My first shift as a professional nurse was in a 10-bed inpatient psychiatric unit. The director of the unit was an old friend who insisted that “every nurse needs a basic training in psychiatry,” so, I agreed to work part-time on the unit. On that first night I sat next to Elizabeth, a nurse who was running “wrap-up group,” where patients shared their experience of the day, comparing their treatment during the day with the goals they had set for themselves in the morning.

All of the patients had dual-diagnoses: substance abuse and mental illness. Several of them had been living on the street before coming into treatment. As each one of them talked about their day, Elizabeth looked them in the eyes, smiled, and told them how glad we were to have them on the unit, what good decisions they had made to come into treatment.

Before going to nursing school, I had practiced law for 20 years. I could tell when people were genuine. Elizabeth was completely sincere. She opened her heart in a completely tangible way, and the patients all responded. I was so moved by what I saw that night that I have never really gotten over it. That interaction embodied everything I find compelling about nursing, and it has guided my practice as powerfully working on a med-surg unit as it did working in psychiatry.

continued on page 2
Radical Acceptance
continued from page 1

Elizabeth, as well as the other talented nurses at the Psychiatric Center, gave me a gift that I have tried to pass along in my practice on the medical-surgical unit. The basics of psychiatric nursing not only improve the quality of care for patients, they improve the quality of life for nurses. Learning to engage with patients without being overwhelmed gives nurses access to the emotional richness that keeps our job fresh, interesting, and rewarding.

In her recent book, Educating Nurses, A Call for Radical Transformation, Patricia Benner endorses the same idea while revisiting some of the themes of her previous works, namely The Primacy of Caring (Benner, Surphen, Leonard, & Day, 2010; Benner & Wrubel, 1989). For Benner, knowing how to care for a patient, knowing how to be engaged and involved, is critical to becoming an expert nurse. “[N]urses who did not learn effective skills of involvement...as it related to interpersonal relationships with patients, families, and team members, did not go on to become expert nurses” (Benner et al., 2010, p. 183).

The essential element that often gets lost in teaching psychiatric nursing is that it requires learning particular skills, not possessing a certain personality type. There is a wide variety of personalities among successful psychiatric nurses. They share similar skill sets, just like med-surg nurses. The most basic of these involves learning to validate and normalize patient experience, teaching patients coping strategies, and helping patients dealing with grief and loss. While these approaches can help patients cope, they also help nurses cope, engage with patients without being overwhelmed, and open up to patients without the fear of destroying appropriate boundaries.

Building on the approaches of Cognitive-Behavioral Therapy, Dr. Marsha Linehan created an innovative form of therapy that seeks to help patients reach a balance—or synthesis—between the need to accept their own behaviors and the need to change them (Linehan, 1993). Dialectical Behavioral Therapy (DBT) was originally developed to treat people with Borderline Personality Disorder, but its use has been validated in a wide variety of other disorders.

One of the most instructive DBT techniques is the practice of radical acceptance. Radical acceptance means looking at yourself and the situation and seeing it as it really is without judgment or distortion. It means recognizing that the “present situation exists because of a long chain of events that began far in the past” (McKay, Wood, & Brantley, 2007, p. 10). Radical acceptance does not require endorsing a patient’s viewpoint. It simply means meeting patients where they are, not where you imagine them to be. Radical acceptance means understanding we are all doing the best we can (Dimeff & Koerner, 2007). Imagine radical acceptance as the culture of nursing. When you take over from a nurse who has left some tasks undone, radical acceptance means you don’t make assump-
tions about their work. We as nurses should understand they are doing the best they can. Compassion and kindness toward co-workers is just as nurturing as kindness and compassion to patients.

Validating a patient’s experience is as simple as taking note of the obvious. Needles hurt. Potassium pills are impossible to swallow. Using a bedpan is humiliating. Just acknowledging these truths goes a long way to establishing rapport and trust with patients. Validation strategies are meant not only to communicate empathetic understanding, but also to communicate the validity of the client’s emotions, thoughts, and actions (Dimeff & Koerner, 2007). Validation doesn’t mean endorsing values or behaviors; it simply means acknowledging difficulties. When a patient is belligerent or demanding, sometimes validating his or her pain or loneliness or fear at being in such a strange place can change the patient’s perception—and your perception—of the experience.

Normalizing a patient’s perception of the hospital is simply another kind of validation. Normalizing reassures a patient that his or her pain and fear is to be expected. Anyone would feel the way the patient feels in that situation. The patient is dealing with traumatic experiences in an unfamiliar place with strangers. His or her person is violated in a variety of ways, and the patient loses almost all control over the environment. We can help patients reach “hospital normal” feelings and behavior. By normalizing the hospital experience, we can allow patients to access their own coping mechanisms, to deal with the stress of hospitalization in their own ways. Nurses, thorough in their physical assessment, should complete an inventory of patient-coping skills. It is important to know that your patient listens to music to cope with stress, or needs to knit, or walk. Such simple inquiry can produce significant improvements in increasing patient-coping and reducing patient suffering.

Ultimately, successful nurses are happy nurses. I believe nothing contributes so much to job dissatisfaction and burnout as being unable to do a good job; ultimately, the better our patients feel, the better we feel about ourselves and our work. Therefore, medical-surgical nurses may want to incorporate some of the skills used often by our mental health counterparts to improve both patient and nurse satisfaction.

