The purpose of this retrospective study was to analyze the impact of the Rapid Response Team (RRT) intervention in reducing code blue events in the acute care environment, as supported by the National Patient Safety Guidelines (The Joint Commission, 2012).

The Joint Commission (2012) identifies the need for a method to respond to emergent situations as noted in National Patient Safety Goal (NPSG) 16, which states: “The organization is to select a method that enables health care members to request additional assistance from specially trained individuals when a patient's condition appears to be worsening” (p. 47). Consequently, the Institute for Healthcare Improvement (IHI) has organized a campaign to achieve 5 Million Lives Saved, hence establishing a Rapid Response Team (RRT) in every acute care environment as one of the six changes recommended by IHI. In response to this new safety guideline, Martin Health System (MHS) established the RRT and its protocols and procedures in 2005.

MHS, located in southeastern Florida, is a 268-bed medical center on the north side of town and a 100-bed acute care facility at the southern end of town. MHS has Adult, Pediatric, and Maternal-Child RRTs. A nursing supervisor, critical care nurse, and a respiratory therapist are on each team. Any staff or family/visitor who thinks that a patient needs immediate medical attention can activate the RRT (MHS, 2008).

The RRT is described as a “team of clinicians who bring critical care expertise to the patient’s bedside (or wherever it is needed) in the acute care setting” according to the Agency for Healthcare Research and Quality (AHRQ, 2010, p. 608). When called by the medical-surgical nurse, the RRT assesses the patient’s need for a higher level of care or for immediate medical intervention with the goal of preventing imminent cardiac arrest (code blue) or death (Jacobs, 2006; MHS, 2008). The RRT can assist the medical-surgical nurse in communicating and articulating the patient’s sudden change of condition with the attending physician (Shapiro, Donaldson, & Scott, 2010). The competence and empowerment of the medical-surgical nurse is evident by the activation of the RRT.

continued on page 13
I feel very privileged that I have been able to attend national conventions for several years. I always feel rejuvenated because I come back to the workplace with so many new and interesting ideas. One of the sessions that I find especially invigorating is the Town Hall at the AMSN National Convention. It is a great avenue for hearing all the innovative and exemplary activities that med-surg nurses are accomplishing. The title of the Town Hall at the AMSN 21st Annual Convention, recently held in Salt Lake City, was “Exemplary Medical-Surgical Units and Improved Outcomes.”

Here is just a snapshot of some of the activities we heard about, which are occurring throughout the country: 1) Med-surg nurses going down to the ED to greet patients before they arrive on the med-surg unit; 2) Providing a room for “purposeful” napping for staff; 3) Mobilizing a turning team for those patients requiring more than one person for turning; 4) Utilizing stickers when patients accomplish important milestones such as first ambulation or first bowel movement after surgery; 5) Reminding coworkers when they display a negative attitude by flashing a “crabby pants” sticker that is located on the back of their name badge; and 6) Instituting safety rounds. An individual may have suggested each of these initiatives, but it took a team effort to implement them. Now, you might be saying to yourself, “We do that,” or, “What’s so great about that?” Here is your chance to tell other med-surg nurses about your exemplary unit.

Have you heard about the Big Reveal that happened at the AMSN National Convention? If not, let me fill you in on the AMSN PRISM (Premier Recognition in the Specialty of Med-Surg) Award™, which was developed with you in mind. This award is a joint effort between AMSN and the Medical-Surgical Nursing Certification Board (MSNCB). It recognizes elite medical-surgical units for providing exemplary patient care. Isn’t providing exemplary patient care why you became a med-surg nurse? You are responsible for the quality of your own practice but you are also a member of a team, your unit. This award recognizes that team effort. The AMSN PRISM Award will focus on: 1) effective leadership; 2) recruitment and retention; 3) evidence-based practice.
It’s Time to be Recognized

Exemplary performance deserves exemplary recognition, so AMSN and MSNCB have created a new award honoring medical-surgical units for outstanding practice. After all, the best deserves the best!

The AMSN PRISM Award™ will spotlight your unit as a respected model of excellence for others to emulate.

The award will be personally presented to all exemplary medical-surgical units that meet the criteria. Units may apply throughout the year.

Who is Eligible?

• Individual acute care/med-surg units.
• Combined adult/pediatric units classified as med-surg.

How to Apply

Visit www.amsn.org/PRISM for application and instructions.
Prostate Cancer: An Update on Screening and Treatment

Sharon Kumm
Stephanie D. Winright

Prostate cancer occurs in 1 in 6 men and is the second cause of cancer death in men. Routine screening may result in more men being diagnosed with prostate cancer at an early age. Prostate cancer treatment has lifelong consequences of impotence and bladder and bowel dysfunction. Men and their partners need nursing support when making decisions about routine screening and treatment and managing the side effects of treatment.

Risk Factors

The three most common risk factors for prostate cancer are age, race, and family history; however, a high fat diet is an important causative factor. Age is the main risk factor (see Table 2) with the incidence doubling for every decade for men between the ages of 50 and 80. Prostate cancer is rarely seen in men younger than age 40 (Held-Warmkessel, 2006). Black men are more likely to die due to being diagnosed at a more advanced stage of cancer (ACS, 2010). This may be due to Black men having a more aggressive form of prostate cancer (Held-Warmkessel, 2006). Poorer prognosis in Black men is not explained by co-morbidity, prostate-specific antigen screening, or access to free health care. The differences in outcomes may be management or biological (Evans, Metcalfe, Ibrahim, Persad, & Ben-Shlomo, 2008).

A man’s risk doubles if his father or a brother had prostate cancer. Hereditary prostate cancer (mutant gene HPC1) is responsible for 9% of all prostate cancer cases and includes three diagnostic criteria: (1) three or more affected individuals in one family, (2) three generations being affected either on the maternal or paternal side, and (3) two or more relatives affected before age 55 (Held-Warmkessel, 2006). HPC1-linked men develop prostate cancer at a younger age, have higher-grade tumors, and have a more advanced stage of disease at the time of diagnosis. A gene has also been found on the X-chromosome showing a higher incidence of occurrence of prostate cancer between brothers rather than between fathers and sons. A genetic test to differentiate the aggressive form of prostate cancer will soon be available, according the National Cancer Institute (2012).

Clinical Manifestations

Prostate cancer is usually asymptomatic if the cancer is in the periphery capsule of the prostate. See Table 1 for the common manifestations of this type of cancer. Men often ignore early symptoms because they mistake the symptoms for benign prostatic hyperplasia. Malignancy should be considered if the patient has lower urinary tract symptoms without infection (Held-Warmkessel, 2006). As prostatic cancer progresses, urinary frequency, nocturia, and urgency occur as the detrusor muscles and bladder wall weaken. The tumor can extend outside of the gland to the seminal vesicles, bladder, rectum, and pelvic lymph nodes through the prostate capsule or along the ejaculatory ducts. Metastatic lesions cause bone pain in the pelvis and spine, as well as impotence (Held-Warmkessel, 2006).

Objectives

The purpose of this continuing nursing education article is to increase nurses’ and other health care professionals’ awareness of prostate cancer. After studying the information presented in this article, you will be able to:

1. Describe the clinical manifestations of prostate cancer.
2. Identify the risk factors for prostate cancer.
3. Explain treatment options for men with prostate cancer.
4. Discuss the importance of family support for those affected by prostate cancer diagnosis.

Note: The authors, editor, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

This educational activity has been co-provided by Anthony J. Jannetti, Inc. and ANCC.

