Medical-surgical nurses are key players in providing effective pain management for their patients. Patient-controlled analgesia (PCA) is proven to provide effective pain relief and improved patient satisfaction. However, PCA is not without safety concerns. This article will examine those concerns and discuss implementation strategies for the safe use of PCA on medical-surgical units.

An 18-year-old patient, admitted with a sickle-cell crisis, was placed on a ventilator after encountering respiratory difficulties. The patient’s father inadvertently overdosed his daughter by pushing the patient-controlled analgesia (PCA) button thinking it was the call light (“PCA Pump,” 2009). A recent study shows that errors related to intravenous PCA are four times more likely to result in patient harm than errors with other medications (Hicks, Sikirica, Nelson, Schein, & Cousins, 2008; “Study Shows PCA,” 2009). The Institute for Safe Medication Practices (ISMP) has issued recommendations to eliminate basal PCA infusions except for opioid-tolerant patients (ISMP, 2009). The Anesthesia Patient Safety Foundation developed recommendations for safe monitoring of patients utilizing PCA in 2006 (ISMP, 2009). Do PCAs have a place on the medical-surgical unit? Can medical-surgical nurses administer PCAs and monitor their patients safely?

PCA has been used in the United States since 1984 to provide effective pain management (Thomas & Rose, 1993; Williams, 1996). Although PCA can encompass any type of delivery system that allows a patient to exert control over their medication, this article will only address the PCA intravenous pump method. It is helpful to consider PCA as a process, not just a piece of equipment (D’Arcy, 2009).

continued on page 12

Contact hour instructions, objectives, and accreditation information may be found on page 15
Spring Forward with AMSN’s New Strategic Plan

“Spring is when you feel like whistling even with a shoe full of slush.”
— Doug Larson

The AMSN Board of Directors (BOD) and senior staff recently braved the winter elements and gathered to continue to design the new strategic plan. While the BOD members faced cold, snow, and rain during travel, the journey concluded with the first blooms of the new strategic plan breaking through. The first sign of Spring in the air evokes an uplifting of the spirit and keeps the promise of growth and renewal. The design phase of the strategic plan, through the formation of objectives, strategies, and measures of success, positions AMSN to continue to grow, refine, and transform itself to be recognized as the leader of medical-surgical nurses and an influential organization within the health care community.

The winter BOD meeting agenda was devoted almost exclusively to developing the next steps of the design phase of the strategic plan. Work on the strategic plan began in winter 2009 and member input was a critical component in formation of the five goals.

Just as the bedside nurse formulates a plan of care and carefully selects strategies to best achieve progress, the BOD used a knowledge-based decision approach to formulate objectives and strategies for each goal. Initial objectives and strategies below are the highlights of each goal.

Goal 1: Workplace Advocacy

Goal: AMSN will support medical-surgical nurses in meeting the increasingly complex demands of their work environment.

Many medical-surgical nurses described complex demands of their work lives and the ever-changing environment of the medical-surgical nursing unit.

Objective: Develop knowledge-based resources for a healthy work environment.

Strategy: Develop a resource toolkit on the Web site for a healthy work environment.

Goal 2: Evidence-Based Practice, Research, and Knowledge

Goal: AMSN will advance the art and science of medical-surgical nursing.

As the recent member survey showed, members see evidenced-based practice and research as important. Medical-surgical nurses recognize that ongoing research provides validity to their profession and contributes to their role on the health care team.

Objective 1: Expand the awareness and utilization of evidenced-based practice (EBP), research, and performance/quality improvement among medical-surgical nurses.
Nursing Considerations of Combat Veterans with Post-Traumatic Stress Disorder
Cherry Mae Cabacungan

Post-traumatic stress disorder (PTSD) is becoming a trend among military personnel who are involved in combat. Due to the recent war, more and more individuals are affected by this disorder with little support being provided to them. There has been little research done to see why PTSD is caused and how it is affecting individuals. A few studies have cited excess levels of norepinephrine and chronically low levels of serotonin as the main cause of creating the symptoms that patients with PTSD endure. With this growing epidemic and current war, it is important for health care providers, especially medical-surgical nurses, to understand why and how patients with PTSD behave in certain ways. Without understanding and acknowledging the problem, patients with PTSD cannot be provided proper treatment, which may enhance their symptoms.