References

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Primary Biliary Cirrhosis

Primary biliary cirrhosis (PBC) is a serious and life-altering disease that affects mainly women. PBC is slowly progressive and over a period of time may result in cirrhosis and/or liver failure. The etiology of this disease remains unclear. Many patients do not know that they have this disease.

This case study reports the findings on a life experience of a patient just diagnosed with PBC. The pathophysiology, diagnosis, and treatment of one patient diagnosed with PBC are presented. The main symptoms of PBC are fatigue and pruritus, which cause patients to seek medical treatment. These symptoms can be life-altering for an individual. The primary goal is that through this discussion, others may generate additional intervention research to further assist patients with PBC.

Christine, a 49-year-old female, knew nothing about the chronic disease primary biliary cirrhosis (PBC). After three hospital admissions and a battery of diagnostic testing, Christine was diagnosed with early stage II PBC. The entire diagnostic process lasted 18 months. Christine associated cirrhosis with alcoholism, and feared she would be labeled and stigmatized. She had no history of alcoholism and only drank an occasional glass of wine with dinner.

For most patients diagnosed with PBC, the underlying cause of the disease remains unknown. It is extremely important for early diagnosis and treatment to stop the progression of the disease. Without treatment, PBC progresses to cirrhosis and liver failure over 10-20 years. The symptoms usually drive patients to seek medical treatment, or they are diagnosed upon clinical workup for other reasons.

Background

Christine’s medical background includes usual childhood illnesses and type II diabetes mellitus in 1989, which was controlled by diet and exercise. In 1996, she had a tonsillectomy for recurrent throat infections. In 1999, a subtotal laparoscopic hysterectomy was performed for abnormal uterine bleeding. She underwent an oophorectomy in 2003 and hormonal replacement therapy was prescribed. In 2008, Christine was diagnosed with sudden left-sided deafness and a Bone Assisted Hearing Device (BAHA) was implanted. In 2012, a laparoscopic cholecystectomy was performed. Ultimately, Christine was diagnosed with PBC in 2012.

The past family medical history includes a living mother with hypertension, a deceased father who sustained a myocardial infarction (MI), a deceased older sister with colon cancer, and two younger sisters diagnosed with asthma, controlled with medication.

What is PBC?

PBC is a rare, chronic cholestatic liver disease characterized by an immune-mediated destruction of small- and medium-sized intrahepatic bile ducts (Invernizzi, Selmi, & Gershwin, 2010). PBC has an insidious onset and is prevalent in 1:2000 women between the ages of 40-60 years old. The female to male ratio is 10:1. Symptoms include fatigue (present in 11-81% of patients), pruritus (18-41%), and jaundice (Invernizzi et al., 2010). Another common symptom is vague nonprogressive right upper abdominal pain that is reported by 10-30% of subjects who have PBC. Complications associated with PBC include pruritus, fatigue, hypercholesterolemia, portal hypertension, and osteoporosis (Hirschfield, 2011).

Diagnosis

The diagnosis of PBC is derived from a very thorough history, a combination of serum enzymes, and an ultrasound investigation of the liver and biliary tree. The specific enzyme, an ele-
vated alkaline phosphatase, is followed for at least 6 months. If PBC is suspected, a very specific diagnostic test, serum antimitochondrial autoantibodies (AMA), is ordered. The final diagnostic test for PBC is a liver biopsy, which analyzes the histology of the bile ducts for staging purposes (Poupon, 2010).

When attempting to diagnose a patient with PBC, conditions such as gallstones, mechanical problems (tumors, cysts, and strictures), primary sclerosing cholangitis (if AMA negative), non-alcoholic or alcoholic fatty liver, viral hepatitis, and sarcoidosis must be ruled out to determine the true diagnosis (Hirschfield, 2011).

**Etiology**

The causes of PBC are not known. PBC is thought to be a genetic factor with superimposed environmental triggers. There is an increased risk of PBC with a history of vaginal infections, frequent urinary tract infections (UTIs), active or passive smoking, use of replacement hormone therapy, and the frequent use of nail polish (Hirschfield, 2011). Hirschfield (2011) found patients once diagnosed with PBC had other autoimmune diseases. The most frequent autoimmune diseases are: Sjogren’s syndrome (17.4%), Raynaud’s syndrome (12.5%), and 6% report at least one family member with PBC (Hirschfield, 2011).

**Treatment**

Ursodeoxycholic acid (UDCA) is the only FDA-approved medical treatment for PBC. According to Lindor, Therneau, Jorgensen, Malinchoc, and Dickson (1996), UDCA has been associated with a reduction of liver biochemistries, delayed in development of esophageal varices, and improved survival rates. UDCA has not been associated with reduction in fatigue. The usual dose is 13-15 mg/kg/day in divided doses or a single dose. UDCA is an acid and may cause gastrointestinal (GI) upset in some patients. Management with proton pump inhibitor (PPI) may be helpful for patients with GI upset from UDCA. Research has suggested that UDCA is extremely safe and has few side effects. Patients taking UDCA may complain of slight weight gain, usually 2 kg at the beginning of therapy. The goal of UDCA is to provide normalization of serum bilirubin, alkaline phosphatase, and alanine aminotransferase (ALT) or aspartate aminotransferase (AST) levels in the first year of therapy. Beneficial long-term effect of UDCA remains unknown (Kuiper et al., 2009).

There are additional adjunct therapies for patients with PBC. These may include glucocorticoids (prednisone, budesonide) and methotrexate. The glucocorticoids and methotrexate are thought to play a role in reducing inflammation and fibrosis of the hepatic ducts and liver (Poupon, 2010). The last treatment available for these patients is a liver transplant. A liver transplant is considered for those patients in advanced stages of PBC. By consenting for a liver transplant, the goal would be to improve the chance of survival in patients with PBC.