Anthony J. Jannetti, Inc. is accredited as a provider of continuing nursing education by the American Nurses Foundation’s Commission on Accreditation.

Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nursing, provider number CEP 5387. Licensees in the state of CA must retain this certificate for four years after the CNE activity is completed.

This article was reviewed and formatted for contact hour credit by Rosemarie Marmion, MSN, RN-BC, NE-BC, ANCC Education Director. Accreditation status does not imply endorsement by the provider or ANCC of any commercial product.
Screening

The ACS revised their recommendations for prostate cancer screening in 2010. Table 3 compares the previous recommendations and 2010 ACS recommendations for prostate cancer screening. Prostate specific antigen (PSA) screening has reduced mortality from prostate cancer but not all men diagnosed with prostate cancer die from this cancer. Based on analysis of benefits and adverse effects, The U.S. Preventive Services Task Force has recommended that PSA screening not be performed for prostate cancer (Moyer, 2012). The digital rectal examination is now optional and the time between screenings may be increased from annually to 2-5 years (Schröder et al., 2012).

Treatment

If the screening indicates a possibility of cancer, a prostate biopsy or imaging scans (bone scan, computerized tomography, and magnetic resonance imaging) will be performed. Deciding whether or not to have treatment and which treatment is the best option can be a difficult decision for a man diagnosed with prostate cancer. Treatment options include watchful waiting, surgery, cryotherapy, and/or hormonal therapy.

Table 1.
Symptoms of Prostate Cancer

<table>
<thead>
<tr>
<th>Early Symptoms</th>
<th>Late Symptoms</th>
<th>Metastatic Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hesitancy</td>
<td>Frequency</td>
<td>Impotence</td>
</tr>
<tr>
<td>Diminished force</td>
<td>Nocturia</td>
<td>Bone Pain</td>
</tr>
<tr>
<td>Intermittent flow</td>
<td>Urgency</td>
<td></td>
</tr>
<tr>
<td>Dribbling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Held-Warmkessel, 2006.

Table 2.
Prostate Cancer: Age Adjusted Incidence and Deaths (2007)

<table>
<thead>
<tr>
<th>Age</th>
<th>Incidence</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Races</td>
<td>White Males</td>
</tr>
<tr>
<td>&lt; 65</td>
<td>62.91</td>
<td>59.26</td>
</tr>
<tr>
<td>65+</td>
<td>877.16</td>
<td>850.39</td>
</tr>
<tr>
<td>All ages</td>
<td>165.81</td>
<td>159.25</td>
</tr>
</tbody>
</table>

Rates are per 100,000
Source: Adapted from Altekruse et al., 2010.

Surgical treatment involves a radical prostatectomy for cancer limited to the prostate gland or involvement of nearby areas such as lymph nodes. Transurethral resection of the prostate is used for palliative care to reduce symptoms in men whose cancer has spread to distant lymph nodes, bones, or other organs. Cryotherapy (localized freezing) is an option for local prostate cancer. Patients with advanced stages of cancer may have surgery followed by radiation and/or chemotherapy. Radiation may be external or internal beam, also known as brachytherapy (ACS, 2010; Berthold et al., 2008).

Hormonal therapy (HT) decreases androgen production and is often used in conjunction with surgery or radiation. Decreased androgen production may be accomplished by orchietomy (removal of testes) or by the administration of medications such as the luteinizing hormone releasing hormone (LHRH), antagonists to LHRH, or androgen depression medications. HT is not used as the initial treatment in early cancers because studies have found men do not live any longer than those who do not receive treatment. In advanced cancer, HT does slow the progression of prostate cancer (ACS, 2010).

Chemotherapy may be used in advanced prostate cancer to increase survival by a few months (Berthold et al., 2008). Chemotherapy medications produce the usual side effects of alopecia, stomatitis, anorexia, leucopenia, anemia, thrombocytopenia, nausea, and fatigue.

Treatment Consequences

Surgery, radiation and cryotherapy all result in some degree of urinary, bowel, and sexual dysfunction. A new form of radical prostatectomy is being used that spares the nerves, resulting in less impotence. Men report significant side effects 12 months after treatment with radiation and surgery (see Table 4) (Krofage, Hak, de Koning, & Essink-Bot, 2006). While men consider urinary, bowel, and sexual dysfunctions as problems after prostate treatment they often do not consider these problems health related. They accept the side effects as inevitable consequences of having been treated for a life-threatening condition (Krofage et al., 2006).

Hsiao (2008) investigated how men manage the complications of prostate treatment. Men reported the most effective strategies for urinary symptoms were wearing pads and Kegel exercises, bowel symptoms were managed by rest or simply enduring the discomfort, and sexual dysfunction was managed by expression of feelings or finding alternative ways to express affection.
**Table 3. Prostate Cancer Screening Recommendations**

<table>
<thead>
<tr>
<th>Category</th>
<th>Previous Recommendations (Smith et al., 2001)</th>
<th>2010 Recommendations (Wolf et al., 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Risk</strong></td>
<td>Annual testing of prostatic surface antigen (PSA) and digital rectal exam (DRE) between ages 50-80, for men who have a 10-year life expectancy</td>
<td>Discuss risks, uncertainties, and potential benefits of screening at age 50</td>
</tr>
<tr>
<td><strong>High Risk</strong></td>
<td>Annual Testing of PSA and DRE begin at age 45</td>
<td>Health care provider discusses risks, uncertainties, and potential benefits at age 45</td>
</tr>
<tr>
<td></td>
<td>Asymptomatic men with less than 10 years life expectancy should not be screened</td>
<td>Asymptomatic men with less than 10 years life expectancy should not be screened</td>
</tr>
<tr>
<td></td>
<td>Men with multiple first-degree relatives with prostate cancer before age 65 should begin screening at age 40</td>
<td>Men with multiple family members with prostate cancer before age 65 should receive screening information at age 40</td>
</tr>
</tbody>
</table>

*High risk – Blacks, first-degree relative with prostate cancer before age 65

**Table 4. Side Effects: 12 Months after Treatment for Prostate Cancer**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Surgery</th>
<th>Radiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erectile dysfunction</td>
<td>52-75%</td>
<td>52-75%</td>
</tr>
<tr>
<td>Urinary dysfunction</td>
<td>27-52%</td>
<td>1-8%</td>
</tr>
<tr>
<td>Bowel urgency</td>
<td>6%</td>
<td>28-36%</td>
</tr>
</tbody>
</table>

*Source: Krofage et al., 2006.*

**Psychosocial Effects**

Men experienced shock, devastation, and feeling out of control upon learning they had prostate cancer (Crighton, 2002). Crighton (2002) found men felt the health care system was not always helpful and produced barriers to treatment, decision-making, and obtaining care. Prior to treatment men focused on survival; however, after treatment, the side effects became real. Men felt their own self-care activities empowered them to find creative strategies to regain urinary control, erectile function, and physical stamina (Crighton, 2002).

Female partners of men who had surgical treatment for prostate cancer reported increased need for support and the need to share their experiences. The women experienced confusion and feelings of abandonment when care was transferred back to the primary physician. Men became dependent on women to be the primary caregivers and communicator with health care providers (Evertsen & Wolkenstein, 2010).

**Nursing Implications**

Nurses must be involved in all stages of prostate cancer to assist men and their families in adjusting to the diagnosis and in treatment decision-making. High patient and family anxiety will interfere with comprehension of information regarding alternatives. Nurses can decrease this anxiety by providing concrete information, nonjudgmental listening, and emotional support. Nurses need to remember the decision-making time is a very stressful time and men often overestimate the benefits of treatment and underestimate the decreased life expectancy. Nurses need to assess patient and family comprehension of information provided by physicians, clarify misconceptions, and reinforce explanations. Recognition of patient and family preferences is essential (Evertsen & Wolkenstein, 2010).

