The patient is on the call light. Again! You are three hours into your shift, and you have not opened one chart. Pumps are alarming, medications are overdue, and your stress level is nearing maximum overdrive!

Does this sound familiar? Most nurses have experienced this scenario at least once in their career. It is easy to chalk it up to a needy patient, but have you considered it may be how you’re managing your time? This article discusses utilizing the concepts of “purposeful rounding” and “clustered care” to make the most of your time in the patient’s room, maximize patient outcomes and satisfaction, and finally give you back the time you need.

A study by Stimpfel, Sloane, and Aiken (2012) suggested that 65% of nurses work at least 12-13 hours shifts, with approximately 9% working more than 13 hours per day. Extended work hours have been directly associated with higher premature mortality rates. Stone and Treloar (2015) said, “…compliance with professional standards, such as hand washing in hospitals, decreases…when health professionals are at the end of a long shift” (p. 409). As fatigue increases, productivity decreases and mistakes are made. Therefore, it is important to maximize working hours by utilizing time management strategies that enable nurses to provide patient-specific clustered care that is predictive and methodically planned. Two strategies to achieve this goal include utilization of purposeful rounding and clustering care.

Purposeful Rounding

According to Stanford Healthcare (2015), purposeful rounding is a structured hourly rounding technique that, if used properly, can improve the patient’s overall experience. “Purposeful rounding is a proactive, systematic, nurse-driven, evidence-based intervention that helps us anticipate and...”
During a patient’s hospital stay, there can be a lot of distractions, which can make focusing on any one detail a challenge. Patients “…need help focusing on the few critical changes, practices, and procedures that are most important to pay attention to” both during and after the hospital stay (Gruman, 2012). Discharge teaching should begin on admission and continue throughout the entire length of stay. The nurse should take each opportunity to help the patient connect the dots with each procedure, test, and assessment and explain how it will impact the patient’s discharge and after care. The technique known as teach-back is “a proven method to confirm when the health care professional has explained the necessary information in manner patients can understand” (Tamura-Lis, 2013, p. 267). When a patient can restate a lesson in his or her own words, the nurse can verify patient need.” (McLeod & Tetzlaff, 2015, p. 6). During handoff, the nurse should introduce him/herself, explain the role of the nurse, discuss the plan of care, and formulate goals for the shift. This helps the nurse focus the actions geared toward the patient. The nurse should then educate the patient on the concept of purposeful rounding. Under the purposeful rounding umbrella, we see the following elements: the Four P’s, communication white boards, and discharge teaching.

### The Four P’s

The Four P’s are the foundation of purposeful rounding: pain, position, potty, and possessions (Mercer & Fagan, 2010). With each interaction the nurse and patient have, the nurse should review these foundational areas (see Table 1).

When addressing these needs, the nurse plays a proactive role in prevention of falls and adverse patient events. Berg, Sailors, Reimer, O’Brien, and Ward-Smith (2011) found that when purposeful rounding is utilized appropriately, call light usage decreases 3.7 times per patient per day. One component that is often overlooked when addressing the patient’s needs is that of the family’s questions or needs. The nurse cares for the patient, it is also very important that the family be considered and their needs met. When going through the Four P’s, be sure to ask family members if they need additional blankets, water, directions to the coffee machine, etc. Not only does this help in reducing avoidable interruptions to the patient’s room, it improves the patient’s satisfaction.

### Communication White Boards

The use of patient communication white boards is not necessarily a new concept. These patient-centered boards are meant to improve communication between staff and the patient and encourage patients to actively participate in their own care (Massaro & Murphy, 2013). As the nurse communicates with the patient, the white board should be utilized to document a variety of items (see Figure 1). Depending on the unit in which you work, information can be added or eliminated to better serve your patient population and service line.

### Discharge Teaching

Discharge teaching is one of the most important aspects of purposeful rounding. During a patient’s hospital stay, there can be a lot of distractions, which can make focusing on any one detail a challenge. Patients “…need help focusing on the few critical changes, practices, and procedures that are most important to pay attention to” both during and after the hospital stay (Gruman, 2012). Discharge teaching should begin on admission and continue throughout the entire length of stay. The nurse should take each opportunity to help the patient connect the dots with each procedure, test, and assessment and explain how it will impact the patient’s discharge and after care. The technique known as teach-back is “a proven method to confirm when the health care professional has explained the necessary information in manner patients can understand” (Tamura-Lis, 2013, p. 267). When a patient can restate a lesson in his or her own words, the nurse can verify patient needs.” (McLeod & Tetzlaff, 2015, p. 6).
understanding (Tamura-Lis, 2013). Ensuring the patient understands every portion of care, both during and after a hospital stay, increases the likelihood of positive outcomes and decreases readmissions.

## Clustering Care

Clustering care is another time-saving technique. This technique is used within the Intensive Care Unit and limits sleep disturbances, enabling the nurse to evaluate patient care, postpone non-essential activities, and prioritize interventions (Iversen, Neidig, & Shannon, 2015). This concept can be utilized on a medical-surgical unit in combination with purposeful rounding to maximize time spent with the patient, completing important patient care tasks and prioritizing remaining assignments at times that are more impactful for the patient. If your patient requires medication at a specific time, what other care interventions could you cluster at the time you’re in the room delivering medication? Is a physical assessment due? Does the patient need vital signs soon? Is there a scheduled therapy that can be clustered at the same time? Coordinating with supportive departments such as radiology and physical therapy to deliver care in a collective manner will reduce patient interruptions, allowing for adequate rest.

## From Concepts to Care

So, what does all of this mean to you, the nurse? It means you will see an increase in patient satisfaction and a significant reduction in patient call light usage, therefore decreasing nursing workload (Meade, Bursell, & Ketelsen, 2006).