**The Case Study**

Christine started the journey of a medical diagnosis in July 2011. At this time, she presented with vague abdominal pain and nausea. A consultation with her primary care physician (PCP) led to a physical examination, various lab tests, and an ultrasound (US) of the gallbladder (GB). The US showed thickening of the walls of the GB with sludge in the GB and common bile duct (CBD). The abnormal lab reports (see Table 1) were: alkaline phosphatase of 186 units/L (normal levels are 38-126 units/L), AST 60 units/L (normal levels are 8-34 units/L), and ALT 68 units/L (normal levels are 10-44 units/L) (VanLeeuwen & Poelhuis-Leth, 2013). The PCP ordered a repeat liver blood test one month later if symptoms continued.

One month later, Christine’s lab work (see Table 1, August 2011) and condition were unchanged. The PCP analyzed the diagnostic data and could not conclude a true medical diagnosis, so suggested treating symptomatically. She was given a prescription for Phenergan (an antiemetic) as needed for nausea. The vague pain and nausea continued, but she managed to continue with her normal activities. She used the Phenergan only if the nausea was intruding on activities that she needed to complete.

The symptoms continued to be vague through April 2012. Subsequently, Christine experienced intermittent nausea, resulting in weight loss of approximately 10 pounds. She developed fatigue that was not relieved with rest. There was no explanation for the increased fatigue. A short time later,
she became ill with nausea/vomiting and significant right upper quadrant (RUQ) abdominal pain. She was taken to the emergency room and was diagnosed with pancreatitis. (Refer to lab work in Table 1.) Christine’s lipase level was 1257 units/L (normal 73-393 units/L). Several diagnostic tests included computerized tomography (CT) of abdomen, US of abdomen, and Hepatobiliary Iminodiacetic Acid (HIDA) scan. According to VanLeeuwen and Poelhuis-Leth (2013), a HIDA is a nuclear medicine study of the hepatobiliary excretion system used to determine overall hepatic function, gallbladder function, presence of gallstones, and sphincter of Oddi dysfunction. Gallbladder emptying or ejection fraction can be determined by administering cholecystokinin. A normal ejection fraction of the GB is 35-65% (VanLeeuwen & Poelhuis-Leth, 2013). The scan showed an ejection fraction at less than 26%. The lipase slowly decreased and a surgeon was consulted. Two days later, Christine had a laparoscopic cholecystectomy. After a two-day hospital recovery, she was discharged home and lab work was in normal range. Christine rested at home for two weeks, still feeling very fatigued. Over the next few months, she experienced some improvement of energy but felt she still needed extra rest and sleep.

Five months later, she was exercising regularly and walking four miles 3-4 times a week. One morning while walking, she tripped on the sidewalk and fell. She landed on the right side of her abdomen, resulting in a few abdominal scratches with no bruising. She was unable take a deep breath due to the pain. Christine developed severe chills, a fever of 103° Fahrenheit (F), and was diagnosed with pneumonia. The chest x-ray showed left lower lobe (LLL) peribronchialvascular wall thickening consistent with an infiltrate. CT scan of abdomen showed mild bile duct dilatation. She was admitted to the hospital and started on intravenous (IV) antibiotics. Thirty-six hours after hospital admission, she developed Clostridium Difficile Toxin (C. diff).

A gastroenterologist was consulted. A CT scan was ordered and showed dilatation of several ducts in the liver and bloodwork revealed elevation of the liver enzymes (see Table 1, September 2012). The GI specialists diagnosed her with Primary Sclerosing Cholangitis. This is a disease of the CBD involving inflammation of the bile duct, which causes hardening and scarring of the bile ducts (Smeltzer, Bare, Hinkle, & Cheever, 2010). Upon returning home, she slept for many days, still feeling fatigued.

One month later, under the consultation of a GI specialist, she agreed to an outpatient endoscopic retrograde cholangiopancreatography (ERCP). An ERCP allows direct visualization of the pancreatic and biliary ducts with a flexible endoscope after injection of contrast material and using x-rays (Smeltzer et al., 2010). This test showed no gross abnormalities in the structure of the biliary tree (see Figure 1). There were no stones, and a sphincterotomy was performed. A sphincterotomy is performed to allow bile, or gallstones, to enter into the intestines (Smeltzer et al., 2010). The ERCP was conducted to assess for a stone in the CBD that could not be seen on x-ray (See Table 1, October 2012).

After three hospitalizations, Christine still had no answers to the RUQ abdominal pain, nausea, and extreme fatigue. The gastroenterologist suggested a liver biopsy to conduct a histological examination of liver tissues. Realizing the necessity of the procedure for diagnosis and accurate treatment, Christine consented.

The pathology report showed granulomatous inflammation almost exclusively involving the portal tracts with focal bile duct damage. Granulomas are non-necrotizing and are surrounded by a lymphocytic infiltrate with mild spillover into the hepatic parenchyma (Hirschfield, 2011). These findings are consistent with primary biliary cirrhosis, stage II (see Table 1, November 2012).

**Staging of Liver Histological Tissue**

Stage I. Injured bile ducts surrounded by a dense infiltrate of mononuclear cells, most of which are lymphocytes, these florid, asymmetric destructive lesions of interlobular bile ducts are irregularly scattered throughout the portal triads and often seen only on large surgical biopsies of the liver in which adequate representation of small bile ducts occurs; inflammation is confined to the portal triads (Hirschfield, 2011).