Following treatment, both men and their partners require extended support and education about managing the side effects. Referral to a support group can benefit both partners and provide assistance in managing the physical and psychological side effects of treatment. The American Cancer Society or a Web search can provide information about local support groups. Table 5 provides some credible online sites.

In conclusion, while the changes in prostate cancer screening recommendations may be confusing to men, routine screening may result in more men being diagnosed with prostate cancer at an earlier age. Nurses are in an excellent position to help men and their partners navigate all stages of prostate cancer.

**References**


This award is available for any acute care unit that cares for primarily adult/elderly patients with medical-surgical diagnoses. Step-down units or progressive units are not eligible. If a facility has more than one med-surg unit, each unit may apply for the award using a separate application.

AMSN PRISM Awards will be awarded throughout the year. There is no deadline for applications. The cost for the application process is $500, which is less than similar awards for other professional organizations. The award is valid for three years. The award, a 19" x 16" plaque, will be presented at the winning facility by a board member of AMSN or MSNCB. The unit will also be recognized at the AMSN National Convention, which is held in the fall, and on the AMSN and MSNCB Web sites.

This is an exciting time for med-surg nurses. It is a time to highlight your accomplishments in establishing and maintaining a healthy work environment. It is a time to celebrate our commitment to our patients and each other. AMSN wants to support you in meeting the increasingly complex demands of your work environment. The AMSN PRISM Award is a direct response to your request for workplace advocacy. I want to highlight your innovations in a future issue when your unit is awarded the AMSN PRISM Award. Please visit www.amsn.org/PRISM for more information, and start working on those applications!

Kathleen Lattavo, MSN, RN, CNS-MS, CMSRN, RN-BC, ACNS-BC
AMSN President

**Table 5.**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Web Site</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Cancer Society</td>
<td><a href="http://www.cancer.org/cancer/prostatecancer/index">http://www.cancer.org/cancer/prostatecancer/index</a></td>
<td>Information, support, treatment options</td>
</tr>
<tr>
<td>Prostate Cancer Research Institute</td>
<td><a href="http://prostate-cancer.org/pcricms/">http://prostate-cancer.org/pcricms/</a></td>
<td>Decision aide, online support, resource materials</td>
</tr>
<tr>
<td>Women Against Prostate Cancer</td>
<td><a href="http://www.womenagainstprostatecancer.org/">http://www.womenagainstprostatecancer.org/</a></td>
<td>Online support group</td>
</tr>
<tr>
<td>Prostate Cancer Support</td>
<td><a href="http://www.prostatecancersupport.info/">http://www.prostatecancersupport.info/</a></td>
<td>Online support group</td>
</tr>
<tr>
<td>Healing Well</td>
<td><a href="http://healingwell.com/prostatecancer/">http://healingwell.com/prostatecancer/</a></td>
<td>Online support group</td>
</tr>
<tr>
<td>Prostate Cancer International</td>
<td><a href="http://pcainternational.org/">http://pcainternational.org/</a></td>
<td>Information, online support group</td>
</tr>
</tbody>
</table>

---

**President’s Message continued from page 2**

based practice; 4) positive patient outcomes; 5) healthy work environment and 6) lifelong learning.

This award is available for any acute care unit that cares for primarily adult/elderly patients with medical-surgical diagnoses. Step-down units or progressive units are not eligible. If a facility has more than one med-surg unit, each unit may apply for the award using a separate application.

AMSN PRISM Awards will be awarded throughout the year. There is no deadline for applications. The cost for the application process is $500, which is less than similar awards for other professional organizations. The award is valid for three years. The award, a 19” x 16” plaque, will be presented at the winning facility by a board member of AMSN or MSNCB. The unit will also be recognized at the AMSN National Convention, which is held in the fall, and on the AMSN and MSNCB Web sites.

This is an exciting time for med-surg nurses. It is a time to highlight your accomplishments in establishing and maintaining a healthy work environment. It is a time to celebrate our commitment to our patients and each other. AMSN wants to support you in meeting the increasingly complex demands of your work environment. The AMSN PRISM Award is a direct response to your request for workplace advocacy. I want to highlight your innovations in a future issue when your unit is awarded the AMSN PRISM Award. Please visit www.amsn.org/PRISM for more information, and start working on those applications!

Kathleen Lattavo, MSN, RN, CNS-MS, CMSRN, RN-BC, ACNS-BC
AMSN President

**Nurses Still Reign as Most Trusted Professionals**

Nurses consistently place at the top of the Gallup poll list of most trusted professionals in the United States, and 2012 was no exception. Nurses ranked highest in perceived honesty and ethical standards in the annual poll, followed by pharmacists and physicians. Of all respondents, 85% rated nurses’ ethics and honesty as high or very high. To see the complete results, visit http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx
Work Environments

Personal Civility in Health Care

Cheryl Spencer

Bullying has gained significant media attention in recent years. At the forefront of these reports is bullying amongst school-aged children. Some of these reports are about children bullied to the point of suicide. While bullying is not new, the anonymity of the Internet allows bullying to reach victims long after the face-to-face interaction, giving bullies an even larger landscape to abuse their victims. Bullying is not restricted to the playgrounds of elementary schools, the halls of high schools, and college campuses. Bullying is alive and well in health care environments. Hospitals and health care are a reflection of our culture (Kerfoot, 2008). Like news reports, the nursing literature has reports, insights, and recommendations to address bullying and the impact bullying behaviors have on the work environment (Broome & Williams-Evans, 2011; Norris, 2010). Bullying is defined as any type of repetitive abuse in which the victim suffers threats, humiliation, or intimidating behaviors that interfere in job performance (Murray, 2009). Bullying is in need of immediate intervention in the health care environments. The urgency to address bullying behaviors is that just as children have been made to feel uncomfortable in their learning environment, so too do bullied adults feel uncomfortable in their work and learning environments.

Jones-Warren (2011) described bullying as a phenomenon where there is an imbalance of power between the bully and the bullied. The bully is an individual who frequently misinterprets social cues, can be impulsive, insecure, and may exhibit high levels of stress. The bullied individual may also have high levels of stress and may lack self-esteem. A third person, the bystander, is involved in the bullying phenomena and contributes to the continued behavior. The bystander may either identify with the bully or may be fearful of taking a stand in defense of the bullied victim. In most instances, the bystander, whether an individual or a group, has the greatest influence on whether bullying continues. Oftentimes the bystanders and witnesses outnumber the bully, so quick action can defuse a bullying situation (Steward, 2012). Any intervention to curb bullying must focus some energy on the bystander, who through silence and inaction fosters an environment where bullying continues.

Bullying in Nursing

Civility is a polite act or expression of courtesy (Merriam-Webster, 2012). It is an ethical code that people must live by, thus any breakdown results in incivility. Civility is not just merely a nice concept to have in the workplace, but it is necessary for the orderly function of an organization (Kerfoot, 2008). According to Murray (2009), workplace bullying and acts of incivility are a silent epidemic in which the perpetrator attempts to control an individual despite the pain and suffering caused by bullying. In some instances, “bullying behavior also exists because of a white wall of silence that often protects the bully” (Murray, 2009, p. 273). Nurses are taught to report suspected or actual abuse of children and adults as part of their licensure requirement, yet many nurses fail to act when co-workers are being abused. Too often such bullying behaviors are brushed off or minimized. Whenever a bullying behavior is not addressed, it sends a message to the aggressor that the behavior is tolerated. Even worse is the message sent to the receivers of such behaviors that their feelings are not valued and no one will protect them. School-age children who are bullied often change schools to avoid abuse. Likewise, adult workers request a change of assignment to distance themselves from abusive behavior. These actions do nothing to curb the behavior and often the behavior is merely transferred to a new victim.