When you plan your shift, start by mapping out your patient’s necessary tasks that must be completed at a specific time. Look at your own task list and determine what coordinating interventions can be completed at this same time. Upon collection of all materials needed, enter your patient’s room and survey the environment. Does the patient have family or friends present and will they stay the night? After proper introductions, discussion of plan of care, and determination of the patient’s goal(s) for the shift, educate the patient on your use of purposeful rounding and clustering care to enable them more restful periods with fewer interruptions. Discuss potential discharge date(s), if available, and match discharge teaching with current nursing tasks being completed. Be sure to utilize teach-back to ensure adequate retention of the information provided. An example of this is teaching the patient about medication at the time of administration, its use, and potential side effects. Upon completion, ask the patient, “Can you repeat that information back to me? Do you have any concerns about taking this medication at home?” Address the patient’s Four P’s and document all necessary information on the patient’s communication board. Fill the water pitcher and straighten and tidy the patient’s room for safety. Interview the family staying with the patient and determine if there are any needs family members may have. Educate family/friends on the location of refreshment room, vending machines, cafeteria, and other necessary areas within the hospital.

This may seem like a lot to do in one visit into the patient’s room, and you would be right! Spending more time in the patient’s room now will increase your patient satisfaction, lead to positive outcomes for your patients, and give you back the time you need!

## References


Stimpfel, A.W., Sloane, D.M., & Aiken, L.H. (2012). The longer the shifts, the higher the levels of burnout and patient dissatisfaction. Health Affairs, 31(11), 2501-2509. doi:10.1377/hlthaff.2011.1377


Cyndi B. Kelley, MSN, RNC-LRN, is Nurse Manager, Special Care Nursery, Texas Health Presbyterian Hospital, Dallas, TX.
Safe Patient Handling: Keeping Health Care Workers Safe

An increasingly important focus for health care facilities is investing in the human capital that is so vital to the provision of patient care. While investments in caregivers can come in the form of educational credits and clinical ladder programs, investments in provider health and safety are vital for maintaining a viable workforce. Being proactive and taking decisive action to address preventable injuries to nursing and support staff is critical to maintaining a healthy workforce and bottom line. The risk of significant bodily injury in the medical field is real, and these scenarios play out daily in facilities across the nation. This article will highlight the important role that safe patient handling programs play in increasing employee satisfaction, preventing injuries, and reducing worker compensation claims.

Four nurses assist in rolling a 300-pound, unresponsive ICU patient who is unable to follow commands. Can this intervention be performed without injury? In another scenario, a nurse accepts the task of holding a patient on his side while a wound care nurse completes a dressing change on a wound. The dressing change will take 15 minutes to complete. Can the nurse do this without risking injury to him/herself and the patient? Three patient care technicians are helping a patient up from the floor after a fall due to the patient’s inability to bear weight. The patient weighs 186 pounds and offers no real assistance. Data released by the Department of Labor stated that in 2011, injuries among health care workers increased to 6.8 cases per 100 workers (Kuehn, 2013). According to the Bureau of Labor Statistics (BLS), patient handling injuries account for over 200,000 health care worker injuries each year.

The cost of these injuries is astounding; over $7 billion is spent on these types of injuries annually. According to the BLS, strains, sprains, and tears caused by overexertion, repetitive motion, and unexpected patient movements during lifting make up the largest amount of patient handling injuries (BLS, 2016). One in ten nurses report being injured at work three or more times per year; and many of these injuries result in debilitating musculoskeletal injuries (BLS, 2016). Many who experience these injuries are unable to return to the health care profession. In 2015, nurses ranked fifth among all occupations for highest incidence rates of musculoskeletal disorders (MSDs), resulting in days away...
Evidence for Best Practices

Health care facilities’ decision not to implement safe patient handling programs is related to a variety of barriers and facilitators. The most common cited barrier to these programs is cost. The evidence, however, suggests that many safe patient handling programs pay for themselves in a relatively short period of time.

An 18-month observational study that took place at the Veterans Health Administration (VHA) evaluated the effectiveness of a safe patient handling program. The study measured the incidence and severity of patient handling injuries nine months before and nine months after the implementation of the Safe Patient Handling and Movement Project (SPHMP). This project supported the safety of staff and patients. After spending $22 million annually on caregiver injuries, plans for a back injury program were introduced at the VHA in Florida (Powell-Cope et al., 2014).

The SPHMP consisted of the following components: mobility assessment protocol, implementation of patient handling equipment, and six decision algorithms to assist nurses in critically thinking through the best equipment for patient handling. Several lifting resources were implemented for the safety of staff. Peer safety leaders were implemented and known as back injury resource nurses (BIRNs). These nurses were similar to safety coaches, supporting staff as they completed work safely. BIRNs also helped brainstorm the safest and easiest way to transfer and mobilize patients (Powell-Cope et al., 2014).

The study successfully demonstrated that the SPHMP represents a necessary component to decreasing injuries. Prior to the implementation of the program, there was an injury rate of 24.0 per 100 workers per year. There were only 16.9 injuries per 100 workers post implementation (2014).

The costs of medical treatments pre- and post-program implementation decreased by almost $50,000. Absenteeism rates dropped from 256 days to 209 days, and the cost of those lost days went from $24,047 to $18,657. Direct net savings of $2 million savings. It was estimated that it took 4.3 years to break even on the costs of the SPHMP’s initial costs. Limitations of the study included addressing patient satisfaction and quality of care related to the SPHMP, implementing lifting teams for patients whose medical condition prohibits the use of lift equipment, and the fact that workplace design represents a necessary component to decreasing injuries.