Stage II. The lesion is more widespread but less specific; there may be reduced numbers of normal bile ducts within portal triads and increased numbers of atypical, poorly formed bile ducts with irregularly shaped lumina. There is diffuse portal fibrosis and mononuclear cell infiltrates with triads. The inflammation may spill into the surrounding periporal areas and ductopenia in another wise unremarkable liver

**Source:** National Digestive Diseases Information Clearinghouse (NDDIC), 2013.
biopsy should raise the specter of primary biliary cirrhosis. Histology is valuable for prognostic evaluation and treatment strategies (Hirschfield, 2011).

The same day that she received the pathology report, she was sent for an antimitochondrial antibody (AMA) titer. The major hallmark of PBC is the presence of AMA in serum (Poupon, 2010). Antimitochondrial antibodies are found in 90% of patients with PBC. An AMA titer of 1:160 or greater is seen in more than 90% of patients with PBC (VanLeeuwen & Poelhuis-Leth, 2013) Christine’s titer was greater than 320 (see Table 1, December 2012). At this time, she was started on UDCA at 300 mg twice a day. In three weeks, the dose was increased to 300 mg three times a day. She consulted with a liver specialist and is on a waitlist for a liver transplant.

Summary

The majority of patients with PBC have normal life expectancy with treatment. Fatigue has a significant impact on quality of life. Treatment for PBC needs to start early. There is a paucity of research on PBC. Further research may give important insights to help patients cope with this disease. PBC is rare occurrence and may go undiagnosed. This article is being presented in hopes of providing education to other medical professionals who may care for a patient with PBC. The goal is to increase awareness of this disease and provide patients with PBC with quality, evidence-based care.

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A Runaway Train

Just weeks after completing orientation, Susie already had several counselors in her file and multiple comments from peers regarding her weaknesses as a professional nurse. When giving report to the next shift, the nurses were not being kind to her in their comments. Patient safety has to be a primary concern, but there also has to be a way to create a culture of support that helps the new nurses develop. Remember Newton’s law, “a body in motion will remain in motion until acted upon by an external force.” Susie not only has the “group think” that she was not cutting it working against her, but with the constant negative feedback, her own mind was working against her. The conditions were set in place for Susie to fail. It was a “runaway train” that somehow had to be turned around.

Really the first step in stopping this runaway train (the failure of your new nurse) is to manage your own expectations. The Pygmalion Effect, a simple and effective way to boost performance, has repeatedly demonstrated, “Expecting success promotes success and expecting failure increases the likelihood of failure” (Pathak, 2012, p. 46). In essence, the expectations you hold drive the train.

The next step is to CARE. When new nurses make errors, they may feel shame and diminished confidence. A supervisor, mentor, or co-worker can reach out with compassion, acknowledge the complexity of the new nurse’s role, offer reassurance, and provide encouragement. According to Guhde (2005), a second preceptor or “buddy” on the shift following the new nurse led to earlier intervened-tions with problems, improved teamwork between the shifts, and the new nurse receiving more positive feedback. Twibell and colleagues (2012) stated that mentors can be utilized after the initial orientation to provide advice on complex cases, workplace issues, and professional development. Combining the concepts from the two references, a nurse from the next shift could be recruited to take report from Susie and mentor her. In receiving report, the mentor could address knowledge deficits and help her develop critical thinking skills.

Like all nurses, practice satisfaction for new nurses is greatly influenced by practice culture. Respectful peer relationships help the new nurse feel safe enough to admit shortcomings, so true growth and development can occur. If you have a nurse who is struggling, ask yourself if he or she takes responsibility or makes excuses. If he or she is slower to learn and really wants to be a good nurse, you can help that nurse develop. If you are the nurse who is floundering, seek out your own mentor by expressing your strong desire to succeed, or ask your supervisor to assist you. A formal mentoring program may actually prevent a runaway train.

References


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Non-Pharmacologic Methods of Postoperative Pain Management

Cynthia W. Ward

There are many basic nursing activities that can help individuals deal with pain beyond traditional medicines. Many such interventions are described in the following article and are useful in the reduction of pain perception by patients. These techniques can be used in combination with other treatment modalities and should not be relied on as the only method of pain management.

Positioning

Positioning can help relieve muscle pain and promote comfort. Elevating an extremity postoperatively may help prevent edema and decrease pain. Splints or other supportive devices may be used following orthopedic surgical procedures to maintain joints in functional positions and promote comfort. Lying on the right side may be more comfortable for individuals with gastrointestinal disorders (Arnstein, 2010).

Cutaneous Stimulation

Physical non-pharmacologic techniques relieve pain through stimulation to the skin and subcutaneous tissue. Pain relief occurs by interrupting the pain pathway (Ignatavicius, 2013). Although these methods are most often applied directly at the site of the pain, there is evidence that the methods are also effective when applied to other areas, such as proximal or distal to the area of pain or on the opposite side (McCaffery & Pasero, 1999).

Application of Cold or Heat

The application of either heat or cold may decrease the area’s sensitivity to pain and may be used interchangeably. Heat or cold may be useful for muscle spasms, joint stiffness, back pain, or muscle pain. Alternating heat and cold may be more effective than either one alone. With both methods, care must be taken to avoid tissue injury (McCaffery & Pasero, 1999). Particular care should be taken in applying heat or cold to individuals with impaired tissue sensation, peripheral vascular disease, cognitive impairment, bleeding disorders, hypertension, Raynaud’s disease, rheumatoid arthritis, or metastatic tumors (Arnstein, 2010; Zacharoff, Pujol, & Corsini, 2010).