The health care environment has various roles and responsibilities where nurses must interact with several members of the health care team. Busy, high-volume patient areas and inflexible rules contribute to the incidence of lateral violence (Roche, Diers, Duffield, & Catling-Paull, 2010). Nurses often work in high-stress environments, and when interacting with other health care workers, there is a potential risk for lateral violence. As described by Norris (2010), lateral violence is a threatening act, humiliation, or actual physical, mental, or emotional harm on a peer or group. While these acts appear vivid and harsh, Norris also refers to condescending language, impatience, rudeness, and belittling as other examples of lateral violence. The work environment can evoke fear and anxiety when individuals are exposed to such behavior.

Nurse-Nurse Relationship

Peer relations can be a reservoir for bullying behaviors and while reported by new nurses, experienced nurses are also at risk for lateral violence (Norris, 2010). Competition for promotion can cause nurses to turn against each other. In many organizations, seniority plays a role in vacation and promotion, thus junior employees may feel threatened by senior employees and often feel unrewarded. When organizations fail to follow fair and equitable standards for promotion, it fosters an environment for incivility. Such actions may lead to whisperings and the spread of false accusations. Even discussions about truthful events that have nothing to do with the workplace are also examples of behavior that can disrupt the work environment.

Nurse-Physician Relationship

The nurse-physician relationship is one that has evolved over time and there are reported instances of horizontal violence and incivility from physicians directed at nurses. As the nursing profession has grown and gained its own identity as a profession with varied roles, conflicts arise amongst other professions in the health care environment. Having others understand the roles of nurses is a challenge for many because nurses are no longer just at the bedside caring for clients. Regardless of the nurse’s role, nurses advocate for the best care for those needing care. Physicians, similar to nurses, take an oath to care for others, and nowhere in these oaths is there a line about car-
ing for others by disrespecting others. The health care environment cannot exist without nurses and physicians, and both groups must refrain from bullying each other and instead demonstrate mutual respect in order to foster a healthy work environment.

Educator-Student Relationship

Nursing students and graduate nurses tell their stories of nurse educators who threaten and humiliate them in front of patients, hospital staff, and other students. “New graduates, students, and subordinates may experience a phenomena known in nursing as eating our young” (Broome & Williams-Evans, 2011, p. 32). The irony is that nurse educators are on the frontline when educating students about caring and compassion, yet from the perspectives of some students, the behavior from some educators is anything but caring. The role of the educator is complex, but the educator is expected to model the behavior that is required of the professional nurse; thus, students who learn caring behaviors from educators gain valuable examples of how they should act toward clients.

Incivility among educators and students is a two-way street and students at times demonstrate unprofessional behaviors toward institutions, peers, and faculty (Luparell, 2011). Such behaviors include disrupting classrooms and preventing others from learning. Students also witness faculty who disrespect and demean one another and engage in dishonesty by taking the work of others. In preparation for the workplace environment where graduate nurses will work and faculty will train them, schools of nursing must set clear standards for the professional behaviors of faculty and students.

Nurse-Unlicensed Assistive Personnel

No health care organization could ever survive without all members of the team. The unlicensed assistive personnel (UAPs) who help licensed professionals manage the care of clients often do not receive the credit deserved. These individuals may feel unappreciated and some can be on the receiving end of uncivil behavior. For most nurses, UAPs work hand in hand with them to care for clients. Many UAPs have aspirations of being nurses, while others have attempted nursing school but were unsuccessful. In either instance, the nurse can offer guidance to UAPs and make them feel they are important members of the team.

Creating a Healthy Work Environment

It is important to acknowledge that bullying is real and causes problems that lead to both psychological and physical harm (Jones-Warren, 2011). Dismissing bullying as teasing or making fun minimizes the damage bullying causes and does nothing to curb the behavior. For bullying to cease, the bully needs appropriate coping skills to handle his or her emotions. Efforts must be made to refrain from blaming the victim. The bullied individual also needs to learn techniques for self-protection and to enhance self-esteem (Jones-Warren, 2011). The first step in doing so is that the victim of the bullying must recognize what is happening to him or her (Steward, 2012). The victim must acknowledge that the bully is the problem and in order for the environment to be rid of this behavior, incidences of bullying must be identified and reported.

While there are many roles within health care systems, the nurse interacts with almost all members of the health team. These interactions, when approached in a professional manner, keep the client at the center of care and demonstrate respect for all members of the health care team. These interactions are key to a healthy work environment and, as proposed by the Joint Commission sentinel event, are necessary to reduce errors and improve patient satisfaction (Joint Commission, 2008). Table 1 highlights some common role perceptions and misbehaviors, and offers positive relationship behaviors found in healthy work environments (Kerfoot, 2008).

Conclusion

A healthy work environment is necessary to allow each member of the health care team to develop and contribute to the optimal care for the client. Addressing bullying is the respon-
sibility of all members of the health care team. Greater responsibility may be asked of managers and leaders who set the standards and shape the culture of the working environment. Bullying behaviors and the expected norms are fostered through orientation to the environment and leaders must establish a healthy work environment and hold members accountable for their behaviors. If the leaders are the source of the bullying then changes in the environment may be slow. Workers must not remain silent when bullying is present in the workplace because the action of one affects the entire environment.

The experiences of new nurses to the work environment and appropriate behavior begin with education. Educators must model the behavior that they want students to learn, just as nurses must model behavior for new graduates. Socialization into any culture includes observation of others; thus, when new members observe signs of incivility, they will draw conclusions about the environment that may not be indicative of the thoughts and behavior of all. The health care environment in many instances is fast-paced and stress-inducing and incivility only adds to the level of stress resulting in an unhealthy workplace. This may cause talented individuals to leave the environment because bullying is so intolerable. It takes a brave person to stand up to a bully but often when one person does, it can cause a domino effect and create positive change.

References

Cheryl Spencer, PhD, RN, is Assistant Professor, Nursing, Clinical Instructor and Lecturer, Queensborough Community College, Bayside, NY.

Surprising Origins of Three Common Medications

Jennifer Marvelous

Medications are so widely used that medical-surgical nurses may not give a second thought to the origin of these substances. Chest pain or a potential myocardial infarction, such as seen on the telemetry floor, can lead to orders for a trio of medications as standard protocol in many cases: aspirin, warfarin, and morphine (Braunwald, 2012). Where did these medications originate? The answers may surprise you.

Aspirin

From the classic line of “take two and call me in the morning” to current prophylaxis in cardiovascular disease, aspirin has undergone numerous cultural changes in the United States. Aspirin’s history dates back over 6,000 years to early Mesopotamia, now Iraq, where people left behind clay tablets with instructions on how to use willow leaves for pain and swelling (Mahdi, Mahdi, Mahdi, & Bowen, 2006). The Assyrian people of approximately 3500 BC recorded pharmacological information about willow leaves and also used them for pain and swelling. Archeological information from China and Greece shows that approximately 2,000 years ago, willow bark was again used for pain and inflammation. By 1300 BC, Egyptians were using willow tree extracts for similar reasons (Mahdi et al., 2006).