Post-traumatic stress disorder (PTSD) is a mental disorder that affects many people who endure a traumatic event. PTSD is a profound problem in the military due to the many traumatic experiences encountered by military personnel during the current war. PTSD is often undiagnosed in this population because of the stigma associated with having a mental problem. The effects of PTSD cause veterans to become depressed, anxious, guarded, and at times suicidal upon returning to their home environment. Reasons as to why this occurs are still undergoing research. However, a few studies have developed theories as to what causes individuals – specifically military personnel – to develop symptoms of PTSD.

Theories Regarding Post-Traumatic Stress Disorder

There are many theories as to why and how combat veterans develop PTSD and the effects it has on their interpersonal relationships with others. Studies have found that the brain and certain hormones are responsible for the signs and symptoms an individual diagnosed with PTSD experiences. For instance, norepinephrine plays an important role in the conditioned fear response and nightmares that are associated with PTSD. According to Olszewski (2005), the conditioned fear response of PTSD is due to the constant attention to environmental stimuli that may be threatening to the individual. Furthermore, excessive norepinephrine in the brains of people with PTSD disenables the individual to block irrelevant stimuli, which causes the emergence of traumatic memories. The continuous elevated norepinephrine levels in those with PTSD cause nightmares that replay the trauma and lead to a self-sustaining disorder (Olszewski, 2005). Other signs and symptoms that elevated levels of norepinephrine cause are: increase in fear, startle response, difficulty sleeping, hypervigilance, and trouble concentrating (Romanoff, 2006). Also, memory processing is disenabled due to the hyperarousal of the limbic system.

Another important factor in PTSD is the amygdala (an almond-shaped structure of the brain) and serotonin. Mood stabilizes and impulsivity decreases when the amygdala is stimulated by serotonin. Chronic low levels of serotonin can cause anxiety, aggression, suicidality, and impulsivity (Olszewski, 2005). Many combat veterans who return home often tend to be anxious about their surroundings and feel suicidal. For instance, in an article by Friedman (2006), a combat veteran “reported that he sometimes experiences strong surges of fear, panic, guilt, and despair and that at other times he has felt emotionally dead, unable to return the love and warmth of family and friends” (p. 586). The article further states, “he reported that he sometimes thinks everyone would be better off if he had not survived his tour in Iraq” (p. 586). The disinhibition of the amygdala causes an abnormal psychobiological state of hypervigilance in which stimuli are more likely to be misinterpreted as threatening. In a war zone, it is normal to be hypervigilant, whereas, at home it is not (Friedman, 2006). This illustrates how it may be hard for military personnel to adjust to their home lives upon returning from combat. The sudden adjustment of environment atmosphere may worsen one’s symptoms of PTSD.

Research from Nursing, Psychology, and Related Fields

Research studies have found that the constant threat of loss of life and limb play an important role as to why veterans feel anxious. A common thread for many veterans is the experience of having sustained anticipatory anxiety about potential threats at any hour of the day and at any place within the theater operations (Friedman, 2006). For instance, after months of deployment to a war zone in which the threat to life and limb is continually reinforced by surprise attacks, direct assaults, deaths of colleagues, inadvertent civilian casualties, and narrow escapes, it can be difficult to adjust quickly into a quiet environment (Friedman, 2006). The traumatic stimulus, such as the explosion of a roadside bomb or a suicide bomb attack, automatically triggers the posttraumatic responses, such as fear, helplessness, and horror (Friedman, 2006). This explains why individuals with PTSD react to certain stimuli once they return home from combat. Many veterans return home from combat feeling isolated, numb to things they used to enjoy, and guarded due to the trauma.
matic triggers they endured on a daily basis in combat. These triggers cause the individual to have perpetual anxiety, impaired social function, and loss of interest in other activities (Olszewski, 2005). Small things, such as a tire popping, can cause a startle arousal from a veteran because the stimulus triggers memories from his/her experience while in combat. Such flashbacks are suggested to be caused from the “overactivation of some norepinephrine receptors in the prefrontal cortex” (Olszewski, 2005, p. 43).