The application of cold is helpful to relieve inflammation, constrict blood vessels, and slow the transmission of pain impulses, which may also help relieve pain (Arnstein, 2010; Ignatavicius, 2013). Cold application is preferred in the case of acute trauma, bleeding, or swelling. It is also effective for headaches, particularly migraines. Cold may be more effective for pain relief than heat and the effect may last longer. Cold application may lead to numbness of the skin, and is contraindicated in individuals with peripheral vascular disease (McCaffery & Pasero, 1999).

Heat application increases blood flow, enhances circulation, and relaxes muscles (Arnstein, 2010; Ignatavicius, 2013). It is especially helpful for conditions such as superficial boils, thrombophlebitis, and for absorption of hematomas after the acute bleeding has ceased. Heat is contraindicated in the presence of acute bleeding (McCaffery & Pasero, 1999).

Massage

Superficial massage aides in relaxation and may relieve muscle pain through relaxing the muscles. Other therapeutic benefits of massage include decreased muscle tension, improved circulation, enhanced sleep, and release of endorphins (Zacharoff et al., 2010). The use of long, slow strokes on the back or shoulders may enhance comfort and relaxation (McCaffery & Pasero, 1999). This type of massage can be used by a family member or caregiver to help soothe the individual. Other types of massage, such as Swedish or Shiatsu are performed by licensed massage therapists.

Massage increases blood flow to the muscles and decreases stress and muscle tension. It may enhance pain relief; however, there have been few clinical trials to measure the effectiveness of massage for pain management (O’Conner-Von, Osterlund, Shin, & Simpson, 2010). Massage is thought to eliminate pain generators, reduce inflammation, and disrupt the psycho-neuro-endocrine pathway. It also provides positive distraction that can help with pain relief. Nursing education traditionally includes basic massage techniques such as the long, light strokes known as effleurage, and kneading or petrissage (Merlo, 2012).

Cognitive-Behavioral Techniques

Distraction

In simple terms, distraction serves to focus the individual’s attention away from the pain. Distraction can include activities such as deep breathing, listening to music, talking to visitors, or watching television (Ignatavicius, 2013). The way distraction works is unclear, but may be due to the fact that less attention is available to focus on the sensation of pain, causing that sensation to be decreased. Distraction may be a useful technique for both acute and chronic pain. Caregivers need to be aware of the use of distraction and avoid labeling individuals as not “looking like” they are in pain (McCaffery & Pasero, 1999).

Relaxation

Relaxation techniques can be either physical or psychological and are used to decrease tension or anxiety (Ignatavicius, 2013). Relaxation may decrease muscle tension and anxiety and reduce the emotional distress associated
with pain. It may be used for any type of pain, but may be most useful with chronic pain. A behavior such as taking a slow, deep breath and letting it out slowly is used to help produce relaxation. Progressive relaxation is another technique. Using this technique, the individual tenses then relaxes various muscle groups. Relaxation techniques may be combined with imagery (McCaffery & Pasero, 1999).

A study of 60 postoperative patients, 1-4 days post surgery, in Turkey who had upper abdominal surgery was conducted to learn the effect of relaxation exercises on postoperative pain. The patients used audiotapes to learn the relaxation exercises. The relaxation exercises included breathing techniques and contracting and relaxing muscle groups. The patients’ pain levels were measured before and after the relaxation exercises were performed. The number of patients who reported no pain increased from 1.7-36.7% after the relaxation exercises. Pain was significantly reduced after the relaxation exercises, with 71.7% of patients reporting less pain (Topcu & Findik, 2012).

**Imagery**

Imagery is a technique where the individual visualizes a location or event that he or she finds pleasurable or meaningful. The sights and smells of the location are included in the imaging. This technique helps distract the individual from the pain (Ignatavicius, 2013).

A randomized, single-blind, quasi-experimental study was done with 44 patients having head or neck surgery as outpatients. All of the patients were given privacy and asked to complete the Amsterdam Preop Anxiety and Information Scale (APAIS) to rate their anxiety and the vertical visual analog scale (vVAS) to rate their pain. The intervention group used headphones to listen to a 28-minute guided imagery compact disc (CD). The patients’ pain was assessed at one hour and two hours after the end of the procedure. The intervention group had a significant decrease in anxiety levels ($p = .002$). There was no significant difference in opioid use between the two groups. The pain level for the intervention group was significantly lower than the control group at 2 hours postop ($p = .041$). The length of stay for the intervention group was lower and approached statistical significance ($p = .055$). There was no significant difference in satisfaction (Gonzales et al., 2010).

**References**


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Repetitive Transcranial Magnetic Stimulation as Potential New Treatment For PTSD

Approximately 20% of combat veterans develop post-traumatic stress disorder (PTSD) with or without concomitant depression (Tanielian & Jaycox, 2008). PTSD has been defined as a mental health disorder triggered by an event outside the norm of human experience, which produces symptoms of intrusive thoughts, hypervigilance, and panic attacks (National Institute of Mental Health [NIMH], 2015). While there is no established standard of care or clinical pathway to treat PTSD, most veterans with PTSD are treated with a combination of antidepressants and cognitive behavior therapy (NIMH, 2015). Results of these treatments have produced mixed and moderate results. Sadly, many of our veterans continue to live with and suffer from the effects of PTSD. PTSD can affect daily life as characterized by hypervigilance, depression, substance abuse, and avoidance of stimuli that may trigger a flashback (NIMH, 2015).