In modern times, the first documented scientific study of the use of willow leaves and bark for relief of pain and swelling was by Reverend Edward Stone in England in 1763. Stone wrote that he had used a powder made from willow bark to successfully treat malaria-related fevers in 50 of his patients (Miner & Hoffhines, 2007). Over the next century, improvements in chemistry technique enabled scientists to purify and identify a compound from the willow bark that was effective in managing pain and fever. In 1829, it was named salicin from the Latin word for willow. Eight years later, a Sorbonne scientist used salicin to create salicylic acid. In 1853, Charles Frederic Gerhardt created acetylsalicylic acid, but failed to patent it or otherwise profit from it (Miner & Hoffhines, 2007).

In 1897, Fredrich Bayer and Company of Germany had a chemist by the name of Felix Hoffman who developed acetylsalicylic acid. Bayer named the compound aspirin in this manner: ‘as’ from acetyl, ‘spir’ from the spirea plant (which yields salicin), and ‘in’ from a common suffix for medications (Bayer Corporation, 2012). The product was not initially seen as important because Bayer leaders were engrossed in another novel medication they had created in 1897 and were planning to introduce as a cough suppressant – heroin (Miner & Hoffhines, 2007). The heroin distraction, coupled with the doubts about aspirin held by an influential chemist, Heinrich Dreser, slowed the introduction of aspirin to the world. Dreser was convinced to reconsider his opinion; after testing aspirin on himself and rabbits he owned, Dreser reversed his opinion and aspirin was launched in earnest. It soon became known as “the wonder drug” (Miner & Hoffhines, 2007).

The cardiovascular effects of aspirin, primarily in connection with reducing heart attacks, were suggested and documented by a little-known California physician, Lawrence Craven, in the mid-20th century (Miner & Hoffhines, 2007). Craven noticed that women, who tended to seek medical help more often than men and therefore take aspirin more frequently, had a lower inci-
idence of heart attacks. Craven also noticed that people who chewed aspirin tended to experience bleeding gums. In the 1940s and 1950s, Craven recommended aspirin to several hundred men who were judged to be prone to heart attacks—sedentary, overweight men between 45 and 65 years of age. He reported that none of these men died from a blood clot. Craven’s findings were questioned, criticized, and ultimately verified by subsequent studies by the medical community, leading to its use as a prophylactic agent for cardiovascular health today (Miner & Hoffhines, 2007).

**Warfarin (Coumadin®)**

During the 1920s, cattle across the U.S. and Canada were dying from a new disease, and farmers as well as veterinarians wanted to know why. Economic times were harsh and many farmers were feeding lower quality fodder to their cattle, in particular, sweet clover hay that had rotted. In better economic times, farmers would not have resorted to this feed, but now they were doing so in larger numbers and seeing bleeding disorders in their herds. The farmers suspected sweet clover hay was the cause of the new illness and the bleeding disease became known as “sweet clover disease” (Roderick, 1931).

In Wisconsin at the end of 1932, Ed Carlson had lost not only his favorite cow, but four young cattle as well (Duxbury & Poller, 2001). When his prized bull began to bleed from the nose, Carlson decided to seek help from a nearby agricultural station. Carlson drove his van loaded with the evidence—blood, the deceased animal’s remains, and the feed—to Madison to the laboratory of Carl Link and his student Wilhelm Schoeffel. Carlson was advised to use higher quality fodder; provide transfusions for his sick cattle, and was sent away. Carlson deposited his evidence there in the lab and returned home. It was a fortuitous circumstance, because Schoeffel felt for the farmer and Link had recently become involved in the sweet clover issue. Schoeffel experimented on the blood extensively that night, initiating intensive study that resulted in the isolation and identification of dicoumarol, a precursor to warfarin (Stahmann, Huebner, & Link, 1941).

Many people had drawn a connection between the sweet clover and the cattle bleeding disease, but it was not well understood. Over the next six years, using the blood of Carlson’s cattle, Link and colleagues isolated dicoumarol and described the formation of the substance from bacterial action in moist stored sweet clover (Stahmann et al., 1941). A synthetic version of dicoumarol was presented on April Fool’s Day 1940. It is believed that the name warfarin was taken from the initials for the Wisconsin Alumni Research Foundation (Duxbury & Poller, 2001). The most popular use of warfarin at first was as a rat poison, but after it was given to President Eisenhower in 1953 for a coronary thrombosis, its medical reputation soared (Duxbury & Poller, 2001). Americans held the war hero and president in high regard and suddenly saw warfarin as something more dignified and worthy of medical use as opposed to rodent control (Duxbury & Poller, 2001). Warfarin grew to wide international use and was the sole drug used for anticoagulation in thrombotic events until recently (Duxbury & Poller, 2001).

**Morphine**

The milk from the poppy plant of the country of Turkey alleviates pain for patients today much as it has for thousands of years (Pasternack, 2001). The white liquid of the poppy seed pods also forms the basis for a raging drug addiction worldwide, and has been a problem for centuries. In addition to alleviating pain and causing substance addiction, the plant decorates our bagels, produces lovely flowers, and induced sleep for the characters in the movie The Wizard of Oz. The scientific name for the poppy is *Papaver somniferum.* Morphine is one of the pharmaceuticals that has been derived from the poppy plant, along with opium, laudanum, heroin, and codeine. The whole class of medications and recreational drugs known as narcotics owes much to this simple plant. *Papaver somniferum* has provided pain relief to prehistoric peoples of the Middle East, addicted well-to-do British ladies of the 19th century, and is even a modern-day ingredient in Doritos® a la Turka, the packaged snack food called Turkish Doritos (Evered, 2011).

Opium has an extensive and storied history ranging from the Middle East to India, Asia, Europe, and the U.S. dating back to around the 16th century BC (Kramer, 1979). From the eastern Mediterranean area of its origin, it was passed to Greek and Roman cultures. Arabic physicians learned of the medication from the Romans and brought it to Asia in the 7th and 8th centuries (Kramer, 1979). Wherever opium was used, it was noted for its strong palliative and sedative effects. In China, opium use was recreational as early as the 15th century and was addressed as a problem in the 17th century, and led to not one, but two Opium Wars in that country during the 18th and 19th centuries (Vassilev, 2010).

In 1680, a mixture of opium in sherry was called *laudanum* (Santoro & Savica, 2011). A Swiss chemist, Paraclesus, was the first to use and name laudanum. Until the temperance movement of the early 1800s, it and similar opium products were used liberally, without prescriptions or shame, in places as varied as European cities and the American Prairie (Aronson, 2011). Laudanum was freely used to treat various medical conditions such as diarrhea, and during procedures such as childbirth, surgery, and wound care. It was the gold standard for pain relief and sedation for over a century (Aronson, 2011).

Morphine was isolated from opium by Friedrich Wilhelm Sertturner in 1803, who named it *Morpheus* after the Greek god of dreams. Sertturner described its injection as well as topical administration (Santoro & Savica, 2011). The development of the hypodermic needle in 1853 sped up the ease and range of use of morphine (Aronson, 2011).

The opium habit was not restricted to the Chinese, but was also quite a problem for other groups, such as the upper class Britons of the mid-19th century. Wealthy British women were prescribed morphine for various ills, and when they succumbed to morphine addiction (as they frequently did), they became known as “morphinomaniacs” (Zieger, 2005). Opium use meanwhile spread to the western U.S. via Chinese immigrant laborers, and to the eastern U.S. as women with contemporary Victorian ills (such as fainting and hysteria) followed the British trend of morphine use (Zieger, 2005).
By the early 1900s, the problems of addiction to morphine and related substances were alarming, and laws were passed to inhibit the non-medical use of opium products. Today, morphine is a regulated substance and continues to be widely used for pain relief. A surprising twist has come in modern times as endogenous human morphine was suspected in the 1970s, confirmed in the 1980s and continues to be studied today (Neri et al., 2008). Perhaps this area of research will lead to future pain relief by genetic modification of an individual’s morphine-producing capability.