Other studies have found that suicidal behavior, such as depression, substance use, panic attacks, and severe anxiety, are highly associated with PTSD; therefore, the returning veteran is likely to have difficulty coping with ordinary stressors and to be more aggressive and guarded in civilian life (Friedman, 2006). Veterans frequently lose their support systems due to poor coping skills, which makes them more depressed and at risk for suicide ideation.

Another important finding is that guard/reserve military personnel usually have a higher incidence of developing PTSD as compared to active duty military personnel. Guard/reserve members are more likely to be prepared only for combat support roles, but they may end up in direct combat situations because of the nature of the current war (Romanoff, 2006). Guard/reserve personnel do not actively work in a military environment on a daily basis, whereas active duty personnel are exposed to different combat situations every day during training sessions held prior to deployment. Most guard/reserve personnel receive training sessions during their monthly duty weekends. The lack of exposure to combat situations prior to a deployment places guard/reserve personnel at risk of developing PTSD upon returning home from active combat duty.

Applications to Medical-Surgical Nursing Practice

Many veterans with PTSD are undiagnosed because they fear the stigma of having a mental problem associated with their name. It is crucial to screen for this disorder in the primary care setting in veterans who have recently returned from active duty in the current war (Reeves, Parker, & Konkle-Parker, 2005). Veterans typically believe that no one can understand the traumas of war except those who have been there. This thought process makes veterans reluctant to share their experiences when not asked directly (Romanoff, 2006), and this may make it difficult for a primary care provider to evaluate an individual for PTSD. It is important to not rush veterans to talk about their combat experiences. For instance, some will be emotional and need to share their stories, but others will find it difficult to discuss their thoughts and feelings about their experiences during the war. The nurse should recognize the importance of allowing veterans to share their experiences only when they are ready (Reeves et al., 2005).

The first step in treating PTSD is to devise a plan which can involve a referral to a mental health clinic (Romanoff, 2006). Assessing for substance abuse is crucial because PTSD and substance abuse have a high comorbidity (Reeves et al., 2005). The implementation of coping skills, such as anxiety management, anger management, emotional “grounding,” and improved communication could be helpful for patients battling PTSD (Reeves et al., 2005). By engaging in coping skills, veterans will be able to handle daily life stressors better than when they first returned home from combat. Relaxation techniques, such as slow, deep breathing; progressive muscle relaxation; and visual imagery for successful sleep induction or returning to sleep; can be taught to the patients (Olszewski, 2005). Simple tasks like these will help veterans battling PTSD become less guarded, anxious, and isolated. Listening plays an important role in evaluating and treating patients for PTSD. Sometimes patients will indirectly let providers know they are experiencing PTSD when they talk about how they are feeling and what they are or have been experiencing. Most military personnel feel that people do not want to hear about their combat experience, thus increasing their risk for PTSD (Romanoff, 2006).

Health care providers should validate and reassure patients that what they are experiencing is normal (Romanoff, 2006). Health care providers, such as medical-surgical nurses, need to pay special attention to gaining knowledge about their patients’ experiences, either directly or indirectly, and to express empathy and validation for the patients’ situation (Jamil, Nassar-McMillan, & Lambert, 2004). Patients need to feel accepted by others, especially health providers, in order to receive proper treatment for PTSD. Otherwise, they will be discouraged from expressing their feelings to others, which can exacerbate their condition. Validation and reassurance enables veterans to feel accepted and be more open to share their feelings with others because they won’t feel isolated or out of place.