New therapies are on the horizon and show promise in the treatment of PTSD. In recent years, there have been several studies on the use of repetitive transcranial magnetic stimulation (rTMS) in treatment-resistant, combat-related PTSD (Isserles et al., 2013). Many of these studies demonstrate sound methodology, though larger cohorts and additional comprehensive studies are needed (Isserles et al., 2013; Ozur et al., 2014).

rTMS has been used in depressed patients with some success, but is now being found to be efficacious in the treatment of PTSD (Ozur et al., 2014). This non-invasive modality uses an electric coil placed tangential to the scalp with the handle at a 45-degree angle away from the midline to depolarize neurons without triggering seizures or cognitive impairment (Ozur et al., 2014). This magnetic stimulation machine targets the left dorsolateral prefrontal cortex (DLPFC) (Ozur et al., 2014). When used at low-frequency over the right DLPFC, soldiers have reported improved scores in the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) (Ozur et al., 2014). The scores on the Impact of Events Scale – Revised (IES-R) reveal a decrease in hypervigilance (Ozur et al., 2014). Curiously, a high-frequency approach is not used as higher frequency depolarization of neurons in the right hemisphere increases anxiety disorders (Ozur et al., 2014).

Other studies suggest that up to 12 sessions of rTMS can reduce the intrusion symptoms of PTSD (Isserles et al., 2013). Isserles and colleagues (2013) suggested repeated treatments may lessen or actually stop the fear response. This is an important finding as the tamping down of the fear response can reduce the re-experiencing of the combat trauma.

Ozur and colleagues (2014) reported the occurrence of headache as an infrequent side effect of rTMS. No loss of memory or attention has been reported. The treatment has shown no adverse effect on blood pressure or heart rate (Isserles et al., 2013). Nurses should be familiar with exclusionary criteria for transcranial magnetic stimulation including metal in the head or scalp, implantable devices, seizures within the past year, recent substance abuse, and epileptic abnormalities on the screening electroencephalogram (EEG) (Ozur et al., 2014).

References

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Cancer Lobby Day for the Medical-Surgical Nurse

Health care policy affects medical-surgical nurses in their professional role, yet the regulations and legislation are frequently designed without medical-surgical nursing insight. Medical-surgical nurses have valuable knowledge, but lack the access to provide that knowledge and expertise to lawmakers. The Academy of Medical-Surgical Nurses (AMSN) supports med-surg nurses taking an active role in influencing health care policy by participating in civic, local, state, and national initiatives that impact medical-surgical nursing and health care quality in the United States (AMSN, 2012). The Institute of Medicine (IOM) identified situations where nursing is uniquely qualified to step into the leadership role with one unique voice to mediate the technical needs of clinical decisions to promote quality clinical care delivery based on patient needs (IOM, 2010). Medical-surgical nurses are well-positioned to influence public policy.

Cancer Lobby Day 2015

Recently, Leslie Gervase, from the Florida Gulf Coast Chapter #223 of the Academy of Medical-Surgical Nurses, had the opportunity to attend the American Cancer Society Cancer Action Network (ACS CAN) Leadership Summit and Lobby Day in Washington, D.C. This intense, four-day Summit consisted of a discussion of the legislative agenda of ACS CAN for the year, as well as key points in addressing important issues with legislators. Through lecture, group discussions, role playing, and networking with other volunteers, each participant learned valuable skills to proficiently interact with legislators. Discussing why the legislation was important to them, all volunteers were encouraged to share their personal stories and how cancer has impacted their lives. Sharing personal stories brings that connection that statistics do not provide. Providing a personal connection provides clarity and focuses the importance of the issue for the lawmaker and provides the legislator reason to evaluate how the legislation will impact the citizens in the district represented.

The Asks

Participants in the ACS CAN Lobby Day are provided with three “asks” to guide their meetings with legislators. “Asks” unify the mission and message of informed citizens in order to influence the development of sound public policy issues important to constituents. Grassroots efforts illicit transformation and change through effective communication about issues to the legislators. The 2015 legislative asks include requesting for the Congress to support legislation to provide the National Institutes of Health (NIH) with $6 billion increase over the next two years, with $1 billion of that going specifically to the National Cancer Institute (NCI). Supporting the funding of the NIH and NCI ensures the research supported currently will provide the cancer treatments of tomorrow, allowing improvement in quality cancer care (Kohler et al., 2015). In December 2015, Congress approved the largest budget increase for cancer research in more than a decade. The efforts of volunteers at the ACS CAN Lobby Day, along with multiple grassroots efforts by members of the American Cancer Society, positively impacted this new funding level (ACS CAN, 2015).

Second Ask

Palliative care is one of the fastest growing yet most misunderstood trends in health care. While many think of palliative care in terms of end-of-life, hospice-oriented care, its application and potential impact are much broader. More than 90 million Americans are living with serious illness. This number is expected to double over the next 25 years. Palliative care is specialized care provided to patients by a team of doctors, nurses, and other health professionals working together with the patient to control pain and other symptoms, understand the patient’s goals, and explain treatment options (ACS CAN, 2016). This proven approach provides an extra layer of support for patients of any age and at any stage of a serious disease, and can be provided alongside curative treatment. By coordinating care and matching treatments with patient goals, palliative care is thought to be the missing link in the health care arena, which may improve the patient’s quality of life while prolonging survival and lowering health care costs (Temel et al., 2010). Policy changes will alleviate current barriers to accessing palliative care services.