**Conclusion**

Aspirin, warfarin, and morphine have roots far in the past, and have benefited many people. As nurses continue to administer these medications, perhaps they can now see them differently. Nurses can consider the history of these medications – the substance that caused wars, the one that killed cattle, or the one that came from the bark of a willow tree – and have a different perspective as they go through daily medication routines.

**References**


Jennifer Marvelous, MSN, RN-BC, is Staff RN, Telemetry Observation Unit, Einstein Medical Center, Philadelphia, PA.

---

We took everything you need for your job search and put it in one place.

Welcome to the AMSN Career Center – your leading resource for an ideal position or effective recruitment. Job seekers:

- Find the right nursing jobs. Quicker.
- Get job alerts.
- Receive targeted e-mails, e-newsletter content, and career advice.

And if you’re hiring, there’s something for you too. Because we’re connected to other disciplines, your job posting is seen by more people every day.

![We took everything you need for your job search and put it in one place.](Image)

[www.healthecareers.com/AMSN](http://www.healthecareers.com/AMSN)

(888) 884-8242 • info@healthecareers.com
Purpose

The purpose of this retrospective study was to analyze the impact of RRT intervention on the reduction of code blue events in the acute care environment. Other underlying purposes of this study were to identify the communication process among the RRT, nurse, physician, patient, and family members as an integral factor to the success of a rapid response intervention, and to determine how rapid response intervention improves patient outcomes.

Conceptual Framework

The MHS nursing department adapted Roach’s six Cs of caring – compassion, competence, confidence, conscience, commitment, and comportment (Roach, 2002). Roach defines competence as “the state of having knowledge, judgment, skills, energy, experience, and motivation required to respond adequately to the demands of one’s professional responsibilities” (p. 54).

Boykin and Shoenhofer (2001) identified a unique nursing theory focusing on the premise that “caring is the intentional and authentic presence of the nurse with another” (p.13). When nurses care for the patients in a rapid response situation, caring reflects competency in that specific moment in time (Boykin & Shoenhofer, 2001). Caring communicated through authentic presence is the initiating and sustaining medium of nursing within the nursing situation such as the rapid response.

Furthermore, Jean Watson’s transpersonal nursing theory (Watson, 2012) goes beyond the nursing situation where it describes the caring moment as in RRT intervention. Watson (2012) elucidated, “the moment of coming together presents them with the opportunity to decide how to be in the moment…each feels a connection with the other that transcends time and space, opening up new possibilities for healing at a deeper level than physical interaction” (paragraph 7).

Methodology

A retrospective chart review was conducted on 106,630 patients admitted between January 2004 and August 2009. The data, which included the adult, pediatric, and maternal/child populations, revealed the following: mortalities per 1,000 discharges (see Figure 1), utilization of rapid response team per 1,000 discharges, code blue events per 1,000 discharges, code blue events outside ICU per 1,000 discharges, percentage of code blue events outside ICU, percentage of patients who experienced a code blue and returned to spontaneous circulation, and percentage of patients who experienced a code blue and survived and were subsequently discharged.

Data Analysis

The Statistical Package for the Social Sciences (SPSS) was utilized for the purpose of quantitative data analysis. Data analysis revealed the following regarding the utilization of the RRT: 417 (53%) patients were transferred to a higher level of care; 307 (39%) patients were stabilized and remained on the unit; 55 (7%) patients coded, survived, and were transferred to a higher level of care; and 8 (1%) patients coded and expired (see Figure 2). There were a total of 787 RRT interventions whereby 724 (92%) patients were stabilized without progressing into cardiac arrest, and 63 (8%) patients experienced cardiac arrest (see Figure 3). Furthermore, this quantitative analysis revealed that code blue events outside ICU, as well as the mortality rate, decreased after the RRT was imple-
and analytical thinking processes (Parker, 2011). Giving voice and empowering patients and family members in time of crisis reflect nursing as caring by applying competent nursing knowledge and skills (Silverberg, 2011). The nurse’s ethical and social accountability is exercised during a crisis as the family is often distraught and the patient is critically ill (Gadow, 1989). The responsibility to provide competent care moment to moment falls on the shoulders of nurses (Boykin & Shoenhofer, 2001). Obtaining prompt attention from an attending physician and patient cooperation in the medical intervention and decision-making increases trust and improves communication, thus emphasizing the effectiveness of RRTs (Jacobs, 2006).

RRT intervention fulfills the National Patient Safety Goals, which may decrease the incidence of code blue events. Furthermore, patients who have undergone rapid response intervention may experience an increased chance of survival, leading to a decreased length of hospital stay and mortality rate.

### Discussion

Data revealed a reduction of code blue events from January 2004 to August 2009 following the utilization of the RRT (see Figure 1). Findings indicate a marked improvement in the patients’ disposition to a higher level of care in a timely manner or discharge following RRT intervention (see Figure 4), which resulted in a reduction in the mortality rate per 1,000 patient discharges (see Figure 1). Findings validate the importance of adherence to The Joint Commission (2012) National Patient Safety Goals and ultimately accomplishing the IHI (2006) 5 Million Lives Saved campaign.

### Implication for Nursing Practice

Implications for nursing practice include empowering nurses in initiating RRT activation through communication and analytical thinking processes (Parker, 2011). Giving voice and empowering patients and family members in time of crisis reflect nursing as caring by applying competent nursing knowledge and skills (Silverberg, 2011). The nurse’s ethical and social accountability is exercised during a crisis as the family is often distraught and the patient is critically ill (Gadow, 1989). The responsibility to provide competent care moment to moment falls on the shoulders of nurses (Boykin & Shoenhofer, 2001). Obtaining prompt attention from an attending physician and patient cooperation in the medical intervention and decision-making increases trust and improves communication, thus emphasizing the effectiveness of RRTs (Jacobs, 2006).

### References


### Maricel B. Hinkulow, MSN, RN, CNL, OCN, is a Nursing Research Fellow and Staff Nurse, Medical Intensive Care Unit, Martin Health System (MHS), Stuart, FL.

Suzanne J. Crouch, EdD, MSN, ARNP, RN-BC, CNE, is a Professor, Chamberlain College of Nursing, Stuart, FL.

Janice Meadows, MBA, BSN, RN, CEN, is former Assistant Vice-President, Critical Clinical Services, and former Director, Frances Langford Heart Center, Martin Health System (MHS), Stuart, FL.
Med-Surg Nurses Week 2012 Celebrations

Central Indiana Chapter Sponsors Med-Surg Bowl during Special Week

The Central Indiana Chapter #304 sponsored their 5th Annual Med-Surg Bowl during Med-Surg Nurses Week in November. The Med-Surg Bowl is a ‘Jeopardy’ style game testing the knowledge of the players. This year’s event had teams from seven area hospitals. The winning team hailed from Hendricks Regional Health in Danville, IN.

Oaklawn Hospital Drew for AMSN Memberships

Oaklawn Hospital in Marshall, MI, had their 6th annual Med-Surg Nurses Week celebration in November. Door prizes included a “Thanks for all you do” lunchbox and water bottle, and staff were treated to snacks on both shifts on Friday and Tuesday. Nurses were asked to write about “What I Enjoy about Med-Surg Nursing,” and entries were placed in a drawing for two memberships to AMSN.