Evaluation of Evidence

Many health care settings are considering the implementation of policies preventing manual lifting. Currently, only 11 states have passed laws mandating that hospitals implement “safe patient handling” programs. Those states include California, Illinois, Maryland, Minnesota, Missouri, New Jersey, New York, Ohio, Rhode Island, Texas, and Washington. Texas became the first state to pass legislation for safe patient han-
Mechanical lifting devices provide a safe environment for caregivers to lift, transfer, and reposition patients. The mechanical devices decrease the risk of injuries (falls, skin tears, shoulder dislocations) to patients during lifts and transfers. Often health care workers get so focused on the task at hand during a difficult patient lifting scenario that the transport takes precedence over the privacy and dignity of the patient. Many facilities provide algorithms to support staff in selecting the best lift equipment for each specific patient handling event. By making the care individualized for the patient, autonomy is provided to the patient and makes them part of their own care. Those patients who were immobile and scared to get out of bed before are now willing to get out of bed and get moving. Mobility increases strength, resulting in decreased patient falls, another large cost to health care facilities. Lifting programs positively impact associate satisfaction, patient satisfaction, and create a culture of safety.

**Recommendations**

Safe patient handling and mobility programs (SPHMPs) have been successful for many health care settings around the country. Leadership at St. Vincent Hospital shares the following components for a successful SPHMP. For the success of any program, leadership support and modeling is needed to lead the way. In order to make the SPHMP successful, the bedside experts must be involved in the decision-making process for program implementation. The plan must be realistic and work for staff. Allow bedside staff to assist in the assessment of the unit’s lifting and mobility needs. Ask staff to trial and use equipment before it is implemented, so they can determine if it is appropriate for their patient population. Ask staff where equipment should be stored; it should be in a central location that makes it easily accessible to all staff. Keep all lift equipment together in one place. If the equipment is in one room, but the slings and slide sheets are in another room, it is highly unlikely that the equipment will be used. Appropriate staff training is vital to success. If staff don’t feel well trained or comfortable using the equipment, it hinders use. Caregiver buy-in will make or break the SPHMP. Staff must be aware that this is a priority for leadership and be encouraged to look at the data to determine the success of their collective efforts.

One recommendation that has proven successful is the implementation of safety coaches to ensure safe lifting and mobility is taking place. Safety coaches are the experts on your unit for safe patient handling. Safety coaches can answer lifting and mobility questions, brainstorm the best option to lift and mobilize patients, and troubleshoot concerns. Safety coaches can be recruited through interest and when an associate experiences an injury due to unsafe lifting. These strategies ensure that the experience is personal and provides motivation for the coach to intervene. Once all the pieces of the program are implemented, evaluate the success; look at patient satisfaction, associate satisfaction, and rates of patient handling injuries.

It’s no secret that implementing a lift program is very expensive. Installation of mechanical lifts can cost from $8,000-$10,000 and additional equipment for lifts can cost upwards of $800. The cost savings associated with decreasing associate injuries are considerable. Table 1 provides an example of the costs of associate injuries on a medical unit since 2014. The costs related to these four injuries total $66,052.69 and will continue to increase, as medical attention is needed in the future. This amount does reflect the indirect cost such as injury investigation, lost workdays, lim-

<table>
<thead>
<tr>
<th>Injury</th>
<th>Medical Cost</th>
<th>Compensation Cost</th>
<th>Days of Restricted Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 – Injury 1</td>
<td>$1,170.69</td>
<td>$1,367.85</td>
<td>162 days</td>
</tr>
<tr>
<td>2014 – Injury 2</td>
<td>$10,991.52</td>
<td>$7,185.37</td>
<td>506 days</td>
</tr>
<tr>
<td>2014 – Injury 3</td>
<td>$22,084.63</td>
<td>$12,156.84</td>
<td>540 days, unable to return to work</td>
</tr>
<tr>
<td>2015 – Injury 1</td>
<td>$6,236.54</td>
<td>$4,859.25</td>
<td>20 days</td>
</tr>
<tr>
<td>Total</td>
<td>$40,483.38</td>
<td>$25,569.31</td>
<td>1228 days</td>
</tr>
</tbody>
</table>
ited productivity, replacing injured employees, and/or overtime pay to those covering for the injured employees. The investments in training and equipment can be recouped in three years in lower worker compensation claims.

In 1994, the National Institute for Occupational Safety and Health (NIOSH) released a statement about recommended lifting limits to support the safety of patients and health care professionals. NIOSH recommends a 35-pound maximum lift weight for patient handling (CDC, 2010). This recommendation was set for lifting during ideal circumstances. As the circumstances of patient lifting and mobility become less than ideal, the maximum lift weight becomes drastically less. Examples of less than ideal circumstances are lifting with extended arms, lifting from the floor, lifting with the trunk twisted, or lifting during a shift more than 12 hours long. If the weight being lifted exceeds this limit or circumstances of the lift aren’t ideal, then lifting devices should be used (CDC, 2010).

**Conclusion**

With all the current technology in health care, it is surprising that we are even discussing manual lifting of patients. According to the ANA (2010):

Healthcare professionals should not have to manually lift, transfer, or reposition patients. In reviewing the availability and success of safe patient handling programs that use mechanical lifts, there is no excuse for why the American health care industry has not achieved this support for healthcare professionals. The benefits of adopting a safe patient handling program for employees, employers, and patients have been clearly demonstrated and are difficult to argue.

Passage of legislation is possibly years away. In the meantime, as health care facilities implement safe patient handling programs, it is important to remember the vital pieces to make it successful: leadership support, caregiver buy-in, facility needs assessment, staff training, and availability of equipment. Aside from providing a safe environment for patients and health care workers, a safe patient handling program promotes staff retention and recruitment by showing that leadership cares about safety and prevents health care workers from leaving the profession due to injury. Our nation is currently experiencing a nursing shortage; we can’t afford to lose nurses because of debilitating lifting injuries.

