEP are theoretically identical. CPAP is usually delivered via a face mask, nose mask, or nasal prongs (Deis et al., 2008). The continuous pressure being applied never allows the alveoli to completely collapse.

PEEP can be explained this way. Blow up a balloon all the way. Now let about three-quarters of air out of the balloon. The amount of air you have left in that balloon represents the effects of PEEP on the lungs. Now apply the same concept to CPAP. You have a continuous pressure set with air flowing into the lungs. The patient exhales with the pressure flowing into the lungs. The pressure exerted in as the patient exhales should allow the alveoli to remain open and avoid alveoli collapse. The same concept of positive pressure allows the airway to remain open for patients diagnosed with obstructive sleep apnea.

CPAP is one continuous pressure, whereas BiPAP is actually two different pressures – one in inspiration called inspiratory positive airway pressure (IPAP) and one pressure on exhalation called expiratory positive airway pressure (EPAP). The two levels of delivered positive airway pressure make up the Bilevel in BiPAP. The IPAP is typically set between 10 to 25 cm H2O, and the EPAP is typically set between 4 to 10 cm H2O. These ranges of settings will vary based on respiratory therapy policy and procedures, as well as provider preference. The IPAP is set higher because a higher pressure is desired to open the airway and assist respiration. A higher pressure on inhalation is also used when a patient experiences CHF because the fluid needs to be pushed back across the alveolar-capillary membrane into the blood stream so diuretics can take care of the fluid. EPAP is present to keep the airway and alveoli open during exhalation. The use of BiPAP is increasing over the years as an alternative to endotracheal intubation.

CPAP and Sleep Apnea

According to the National Institutes of Health, sleep apnea affects more than 12 million Americans (National Institutes of Health, 2008). Sleep apnea is broken down into three categories: obstructive, central, and mixed (American Sleep Apnea Association, 2008). Obstructive sleep apnea is caused by a blockage in the airway. It typically occurs when the soft tissue in the back of the throat collapses and blocks the airway. During the relaxation of sleep, it will typically result in complete or partial obstruction of the airway. Central sleep apnea occurs when the brain does not tell the body to breathe. Mixed sleep apnea is a combination of both obstructive and central sleep apnea. Positive pressure supplied by either CPAP or BiPAP while the patient is sleeping will help in obstructive sleep apnea by keeping the airway open, thus allowing the patient the restorative benefits of sleep. Many nurses who work night shift will be familiar with the CPAP and BiPAP machines going on for patients with sleep apnea.

It’s All in the Fit

The greatest benefit nurses will see from CPAP or BiPAP is based in the fit of the device used to deliver the positive pressure. From this author’s experience, it is a challenge to get a good fit from the masks used in the adult population to the nasal prongs we use for CPAP in neonates. The key to the success of the therapy is the seal of the device. Patients who come to the medical-surgical unit with their CPAP from home know what they have gone through to get just the right nasal mask that works best for them. There are commercial devices that come with the face mask, nasal mask, or nasal prongs. The best advice is to learn how to use the device to keep the mask or prongs in place. Nurses should assess for air leaks around the mask or prongs and adjust as needed, and remember that practice makes perfect.

Complications from CPAP and BiPAP

Complications typically arise because the device is not properly fitted or there is poor patient compliance of the device. Typical complications are skin irritation, skin breakdown, dry mucous membranes, and gastric distention (Stoltzfus, 2006). Skin breakdown often occurs at the bridge of the nose in adults with a face mask and the nares in pediatric and neonatal population who use prongs. Skin breakdown may occur around any area where the mask or prongs touch the patient. This typically occurs because the mask is fit-
ted too tightly. A good tip from the author’s experience is to apply a piece of hydrocolloid dressing on the bridge of the nose when applying the mask.

There is also a risk of drying of the eyes from leaks in the mask. This again is because of improper fit of the mask. The greatest risk is aspiration, especially with the patient on BiPAP with a full face mask. Gastric distension and vomiting may occur because of high pressures (Stoltzfus, 2006). Major complications are rare but need to be noted. These include tension pneumothorax, depressed cardiac output, increased CO₂ levels in the blood (Deis et al., 2008), and depression and fatigue (Wells, Freeland, Carney, Duntley, & Stepanski, 2007). Contraindications for non-invasive ventilation are respiratory arrest, facial trauma, excessive secretions, risk of aspiration, altered mental status, agitation, and severe hypoxia (Stoltzfus, 2006).

Conclusion

As medical-surgical nurses, we experience new technologies as they emerge in our areas, from the use of CPAP at night for patients with obstructive sleep apnea to caring for our increased-acuity patients with the BiPAP as an alternative for endotracheal intubation and respiratory stabilization. Both methods have their risks and benefits for use. However, nurses continue to find non-invasive ventilation saves a tremendous amount of lives, as well as improves the quality of life for many of patients.

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References


Providing timely information about the upcoming presidential election. AMSN does not endorse specific candidates but provides data for you to make an informed decision.

AMSN’s goal is to be an inclusive community for medical-surgical nurses to effect positive change in their sphere of influence. Our Nurses Nurturing Nurses (N3) mentoring program, led by Margie Escobio, has completed its pilot testing and is available online. Members can be involved by serving as mentors to new graduate members. Our new graduate nurse members can benefit when they sign up as mentees. Recently, scholarships were presented to graduating senior nursing students to become AMSN members and N3 mentees.

Other scholarships and grants are available to members. To advance medical-surgical nursing practice, the AMSN Foundation awards scholarships and grants for advancement of your education and career, attendance at the annual convention, research, certification, attendance at the Nurse in Washington Internship (NIWI) program, and for excellence in care of older adults. Please consider applying for these scholarships and grants, especially as costs continue to escalate.

Last November, we effectively launched Medical-Surgical Nurses Week. Many of you shared how your celebrations highlighted the specialty of medical-surgical nursing within your facilities. We all benefit when we share our successes with one another. Networking with other medical-surgical nursing colleagues is a tremendous benefit of membership. Whether networking is through personal contact at the convention, work on task forces or committees, or via electronic communication, it helps us to be an inclusive community for medical-surgical nurses.

As the direction of our economy remains uncertain, you can count on AMSN to offer you member benefits that are affordable and will help you excel in your medical-surgical practice. I encourage you to take advantage of your benefits and receive value for your membership investment. Use the checklist on this page to be sure you are receiving the most from your AMSN membership.

One definition of the word academy is “a society of learned persons organized to advance art, science, or literature” (Merriam-Webster, Inc., 2008). Thank you for being a member of the Academy of Medical-Surgical Nurses, the specialty organization dedicated to advancing the art and science of medical-surgical nursing. You make a positive difference in our organization and in our profession.

Kathleen A. Reeves, MSN, RN, CNS, CMSRN
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References

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