The responses were posted throughout the unit on November 1, along with AMSN Med-Surg Nurses Week posters. Here’s a sample of some of the encouraging and heart-warming answers:

“Being part of the Oaklawn M/S Team means ‘a working family’ to me. I enjoy coming to work every day, happy, tired, or with my mind elsewhere, knowing that I have fellow, dependable employees to help me through the day. In knowing this, I feel that I am able to better support and care for my patients each and every day.”

– Laura Misiak, RN

“If I was ill or any member of my family needed care, I would feel VERY secure that myself or family is getting the ‘BEST of Care’. What I like about my unit: The compassion for the patients. I feel that they are getting quality care.”

– Sandy Wimberly, Unit Secretary

Chicago Chapter #317

The Chicago Chapter #317 planned for big celebrations during Med-Surg Nurses Week throughout different hospitals in Chicago, including receiving an official proclamation from the Mayor! Baked goods were handed out to every unit. The chapter organized three presentations during the week on Spirituality, Research, and Future of Nursing. AMSN Immediate Past President Sandy Fights gave a keynote speech to 52 nurses in a session that closed the end of the week. The celebrations were a big hit!

Chicago Chapter #317 President Cora Palmer and AMSN Immediate Past President Sandy Fights

Judith A. Paice and Janet Fitzgerald

Presenter Lisa Burkhart and Amanda Thullen

Kerry Shanklin and speaker Sheila A. Haas
Test anxiety is a universal emotion, so you're really going to enjoy this news from the Medical-Surgical Nursing Certification Board (MSNCB). With our new Fail Safe Certification Program™, we’ve eased some of your testing fears and we’ve made it more affordable than ever for you to get certified.

Under the program, if you don’t succeed on your first test-taking attempt, your facility does not have to pay a penny until you pass. That’s why our nurse is jumping with joy, and also why we picked the tagline “Only pay when you succeed, guaranteed!”

Here’s how Fail Safe works:

• A health care facility agrees that within one year’s time, 10 of its medical-surgical nurses will take the certification exam to earn the Certified Medical-Surgical Registered Nurse (CMSRN®) credential.

• If the nurses pass the exam, the facility pays the exam fees.

• If the nurses are unsuccessful, they can take the exam an additional time before the contract ends.

• If the nurses pass the second time around, the facility pays.

• If the nurses do not pass, no one pays.

“The financial aspect alone relieves a lot of pressure for nurses,” said Cynthia Ward, MSNCB president. “And, if you’re a nurse manager, Fail Safe is great because you’re going to have more certified nurses at your facility and that translates to better patient care.”

Ward added that nurses often feel uncomfortable if their institution has paid for them to take the test and they do not pass, so Fail Safe is a great safety net for all parties.

“Nurses get a second chance to take the exam if they need it,” Ward added, “This reduces test stress and fear of failure, and their confidence grows.”

Participating facilities are eligible for a reduced rate on the AMSN Certification Review Course On the Road. Yes, AMSN will bring the course right to your facility! Statistically, the pass rate is higher for nurses whose facilities make special efforts, such as a review course, to prepare their medical-surgical nurses for the exam.

“I’ve seen nurses just fill with pride when they get certified. It’s a great feeling,” Ward said. “That’s why we’re so excited about this program and we know nurses, administrators, managers, everyone... are going to love it.”

Complete information about the MSNCB Fail Safe Certification Program is available at www.msncb.org/fail-safe-program. You can also contact MSNCB at 866-877-2676 or via email at msncb@ajj.com.

MSNCB Board Changes
October 2012

The Medical-Surgical Nursing Certification Board (MSNCB) Board of Directors met in October 2012 for the first time with its new changes. Karen Hein Gregg, RN, CBN, CMSRN, began her new role of Treasurer after serving as Director since 2009. As the new AMSN President, Kathleen Lattavo, MSN, RN, CMSRN, became the ex-officio member of the MSNCB board. Mimi Haskins, MS, RN, CMSRN, began her year as President-Elect before becoming President in the fall of 2013. She joined the board in 2009 and served as Treasurer for the past year. Congratulations, Karen, Kathy, and Mimi, and best wishes in your new roles!
CNSRN (Certified Medical-Surgical Registered Nurse) certification is a rewarding endeavor that reflects specialized knowledge in medical-surgical nursing practice. Here are some of the most common questions about certification and their answers.

Certification

Q: Should I take the CNSRN exam by paper-and-pencil or by computer?

A: This depends on your preference. MSNCB offers the same exam in two different formats. Computer-based testing (CBT) is offered year-round. With CBT, your exam permit assigns a 90-day window within which you schedule your test. You select your exam date and location after you receive your permit. Paper-and-pencil exams (PP) are given twice a year nationally and once at the AMSN Convention. Each PP exam date has an application deadline. The paper exam provides an extra hour to test because we include 25 trial questions which will not be scored. To learn more or apply for either of these exams, go to www.msncb.org/exam-formats.

Recertification

Q: How can I get the CNSRN Recertification Application Guide?

A: If you are recertifying your CNSRN credential in the next year, acquire a copy of the CNSRN Recertification Application Guide from the MSNCB Web site. You can print the full application or download a Microsoft Word version to complete on your computer. You can also ask MSNCB to send you an application by contacting us at msncb@ajj.com or 866-877-2676. All versions of the application must be submitted by mail only. For more information, visit www.msncb.org/recertify.

Miss the Convention? Learn Online

Didn’t make it to convention this year? Through the AMSN Online Library, you can virtually attend any session* of the 21st AMSN Annual Convention held in September 2012. You can browse by speaker, date, or title. If you love it all, you can purchase the entire convention, which gives you access to all the sessions (CNE additional cost). The recorded convention is hosted at www.amsn.org/library.

Save the date for 2013 — AMSN is headed to Nashville, TN, for its 22nd Annual Convention, September 26-29, 2013!

Grants to Support Our Members

AMSN has awarded about $40,000 a year in grants, scholarships, and awards to our members that strengthen the medical-surgical specialty. When nurses are able to go back to school, attend a convention, apply for certification, or conduct relevant research, they engage in ongoing professional development and ultimately, improve patient care. AMSN thanks you for your support of the Scholarships and Grants program, which meets these goals.

If you are a previous AMSN grant or scholarship winner, we’d love to hear about your experience. What did it mean to you? How did it help you improve? Tell us your story at amsn@ajj.com.
Nursing research is often a course that is dreaded by undergraduate nursing students. To combat this issue, a collaborative learning approach to teaching the course was taken by a nursing instructor and reference librarian to increase students’ reflective thinking skills and satisfaction.

Traditionally, nursing students view nursing research as one of the more boring and labor-intensive classes in undergraduate nursing education; however, the course is necessary as nurse educators attempt to spark students’ interest in nursing research to promote better patient outcomes and graduate education. To meet this challenge, a collaborative learning method was piloted at Penn State Worthington Scranton during the fall semester of 2011 where the use of asynchronous discussion boards through the university’s learning management system, ANGEL, was used to promote active and collaborative learning. The discussion boards, as opposed to synchronous discussions, offered students time to reflect on the question and respond within the specified timeframe.

### Literature Review – Collaborative Learning and Reflective Thinking

Collaborative learning, a strategy where partnerships form between those involved in the class, affords teachers and learners the opportunity to participate in the learning process as peers. Collaborative learning in an online environment offers students an alternate setting in a face-to-face course to express their concerns and is more inclusive for introverted students or those who missed opportunities to speak in class (DeYoung, 2009). Popkess and McDaniel (2011) stated that, “…although nursing students are engaged in rigorous curricula, they do not perceive themselves to be engaged in student-centered and interactive pedagogies” (p. 89). By affording students several outlets to share their experiences, an interactive and student-centered learning atmosphere is created.