**References**


**Victoria D. Andrews, MSN, CMSRN, CNML,** is Manager of the Medical Progressive Care Unit, St. Vincent Hospital, Indianapolis, IN.

**Erik P. Southard, DNP, FNP-BC,** is Chair and Associate Professor in the Department of Advanced Practice Nursing, Indiana State University, Terre Haute, IN, and a Family Nurse Practitioner.
Things Every Hospitalized Patient Should Know

Recently, Prevention Magazine contacted the Academy of Medical-Surgical Nurses (AMSN) to ask for suggestions relating to what every hospitalized patient should know. The Board of Directors brainstormed and came up with the following list. We are pleased to publish this helpful information in MedSurg Matters! and we encourage our readers to share this list with your patients and colleagues. Congruent with the goals of AMSN and MedSurg Matters!, we hope to keep improving the overall quality of health care, particularly in the acute care setting, where medical-surgical nurses frequently lead change for quality improvement.

When you or a loved one is hospitalized, the following tips can improve your hospital stay:

1. Ask everyone – even your provider – to wash their hands before providing care for you or a loved one.
2. Don’t wait until your pain is out of control to ask for pain medication because then it takes longer to get the pain under control.
3. Never try to climb over the bedside rails. If the nurse says to call for assistance when needing to get out of bed, please call for help. Falls often happen on the way to the bathroom when patients think they are steadier than they really are.
4. Nursing leaders are now required to check in with patients. If a nursing leader comes to talk with you, share any concerns or issues you may have because they are in a position to address the issues.
5. When you come to the hospital (or any medical visit), have a list of the names and dosages of all your medications, as well as the names of those who prescribed them. If you have a smartphone, you can easily keep this information handy in your phone.

IDEAS:

- When caring for my Grandmo, we kept all her current medications posted on the fridge so in case of emergency, we could grab them and go.
- As a family, we also put her med list in the computer so we could print several copies for multiple members of the family to have – just in case we needed it for her.
- When hospital personnel are talking about your medications, remember that it is important to include all medicines – even over the counter (OTC) medications, as well as alternative therapies such as herbal supplements.
6. Have the names and phone numbers of all your health care providers (doctors and nurse practitioners) that you see available.
7. Leave all valuables at home. The nursing staff is focused on taking care of your health needs, and it is hard for them to always keep track of your personal items. Do not bring jewelry, money, special objects, and electronics to the hospital, if possible.
8. Bring a copy of your advance directive or durable power of attorney (DPOA) with you to the hospital, and give your nurses a copy for your medical record.

TIP:

- Along with the DPOA and advance directives, talking to your family about your wishes ahead of time is very helpful. For example, if you know your mom will refuse any surgery, you can head off unnecessary pre-surgical appointments while helping her to navigate the parts of the medical system she’d prefer to utilize.
9. Before any surgeries, ask how many tubes to expect following the procedure. It helps to give an idea of what your recovery will be like and set expectations.
10. If you’re going to the hospital for surgery, be ready to begin moving and walking soon afterwards. The best way to heal after surgery is to move as much as you can to regain your strength and reduce your pain.
11. When you are in the hospital, many people from different areas will be taking care of you. Your nurses coordinate all the communication and the plan of care with these individuals. If you get confused about what is being said to you, your nurse can help clarify the situation and answer any questions about your health care team.
12. Ask lots of questions. Nurses want to help you in any way they can. They want you to understand the hospital experience and your health. Don’t hesitate to use them as a resource.
13. When you are discharged from the hospital, make sure you understand what you need to do at home and what follow-up appointments may be needed. If you need help making appointments, let the nurse know. They can help you coordinate your care or ensure you get assigned to a case manager or care coordination and transition manager who can assist you.
14. Make sure you understand your medications and take them as prescribed. Nurses can explain your medications to you and the reasons you must take them.
15. When you leave the hospital, make sure you know what signs and symptoms should cause you concern and how to seek care should you experience any of them.
16. Don’t go to the emergency room for minor ailments; use it only for real emergencies like chest pain.
17. Listen to your body. If you ever get the feeling that “something is not quite right,” bring it to your nurse’s attention right away.

Hopefully by understanding and following these steps, the hospital experience and overall quality of the health of patients will be enhanced. Remember: when in doubt, wash your hands and call a nurse.

Linda H. Yoder, PhD, MBA, RN, AOCN, FAAN
AMSN President

Copyright MedSurg Matters!, 2017, Volume 26, Number 1, p. 8. Information provided as a courtesy of the publisher, Academy of Medical-Surgical Nurses (AMSN), East Holly Avenue, Box 56, Pitman, NJ 08071-0056. For more information, please contact AMSN by phone at 866-877-2676 or by email at amsn-info@amsn.org.
In Support of Opioid Management Legislation

The Legislative Volunteer Unit recommends that the Academy of Medical-Surgical Nurses (AMSN) support the Opioid Management Legislation signed by President Obama on July 22, 2016. Nurses continue to care daily for patients who are addicted to opioids. As a result, AMSN and its nurse members can play an instrumental role in promoting this legislation as well as its funding. The Legislative Volunteer Unit offers educational resources to AMSN members, which are distributed via various avenues (e.g., the AMSN website, social media, enews, journal, etc.).

Opioid management nurses from the nursing community are needed to collaborate with AMSN and other nursing organizations to demonstrate support for the legislation. This will assist in answering the call to action in dealing with abuse, misuse, and the over-prescribing of opioid drugs.

Strategies like those used in the American Nurses Association (ANA, 2016) roundtable discussion to promote treatment modules other than pharmacological tactics (such as physical therapy, acupuncture, and other holistic approaches) can aid in treatment management of opioid addiction. Dialogue will be necessary with insurance companies to ensure payments are authorized for treating addicted clients in this manner.