The Palliative Care and Hospice Education and Training Act (H.R. 3119) is currently pending in the House Energy and Commerce Committee of the U.S. House of Representatives. Introduced by Congressman Eliot Engel (D-NY-16) and Congressman Tom Reed (R-NY-23), this legislation seeks to establish Palliative Care and Hospice Education Centers to improve the training of health professionals in palliative care. The legislation would also provide traineeships for advanced practice nursing, as well as establish fellowship

Join AMSN in Commemorating a Milestone

Look for announcements in the MedSurg Matters! newsletter, Med-Surg Nursing Connection enewsletter, member email messages, and on the AMSN website for ways you can participate in the celebration.
programs within the new Palliative Care and Hospice Educations Centers to provide short-term intensive courses focused on palliative care to provide supplemental training for faculty members in medical and nursing schools. The bill directs the NIH to expand national research to improve the delivery of palliative care to patients with serious illnesses (ACS CAN, 2016). Currently, the bill has demonstrated bipartisan support with 19 Republicans and 18 Democrats co-sponsoring the legislation (ACS CAN, 2016).

Ask Three

The Removing Barriers to Colorectal Cancer Screening Bill (H.R. 1220 and S.624) were introduced by Representative Charlie Dent (R-PA-15) and Senator Sherrod Brown (D-OH) due to a problem within the Medicare rules. In 2010, Congress abolished the Medicare patient deductible for routine screening tests due to the proven public health benefits. Currently, if a patient undergoes a screening colonoscopy, there is no charge for the procedure (Centers for Medicare & Medicaid Services [CMS], 2008). Under Medicare, if that patient has a polyp and the polyp is removed during the procedure, the billing for the procedure is changed from screening to diagnostic. When the procedure is diagnostic, the patient is then expected to pay based on the 20% co-pay. Depending on the area of the country, the co-pay is estimated to be between $300 and $700 (ACS CAN, 2014). This is a deterrent to screening for cancer and provides a financial barrier to patients, especially Medicare patients. The Removing Barriers to Colorectal Cancer Screening bill currently has 112 Democratic co-sponsors and 70 Republican co-sponsors for the House of Representatives. In the Senate, there are 20 Democrats and 4 Republicans currently co-sponsoring the legislation (ACS CAN, 2016).

The Personal Connection

Leslie represented Florida District 12 as the Ambassador Constituent Team Lead (ACT) for Lobby Days. She and her fellow volunteers met with Congressman Richard Nugent (R-FL-11), Congressman Gus Bilirakis (R-FL-12), and Eduardo Sacasa, the Legislative Correspondent for Senator Marco Rubio (R-FL). As a medical-surgical nurse and oncology nurse, Leslie was able to provide a unique perspective in the palliative care discussion. Her story involved a friend and mentor who encouraged her participation in volunteer leadership with ACS CAN. He later succumbed to his own personal battle with cancer. Leslie identified her clarifying moment as the day when her friend’s wife called to give her a condition update and requested information on outpatient palliative care services, and there was nothing to offer her. Leslie became determined to make changes for future patients. In addition, she discussed how many of the patients she cares for receive inpatient palliative care services, yet have no way to continue the services after discharge. She also pointed out the misperceptions that continue to exist in her district about what palliative care truly means. Her colleagues discussed their personal stories related to research funding and how the co-pays impact the Medicare beneficiaries of their Legislative districts.

After meeting conclusions, thank you letters were written to each legislator. Since returning from Washington, Leslie has continued to discuss the agenda with local community members and has presented her experience to local community groups. She has also continued her discussion about the legislative agenda with local district representatives within District 12.

Conclusion

Medical-surgical nurses are knowledgeable in practices and policies that influence patient care, and nurses can impact change through participation in nursing organizations such as AMSN and ACS CAN. Informing your local legislators how issues under consideration affect your practice, patients, and profession allows your perspective and your unique expertise to be heard and may alter future policy. Explore opportunities to be involved with policy and legislative processes including the Nurse In Washington Internship (NIWI). Become acquainted with the elected officials at the local level and communicate with the legislative aides regularly to share your opinion. Attend public hearings on a bill, or attend local Town Halls held in your community offered by local, state, and federal leaders. Med-surg nurses’ opinions are valued and can influence legislative and regulatory processes in all levels
of government. Working as an advocate on behalf of your profession is an essential function to promote nursing issues and further advance the profession.

References


Leslie Gervase, BA, RN-BC, OCN, is a Patient Care Leader, Medical-Surgical Unit, Morton Plant North Bay Hospital, New Port Richey, FL. She is President of the AMSN Florida Gulf Coast Chapter #223 and represents the American Cancer Society Cancer Action Network on the ad hoc Committee with the Florida Department of Health, discussing Palliative Care and participating in State and National Lobby Days representing District 12.

Julie Kennedy, MSN, RN, CMSRN, is an Instructor, Millikin University, Decatur, IL. She is a member of the AMSN Board of Directors.