Self-reflection skills are accepted outcomes of nursing education programs as they are skills necessary to perform at a high level in clinical settings or when entering the research arena. Reflection “enables the students to explore feelings, thoughts, attitudes, and previous experiences” and online discussion forums offer excellent outlets for students to reflect before responding (Hermann, 2006, p. 190). Such conditions support socialization, collaboration, and anxiety reduction. Nurse educators can help students develop reflection skills by creating an environment that builds trust and relationships among the learners and encouraging students to “focus on specific, concrete happenings that were significant to them” (Brookfield, 1995, p. 114). Instructors promote self-reflection by subscribing to learning principles that require actively listening and understanding their students’ various perspectives, which can be accomplished through discussion boards.

### Collaborative Learning in the Course

Institutional review board approval was obtained to collect student data regarding their use of asynchronous discussion forums through collaborative learning. During the first face-to-face class, the course instructor and reference librarian met with the students taking nursing research to explain how the discussion board assignments would be built into the course. A new discussion question (see Table 1) was posted on Monday each week and students were expected to submit their original postings to the question by Wednesday and respond to two peers by Sunday using a thought-extending statement, such as a question, a reference, or an additional idea for peers to consider. The original postings had to be substantial, meaning that the postings had to lead to further thought and feedback, and contain scholarly references.

The discussion forums were monitored by either the course instructor or reference librarian, and comments were made to students as needed. Through collaboration, the course instructor and reference librarian were able to offer the students the best research experience possible through their own unique skill sets. The discussion board questions were designed to help students work through class material and assignments, such as their scholarly paper assignments.

To evaluate reflective thinking, weekly critical incident questionnaires (CIQ) were obtained from the students, which was developed from Brookfield’s (2005) work and used with permission. The tool (http://stephenbrookfield.com/Dr._Stephen_D._Brookfield/Critical_Incident_Questionnaire.html) provided the instructors with qualitative feedback. Finally, a course evaluation survey was conducted at the end of the course to determine student satisfaction levels.

### Results

Results showed that students participated more in the discussion boards during the first four weeks of class when compared to the last three weeks of class. This difference may have to do with the type of questions asked or the increased workload for the students as the semester went on. The quality of the student postings and the CIQ revealed that reflective thinking was enhanced. Students felt engaged, motivated, knowledgeable, and appreciative of the collaborative learning environment.

The course evaluation survey yielded positive results. The majority found that the use of asynchronous discussion boards was valuable to them, would recommend taking other classes that utilized this teaching modality, would apply something that they learned in their professional or academic career, gained knowledge in nursing research from the use of the discussion forums, and agreed that the posting led them to think more critically about the course material. Finally, it should be noted that two of the students were able to present their research at the cam-
To ensure that graduate nurses have the reflective thinking skills necessary to be successful as professionals, it is critical that educators discover innovative ways to enhance these skills. Based on the quality of the student postings and the results of the CIQ and course evaluation surveys, it can be concluded that applying collaborative learning methods in asynchronous discussion boards achieves these goals. This teaching modality has the potential to be applied to other courses and disciplines all while increasing student outcomes and thus, ultimately, patient outcomes.

References

Michael M. Evans, MSN, MSEd, RN, ACNS, CMSRN, CNE, is an Instructor of Nursing, Penn State University, Worthington Scranton Campus, Dunmore, PA.

Tierney Lyons, MLIS, is a Reference Librarian, Penn State University, Worthington Scranton Campus, Dunmore, PA.

Editor’s Note: More information on this topic will be available in future issues of *MedSurg Matters!* Please keep an eye on the “Strategies for Nurse Educators” column for details.

**Table 1. Discussion Forum Topics**

<table>
<thead>
<tr>
<th>Week #1</th>
<th>Introduction of Self</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week #2</td>
<td>Search Strategy</td>
</tr>
<tr>
<td>a. State your clinical question and the significance it has in nursing.</td>
<td></td>
</tr>
<tr>
<td>b. Which search terms will you use? State the terms in Population, Intervention, Comparison, Outcome (PICO) format.</td>
<td></td>
</tr>
<tr>
<td>Week #3</td>
<td>Finding the Evidence: Which information resource(s) did you find most useful for finding articles on your topic and why?</td>
</tr>
<tr>
<td>Sources of Evidence: Discuss the advantages and disadvantages of using primary data analysis, such as original research articles and randomized controlled trials, versus secondary data analysis, such as systematic reviews, meta-analyses, and national guidelines.</td>
<td></td>
</tr>
<tr>
<td>Week #4</td>
<td>Discuss the nursing theory that you are planning on using in your research and how it links to your research.</td>
</tr>
<tr>
<td>Week #5</td>
<td>Describe your proposed implementation and how it can benefit the nursing profession. Are their ethical concerns regarding your proposed research?</td>
</tr>
<tr>
<td>Week #6</td>
<td>Describe how you would disseminate your results.</td>
</tr>
</tbody>
</table>

**Speaking Out on Health Care Reform: A Call for Manuscripts**

*MedSurg Matters!* includes an ongoing column – “Health Care Reform” – which addresses the impact of the Affordable Care Act (2010) as well as the Institute of Medicine (IOM) *Future of Nursing* recommendations on health care and nursing. The first column, which appeared in the September/October 2011 issue, was titled “Patient Protection and Affordable Care Act and the Impact on Medical-Surgical Nursing” and was written by Robin Hertel.

Authors are needed for future columns, in particular to address IOM recommendations for nursing education. Manuscripts are sought on the following topics:

- Life-Long Learning
- Bachelor of Science in Nursing (BSN) Preparation
- Master of Science in Nursing (MSN) Preparation
- Doctor of Nursing Practice (DNP) and Doctor of Philosophy in Nursing (PhD) Preparation
- Funding Sources for Advancing Your Education: government and other incentives for pursuing an advanced degree, cost of the programs, how to find funding, and examples of funding sources

The following are minimal areas to include when addressing education preparation for nursing: overview of the IOM recommendation for nursing education for the specific degree, benefits for attaining an advanced degree (professional, personal, and effect on patient outcomes), core courses, online versus traditional programs, and a list of the top 10 programs.

Queries regarding these and other related topics should be sent to msmnews@ajn.com. Suggested manuscript length is 4-6 double-spaced, typewritten pages (2-3 newsletter pages).

Download the Author Guidelines at http://www.amsn.org/newsletter and get started today!
A Year of Changes: Is Your Profile One of Them?

At the beginning of a new year, we look back at what has changed the year before. Maybe you moved to a new town, started a new position, or celebrated a milestone of being a nurse. Remember to let AMSN know!

In just a few minutes, you can update your information with AMSN. Go online or contact us to update your profile. Check your contact information, change your title, or manage your demographics. Updating your profile helps us to know who you are, how to meet your needs, and how to advocate on behalf of medical-surgical nursing.

**How to Update:** Sign it to my.amsn.org, click *Edit*, and make any necessary changes, or call us at 866-877-2676. AMSN values your privacy and will NOT give out or sell your email address to others. Don’t forget to look over your demographics, too.

Get Ready to Vote!

In May 2013, AMSN members will vote for their next President-Elect and two Directors to lead our organization! Voting is made easy with electronic ballots sent straight to your email. Make sure we have your updated email address so you receive this important link.

AMSN is your specialty organization. Show your commitment and vote for the next Board of Directors!