Legislation S.524 – Comprehensive Addiction and Recovery Act (CARA) of 2016 – became public law on July 22, 2016. It is a collaborative package that authorizes the federal government to award grants to states for opioid-related initiatives around education, prevention, treatment, and recovery efforts. It improves prescription drug monitoring programs and expands access to the opioid overdose-reversal drug naloxone (U.S. Government Publishing Office, 2016).

According to the legislation, CARA grant efforts will:
1. Create training programs for providers to test co-prescription for at-risk patients.
2. Establish an inter-agency task force that will examine best practices for pain management and pain medication prescription.
3. Raise awareness and education around the safe care of infants born affected by illegal substances.
4. Require the Government Accountability Office (GAO) to track and report on the capacity for inpatient and outpatient treatment for opioid abuse disorders.

As previously stated, AMSN should support this legislation and its funding, seek opportunities to collaborate with other organizations to ensure its continued funding and offer and provide educational resources to nurses regarding this matter. In addition, the Legislative Volunteer Unit will monitor the implementation of the legislation and bring forth ideas to the Board of Directors, where AMSN can further their involvement in this endeavor.

For more information from the Legislative Volunteer Unit or to contact the AMSN Legislative Coordinator, please visit https://www.amsn.org/practice-resources/legislative.

References
The Extremes of Human Experience: Caring for Soldiers Who Have Had to Take a Life in the Line of Duty

As the United States has been at war for the past 15 years, there are currently about 22.5 million U.S. military veterans, yet only about 25% seek medical care through the Veterans Administration (VA) system (Johnson et al., 2013). This means that many U.S. veterans obtain care from community, regional, and acute care settings and, likely, bedside nurses will encounter such patients. Veterans bring a different set of experiences and thinking to the health care system. Bedside nurses may miss important caring interventions if not educated about military culture and the care of the veteran-patient who has taken another human life as part of war. The time that a bedside nurse spends with a veteran-patient may be relatively short, so the nurse is best positioned to provide effective care by understanding the veteran's complex emotions (Aloi, 2011).

Lieutenant Colonel David Grossman has written extensively about the psychological cost of war. Grossman (2001) suggests that humans are wired not to kill those within their own species. He further states that a personal attack is the ultimate event that places a human being outside the realm of human experience. The human condition can tolerate and process events that are labeled “Acts of God” (Grossman, 2001). A close-range interpersonal attack that leads to survival or death of another is essentially murdering oneself as the mirror reflects another human being (Grossman, 2001). Grossman’s research suggests that individual combatants not under a direct Commanding Officer’s supervision at a given moment are likely unwilling to fatally act. There are built-in anthropological mechanisms that prevent humans from killing one another for the purpose of species survival (Roscoe, 2007).

Because humans are averse to killing their own species, many authors have described how thinking about the enemy as different from oneself is a psychological mechanism that can facilitate the work of war. Neurobiologists suggest that humans can repeat distasteful acts due to operant conditioning, resulting in neural pathways that change from the metered behavioral control of the socially restrained frontal cortex to the domination of the primitive reptilian brain (Weist, 2012). This switching of control from the frontal cortex to the reptilian brain occurs as socially unacceptable acts are repeated as an act of learning, which results in the formation of new aberrant neural pathways. Some veterans are told to forget their experiences; however, many veterans struggle with a lifetime of disenfranchised grief and spend years trying to reconcile wartime experiences (Aloi, 2011).

Doka (2002) describes disenfranchised grief as that which cannot be openly acknowledged, socially accepted, or publicly mourned. Many nurses are familiar with the Kübler-Ross (1969) stages of grieving; however, this model does not neatly apply to veterans’ war experiences, as these are outside the normal realm of human experience. The effects of disenfranchised grief on the veteran manifest as low self-esteem and difficulty coping with future losses. It is essential that nursing compassionately acknowledges the soldier’s experiences to assist in reintegration into society (Aloi, 2011).

Stress Injury

As part the nursing curriculum, nurses learn about the stress reaction as a normal physiological sequence of events that occurs when a stressor has been encountered. In the stress reaction situation, the person will return to his or her baseline functioning once the stressor has been removed. Soldiers experience a phenomenon akin to the stress reaction, but which is more devastating, in that the stress response remains active even when the immediate stressor is removed. A stress injury can lead to lifelong regrets and unresolvable internal conflicts, and this cognitive dissonance can be reflected in phrases such as “woulda, coulda, shoulda” (Westphal & Convoy, 2015, p. 7). Bedside nurses must be astute to listen carefully to the patient’s words. The veteran-patient can experience even further cognitive dissonance between his or her secrets of war and the public’s ideal of glorifying the soldier as a hero. When the nurse fully comprehends this idea, the kneejerk response of thanking veterans for their service is better tempered by a sentiment acknowledging their service and asking how they are doing now that they are home.

Informed Nursing Care for the Returning Veteran

Aloi (2011) suggests that nurses must be educated about the concept of disenfranchised grief and explore ways to promote dialogue and coping skills. Soldiers are a vulnerable population that struggles with postwar adjustments. Nurses are encouraged to do reflective self-assessments to clarify their thoughts about wartime events. Nurses can activate these self-assessments by visiting a war memorial to better connect with the history, impact, and personal sacrifice of veterans’ experience (Aloi, 2011).
Nursing Interventions

The nurse can introduce calming breathing exercises at the bedside to facilitate postwar adjustment. Autogenic breathing, often used in the yoga tradition, is a simple technique that can be easily taught and practiced anywhere. Autogenic breathing places the breathing process under the participant’s verbal commands (Sadigh, 2001).