Coming soon in…

- Having a Blast: The Double Meaning for Leukemia Patients
- Understanding Celiac Disease: A Recipe for Nursing Care
- Advanced Medical Directives: Med-Surg Nurses Can Make a Difference
- Hypertension
- Dysphagia: Effects on the Older Adult
- Early Conversations About Palliative Care
- Bottoms Up: Nurse-Driven Pressure Ulcer Prevention for Orthopaedic Patients
- How Does Decreasing Stress Impact the Healthy Practice Environment?
- An Acute Exacerbation of Chronic Heart Failure – A Case Study Describing Standards of Care
- Caring for Patients with Schizophrenia on a Med-Surg Unit
- What Does Certification in Professional Nursing Practice Mean?
- Development of an Evidence Based Algorithm to Standardize Nursing Practice in Management of Enteral Feeding Residual Volumes in the Intensive Care Unit
New Year, New Goals... Patient “NEW”rition!

Now that we are knee-deep in our 2016 goals and resolutions, it is a great time to reflect on our progress. Although many of us tend to set new goals at the beginning of the year, many are lost to failure as the set goals are too "lofty" or unreachable. Many of our New Year’s resolutions involve healthy eating and personally improving our nutrition practices. But what nutrition goals did you set for patient nutrition practices for 2016? What new practices in nutrition can you suggest for your unit to focus on in assuring that our patients are getting the best nutrition support we can provide? As you review and implement your NEW professional goals, include a “NEW”rition focus for your patients!

We already know that estimates show 25-50% of patients admitted to hospitals each year are malnourished and that this affects patients regardless of geography, age, or perceived health (Annals of the New York Academy of Sciences, 2014). We also know that the appearance of our patients does not accurately reflect their nutrition status (e.g., an obese patient may still be malnourished due to poor nutrition access or choices). Furthermore, we know that failure to effectively address nutrition results in delayed recovery, increases complications, and strongly impacts the length of stay (Alliance to Advance Patient Nutrition, 2014).

So, as we consider the year ahead, what steps can you take to get your unit on the path to nutrition success for our patients? What ideas can you hardwire into the practice of your unit to assure that we are addressing all that need nutrition attention?

As part of the Alliance to Advance Patient Nutrition, AMSN is committed to promoting a high level of nutrition awareness and nurse focus in order to support our patients from admission to discharge and throughout the continuum of care. To support this commitment, we formed an online community for Nutrition Leaders on the AMSN website (www.amsn.org), which includes a link to the Alliance to Advance Patient Nutrition site.

The first step is to identify patients at risk and guarantee that we bring in the appropriate resources at the onset of the admission. Once identified, we need to provide education and access to the right nutritional plan, with consideration for oral nutrition therapy even in our mobile, less acute patients who screen as “at risk.” So, what actions can we take as we redesign our care to ensure adequate nutrition for our patients? Some considerations include:

- Offer anti-emetics prior to mealtime to those with nausea.
- Collaborate with dietitians to find oral intake substances/textures to address patients with dysphagia.
- Carefully address patients with swallowing disorders with speech therapy and dietitians to assure all oral options are explored (as well as other routes of nutrition).
- Consider oral supplements (in fact, keep them on your unit for use as needed); they are the first line for supplementation!
- Consider enteral or parenteral nutrition when these ideas are not feasible.
- Maintain hydration and ensure reduced risk of aspiration as well as constipation.

Your challenge (should you choose to accept it, and we hope you do!) is to look at a few ways to enhance nutrition for your patients as we accomplish our intentions and goals for 2016.

“Every careful observer of the sick will agree in this, that thousands of patients are starved in the midst of plenty, from want of attention to the ways which make it possible for them to take food.” ~Florence Nightingale

References


Suggested Readings


Andrea Melendez, MSN, RN, CHTP, HTCP, HSMI, RM, is a Clinical Nurse Specialist, University of Maryland Baltimore Washington Medical Center; Glen Burnie, MD. She is an Associate Nurse Representative for AMSN to the Alliance to Advance Patient Nutrition.

If you have any questions or comments regarding the “Nutrition to Improve Outcomes” column, or if you are interested in writing, please contact Column Editor Beth Quatrara at bad3e@hscmail.mcc.virginia.edu.
Update on Nursing and Health Care
In the Veterans Health Administration

As readers may recall, an article reviewing changes in the U.S. Department of Veterans Affairs (VA) health care system was published in the May/June issue of *MedSurg Matters*! last year (Goldstein, 2015). The article included a series of questions that this author submitted to Kathryn Sapnas, PhD, RN-BC, CNOR, Director of Clinical Strategic Planning and Measurement for Patient Care Services at the VA in Washington, DC, on April 17, 2015. As of the time of publication of the present article, ten months since this request, neither I nor *MedSurg Matters*! has received any response from the VA.

A recent article in *U.S. News and World Report* (Levy, 2015) suggests that little has changed since the initial scandals were reported related to delay in care causing deaths of many veterans. Robert McDonald, the new Director of the Veterans Health Administration (VHA), provided recent testimony to Congress that appears contradictory to reports obtained from veterans and veteran groups who suggest that wait times for care remain long and that no employees have yet been disciplined or fired for falsifying treatment and wait-time statistics (Levy, 2015). Mr. McDonald also reports that 2,300 new nurses were recently hired to address increased demands for care, although this author has had difficulty finding any documentation of this claim online or through the VHA.

It is saddening to find that little has changed after multiple Congressional hearings and hundreds of millions of dollars that have been allocated to solve the identified problems. This author encourages all readers to contact their U.S. Senators and Representatives, asking them to focus on the lack of transparency in the VA health care system as well as continuing deficiencies in care provided.

**References**


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**Editor’s Note:** The opinions and views expressed in this article are those of the author and do not necessarily reflect the views of the *MedSurg Matters*! Editorial Committee, AMSN, or its Board of Directors.