As many nurses know, personalized encouragement is a powerful nursing intervention. Bedside nurses can help veterans take stock of their strengths and weaknesses and emphasize veterans’ strengths (Johnson et al., 2013). It is essential that nurses find a way in with veteran-patients beyond active listening and reducing environmental stimuli. Many practice settings offer complementary and alternative therapies including Reiki and pet therapy, which may be ways to improve interaction with veteran-patients.

Many practice settings today have some type of electronic assessment form with standard questions used to evaluate various body systems. There are several assessment questions that are not codified into a specific form, but that are relevant and important to the care of the veteran-patient. Such questions to consider including in your assessment are (Johnson et al., 2013):

1. Tell me about your military experience and how it is affecting you now.
2. Were you deployed? How does it feel to be home now?
3. Have you had nightmares or other thoughts that keep you from sleep?
4. Have you gone out of your way to avoid certain situations?
5. Are you watchful and easily startled?
6. Do you sometimes feel numb or detached from others and your surroundings?
7. Do you have a safe place to stay?
8. Were you around any dogs on foreign soil? This may help us with your treatment and care.

Bedside nurses are encouraged to learn about the experiences of our returning veterans and the psychological impact of having lived through wartime events. Nurses are encouraged to assess their own personal views of wartime activities and ensure their capacity to care for our returning veterans. Nurses have a short timeframe to care for the veteran-patient, and it is imperative that the dialogue be sensitive and open-ended and not avoidant. Nurses are empowered to broaden their assessment questions to support the veteran-patient if he or she is identified as having cognitive dissonance. Nurses can apply their sensitivity, compassion, and supportive resources to the veteran-patient, backed by a deeper understanding of themselves and the veterans who have had to kill another human being in the line of duty.

References


Patricia J. Bartzak, DNP, RN, CMSRN, is a Clinical Nurse, Burn/Trauma Unit, Brigham & Women’s Hospital, Boston, MA. She is the “Joining Forces” Column Editor.
**Healthy Practice Environments**

**You’ve Come a Long Way, But There is Still a Long Way to Go**

“In order to create a culture of safety, all staff members must feel they work in an environment built on mutual trust and respect. The culture is reflected in the way individual team members communicate with one another both on a daily basis, and when the stakes are high.”

(Lee, Shannon, Rutherford, & Peck, 2008)

In 2008, the Institute for Healthcare Improvement and the Robert Wood Johnson Foundation devoted tremendous resources to improving medical-surgical nursing. There were three goals: “to improve the quality and safety of patient care on medical-surgical units, to increase the vitality and retention of nurses, and to improve the effectiveness of the entire care team” (Lee et al., 2008). They found that optimizing communication and teamwork was the most powerful way to transform care at the bedside. While progress has been made, especially in the area of handoffs, the same challenges still plague health care organizations today. More work needs to be done in interprofessional communication, including conflict management.

In Blosky and Spegman’s (2015) qualitative study on healthy practice environments, they found that nurses felt interaction with co-workers was one of the key factors in workplace health. Nurses did well with co-workers who were trustworthy and accountable. In contrast, co-workers’ negative attitudes tended to be disruptive to the environment. This could range from a bad mood, poor morale, or complaining, all the way to verbal abuse and intimidation. This negativity could undermine teamwork. Participants felt they lacked the skills or feelings of safety to confront and resolve issues directly.

Peer-to-peer relationships exert a powerful influence on workplace health. Positive relationships lead to cohesiveness, high morale, satisfaction, and clinical excellence, while negative peer-to-peer relationships undermine the environment and outcomes (Blosky & Spegman, 2015). With so much at stake, it is important to provide nurses with training and support so they are armed with good communication and conflict management skills. With competing demands, providing a communication and conflict management training may be challenging. However, the reward will be a team that actively supports one another and feels proud of the care they provide.

**Communication Solutions**

With all the evidence showing improved clinical outcomes and patient safety in healthier practice environments, it is part of the nurse’s personal and professional responsibility to acquire skills necessary to improve the work environment. The American Nurses Association (ANA) Code of Ethics provision 6 states, “The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care” (ANA, 2015).

To become a great clinician, one must also be effective in communicating with other members of the interprofessional team caring for a patient. Patient safety must always remain at the top of the radar. In most hospitals or organizations, a process should already be in place that allows you to speak up when there is a safety concern with statements such as those in the Team STEPPS® program — “I am concerned” or “I need some clarity.” Often this is all that is needed for a peer or physician to reflect on an order or action they are about to undertake.

The following four steps from Team STEPPS program can also be used when the stakes are high (Agency for Healthcare Research and Quality, 2009).

1. Describe the situation.
2. Express the concerns about what is happening.
4. State the consequences that could occur if the situation is not addressed.

A great learning practice is to mentally walk through a role play using a prior difficult situation or an imagined one. For example, one could think of a time in his or her practice environment where an advocate was needed for a patient because a physician did not see the importance of what was being communicated. Then, the situation is mentally role played or practiced with a partner, using the four steps. The same four steps may be beneficial in many other areas of one’s personal or professional life. Practicing alternative communication strategies ahead of time — until they become automatic — makes them accessible in stressful situations, when they are most needed.

**Dealing with Conflict**

Unfortunately, with all the differing beliefs, backgrounds, and experience, combined with the stressors inherent in health care, conflict is going to happen. Medical-surgical nurses frequently encounter stressed or emotionally upset patients or even co-workers. The key to maintaining a healthy practice environment is how effectively conflict is handled, especially when the emotions or stakes are high.

In tense situations, conflict can be managed using a compassionate approach called PEARLRA, which supports conversation by decreasing emotions such as anger or fear. PEARLRA stands for Presence, Empathy, Acknowledgment,
Reflect (or reframe), Listen openly, Ask questions (Gerardi, 2015). Responding to people with explanations typically does not work when they are emotional. When someone is upset, blaming, or acting disrespectful, adopting an empathic stance (presence plus active listening) can start to establish connection and diffuse a tense situation. Sometimes what the person thinks he or she is upset about is not at all what is at the heart of the matter. Allowing people to tell their stories can often reveal their true concerns. At this point, a solution can often be found. If someone is yelling or being disrespectful, it is appropriate to ask the person to speak respectfully so his or her concerns can be better heard and understood. Acknowledging others does not mean agreement; it is simply done to reassure them that their concerns are being heard and understood. Reflecting what was heard allows understanding of concerns to be validated or clarified. Reframing is another tool that can be used to enable the situation to be perceived from a different point of view. Practicing reflecting and reframing can help one overcome negative reactions to tense situations. Once someone has been reassured that he or she is being heard, the person often is most responsive to hearing what the other has to say. Gerardi (2015) lists four objectives for creating connection during conflict:

1. Deescalate a situation by noticing and acknowledging the emotional state of others.
2. Elicit insight by revealing others’ concerns, wants, and needs.
4. Clarify what’s possible and realistically move forward.

The SET method is another similar conflict management strategy, allowing concise and effective communication. The steps in the SET method include: Support, Empathy, and Truth. According to Annonio (2016), it is important to follow these steps in order. Support refers to an initial statement meant to reassure the other person that his or her needs matter. It is a statement that begins with “I” and demonstrates concern and a desire to help. Empathy refers to “you,” communicating that “you” understand what the other individual is feeling. The empathy statement allows the person to be able to hear what you are saying in the next step. Truth refers to a realistic and honest evaluation of the problem or situation—focusing on “it.” The truth statement is meant to clearly and honestly respond to the demand without placing blame.

The entire idea of effective conflict management is to focus on honest communication so that all participants feel heard. Understanding the dynamics of conflict management also protects communicators from reacting with negative or defensive responses. Each communication solution requires empathy and the desire to build trust and respect.

Generational differences can also lead to communication conflicts. Understanding and embracing generational differences can also help with many of the daily challenges encountered in workplace communication. Numerous differences in communication patterns and styles are noted between interlocutors over the age of 40 and those under 40. Communication and conflict management are essential in fostering a healthy practice environment that allows good clinical outcomes, job satisfaction, and nurse retention. While each nurse’s personal and professional growth is his or her responsibility, organizations that recognize health care providers as a vital resource invest in their people to give them the tools and skills they need to succeed.

Organizational Implications

With an approaching nursing shortage and many health care organizations struggling with decreasing reimbursement, organizations will not be able to simply attract and retain talent by salary alone. Culture will be another component to attracting the best talent to one organization versus another (Rosenstein, Dinklin, & Munro, 2014). Building teams with effective communication and conflict resolution can help create a desirable culture. A culture that cultivates true collaboration and where people have the necessary skills and feel safe to address non-optimum behaviors at all levels allows for more productive interactions and better outcomes. These skills are directly relevant to the challenges nurses and nursing leaders face daily as they work in an emotionally charged environment with both their teams and patients. Organizations that can attract and retain the best talent will be successful in optimal health care outcomes.


References


Debra Kahnen, BSN, RN, CMSRN, is a Nursing Supervisor, Baylor Scott & White Health, Dallas, TX. She is the “Healthy Practice Environments” Column Editor.
Safer, Higher Quality Patient Care: Are We There Yet?

I remember the first electronic health record (EHR) I had the opportunity to use in clinical practice. It was in the late 1990s, and the ICU where I practiced implemented terminals in each ICU pod so that we could document patient admission assessments electronically. We were so excited… at least at first. The record was not accessible for editing after it was completed. We could not review the admission assessment if the patient was transferred to another care area and then transferred back to the ICU. We could not view records from other areas (Emergency Department, Operating Room, other nursing units). The workstation basically had all the functionality of an electronic typewriter. Of course technology was crawling through infancy as evidenced by my ‘mobile phone,’ which was the size of a carry-on suitcase. Things have really changed in the last 20 years!

Since 2009, the federal government has used financial incentives to entice hospitals and physician’s offices to implement EHR – to the tune of $31 billion (Centers for Medicare & Medicaid Services, 2015). EHR documentation has been associated with a decrease in hospital-acquired pressure ulcers, but patient fall rates exhibit no reduction (Bowles, Dykes, & Demiris, 2015). Medication reconciliation via EHR is reported to significantly reduced adverse medication events, while electronic reporting of critical lab values has become more timely (Hoover, 2016). The techies are making progress so far after all!

However, nurses continue to complain about the amount of time away from direct patient care required to document electronically. A 2014 poll of about 14,000 nurses revealed that 92% are not happy with their inpatient EHR. The complaints are job dissatisfaction, nurse and patient communication disruptions, and incompetent support by their IT department (Perna, 2014). If we are still struggling, what can be done to improve functionality/usability, foster clinical decision support, enhance data collection in a meaningful manner, and provide interoperability?

The 2015 release of the IT roadmap for advancement of interoperability issued by the Office of the National Coordinator for Health Information Technology recognizes the unique complexity of health care and health care stakeholders. The goal now is for development of transparent, reliable standards for data exchange to enable electronic health information to flow when and where it is needed (DeSalvo & Galvez, 2015). More seasoned nurses are entering health care informatics with skills that are uniquely qualified to the development of meaningful (real meaningful) use. EHRs integrate clinical decision support into the workflow. Carefully crafted support structured on clinical evidence can guide the nurse via algorithms, risk identification, alerts in the provision of higher quality, and safer patient care.

We may not be there yet in health care information technology, given the enormity and complexity of the information that we require and the data we generate. We are blessed to live in an age with refrigerators that can communicate with our smartphones, doorbells that alert us to intruders on our property, tablets that can open the door to a veritable nursing library that never becomes outdated, and cars that notify us of low tire pressure and unlatched hatches. It won’t be long before we have an EHR we can love.

It is always nice to have some historical perspective on our wonderful, frustrating, fulfilling career in nursing. “In spite of the apparent importance of charting, it probably is one of the greatest ‘hates’ of nurses. Many nurses complain that the time spent charting might be more profitably used in actual bedside care” (Busche, 1928, p. 17). Maybe we haven’t come so far after all!

References
What the Heck Does This Mean?

As I first started my journey working with the Academy of Medical-Surgical Nurses (AMSN) Legislative Team in 2014, I was constantly asking myself, “What the heck does this mean?” Resolutions, rules, hearings, markups, and so on. Hum, the only way I would even know what was going on was to do a little research – the one thing all of us nurses know how to do! There are so many terms used in the ‘Legislative World,’ but I thought I would pose to you a few of the more frequently used terms you may run across when researching enacted or pending bills.

Laws begin as ideas. First, a representative sponsors a BILL. Depending on the chamber of origin, bills begin with the designation of either H.R. or S. A bill is the primary form of legislative measure used to propose law. The bill is then assigned to a committee for study. If released by the committee, the bill is put on a calendar to be voted on, debated, or amended. If the bill passes by simple majority (218 of 435), the bill moves to the Senate. In the Senate, the bill is assigned to another committee and, if released, debated and voted on. Again, a simple majority (51 of 100) passes the bill. Finally, a conference committee made of House and Senate members works out any differences between the House and Senate versions of the bill. The resulting bill returns to the House and Senate for final approval. The Government Printing Office prints the revised bill in a process called enrolling. The President has ten days to sign or veto the enrolled bill (U.S. House of Representatives, n.d.).

A JOINT RESOLUTION (H.J. Res. Or S.J. Res.) is another form of legislative measure used to propose law. Joint resolutions require the approval of both houses and the signature of the President, just as a bill does, and has the force of law, if approved. Proposed amendments to the constitution and continuing and supplemental appropriations are usually drafted as joint resolutions.

CONCURRENT RESOLUTIONS (H. Con. Res. or S. Con. Res.) are measures concerning the affairs of both houses, such as an expression of mutual sentiment of budget limits, the creation of a joint committee, agreement on a joint session or joint meeting, or agreement on the time of final adjournment of the whole Congress. A concurrent resolution must be adopted by both houses, but is not sent to the President for his signature and therefore does not have the force of law.

SIMPLE RESOLUTIONS (H. Res. or S. Res.) are measures that are formal expressions of opinion or proposal for action. A simple resolution deals with matters entirely within the prerogative of one chamber or the other. It requires neither passage by the other chamber, nor approval of the President, and it does not have the force of law. CONTINUING RESOLUTIONS are stopgap measures that keep all un-funded government operations running beyond the end of a fiscal year when any of the 13 annual spending bills have not been enacted. Continuing resolutions are also joint resolutions (National Cancer Institute, 2016).

RULES are regulating principles used in the conduct of legislative business within the House and Senate. Needless to say, these parliamentary rules are too numerous to elaborate on in this article, but can readily be researched should you enjoy a long read.

HEARINGS are formal meetings of a congressional committee (or subcommittee) to gather information from witnesses for use in its activities (that is, the development of legislation, oversight of executive agencies, investigations into matters of public policy, or Senate considerations of presidential nominations) (Congress.gov, n.d.).

MARKUPS refer to meetings by a committee or subcommittee during which committee members offer, debate, and vote on amendments to a measure – which is the legislative vehicle: a bill, joint resolution, concurrent resolution, or a simple resolution.

These are but a few of the hundreds of legislative terms used throughout the legislative world. Want to learn more about getting involved and using your voice? The Legislative Team of AMSN is comprised of five team members, two staff liaisons, and one AMSN Board Director liaison. During the year, articles are posted in the MedSurg Matters! newsletter, and current legislation and hot topics are posted on the AMSN website (www.amsn.org) and Hub online community. Come join us in keeping current on legislation that affects each of us as medical-surgical nurses and use your voice!

References

Sheila Kennedy-Stewart, MSN, RN, CMSRN, is a Clinical Nursing Instructor, Southwestern Oklahoma State University and Oklahoma City Community College, Oklahoma City, OK. She is Coordinator of the AMSN Legislative Team, as well as the “Legislative Issues” Column Editor.

If you have questions or comments regarding the “Legislative Issues” column, or if you are interested in writing, please contact Column Editor Sheila Kennedy-Stewart at srks@cox.net.
**Coming Soon in MedSurg Matters!**

- Social Media Interactions and Professional Boundaries: Be Aware of Negative Consequences
- The Role of the Bedside Nurse During a Rapid Response Call
- Building Bridges from Theory to Practice: What Does Nursing Theory Mean to Everyday Nurses?
- Nursing Students Having a Voice in Medical-Surgical Units
- Fighting the Flames of Nursing Burnout
- The Importance of Certification: Cost as One Barrier to Certification
- The Steel Jacket: Antecedents of Trauma
- Legal Nursing: Not Without Cause
- Healthy Practice Environments: The Customer is Always Right – Can it Backfire?
- Joining Forces: Emerging Pharmacological Treatments for Post Traumatic Stress Disorder
- Legislative Issues: The Legislative Role in Nurse Staffing Ratios
- Quality Matters: Nurses Impact Quality of Care – That’s a Good Thing, Right?
- Nutrition to Improve Outcomes: Malnutrition in the Hospitalized Patient
- Joining Forces: A Smartphone App as Adjunctive Therapy to Help Veterans Cope with Suicidal Thoughts

---

**AMSN National Elections**

**Your Vote Counts**

April 3 – May 2, 2017

President-Elect and Secretary

---

The mission of AMSN is to promote excellence in medical-surgical nursing.