Health care providers should support veterans with PTSD to prevent further feelings of withdrawal and isolation, which can extenuate the symptoms of PTSD. An early consideration can be a referral to a Veterans Affairs (VA) Medical Center, which enables the veteran to meet others who are experiencing the same things and talk with them about their emotions. The opportunity for veterans to connect and be supported by other veterans is a valued experience, which may be difficult to accomplish outside a VA setting (Reeves et al., 2005).

Medications, particularly the selective serotonin reuptake inhibitors (SSRIs), have emerged as the treatment of choice for PTSD. Benzodiazepines have had negative results and are not recommended for PTSD treatment (Friedman, 2006). Despite the effectiveness of SSRIs
for the treatment of PTSD, it is essential to incorporate all three components of the treatment plan: psychoeducation, psychopharmacology, and psychotherapy in the management of the patient (Romanoff, 2006, p. 413). If one of these three components is missing, then the treatment of PTSD will be ineffective.

Cognitive behavior therapy (CBT) and counseling are beneficial for both patients and their families in treating PTSD. According to Friedman (2006), all PTSD practice guidelines published to date recognize CBT as the treatment of choice. CBT helps clients reevaluate their way of thinking by having them look at situations in a positive perspective. Cognitive restructuring allows the therapist to challenge distorted beliefs, thereby enabling patients to overcome intolerable, trauma-related emotions, such as guilt and shame (Friedman, 2006). Cognitive restructuring allows patients to come to terms with what they fear and enable them to grasp the reality of their feelings. Family counseling is beneficial because it allows family members to express their concerns for their loved ones who are battling PTSD and to provide assurance, and validation to patients receiving the effects of norepinephrine and serotonin, but not if either influences the other. Comparing the values of serotonin and norepinephrine levels in military personnel prior to deployment and upon returning home from combat may indicate the severity of PTSD symptoms being experienced by the individual. Another area that would be beneficial to research is how substance abuse specifically affects patients with PTSD. More research is needed on combat veterans with PTSD and their experiences as compared to veterans from previous wars, such as World War I and II and the Gulf War.

Cherry Mae Cabacungan, BSN, RN, PHN, is a Staff Nurse, Medical-Surgical/Telehealth, VA Medical Center, San Diego, CA. She is also Treasurer of the San Diego Chapter of AMSN.

References
Welcome New Chapter!

Southern Ohio Chapter #320

Congratulations to the Southern Ohio Chapter #320, which earned its charter in January 2010. Serving Portsmouth, OH and the surrounding areas, the chapter has appointed the following officers:

- **President**: Teresa Lynn Chamberlain
- **President-Elect**: Malissa D. Warrick
- **Secretary**: Valerie DeCamp
- **Treasurer**: Janis Eldridge

The chapter also has an Education Committee. They will meet quarterly. Goals of the chapter are to:

- Enhance/improve the image of medical-surgical nursing.
- Increase staff nurse involvement in professional organizations.
- Provide educational opportunities for medical-surgical nurses.
- Mentor others to take on leadership roles in the local chapter.

Deep South Chapter #218

During the 18th Annual Convention for AMSN, four members of the Deep South Chapter attended the session “The Evolving Multimodal Management Plan for Postoperative Ileus,” sponsored by Adolor. The members found the presentation very informative and relative to their practice.

Board members communicated with Elizabeth Facchini, from The France Foundation, to plan an educational event and dinner meeting for members of the chapter, which was held on November 19, 2009, at a local restaurant. The topic was “Improving Recovery Time for Patients Undergoing Bowel Resection,” presented by Dr. David Beck, Chairman of the Department of Colon and Rectal Surgery at Ochsner Clinic Foundation in New Orleans, LA.

The objectives of the program were to:

1. Describe the prevalence, pathophysiology, and defining criteria for postoperative ileus (POI).
2. Distinguish evidence-based therapeutic options for the management of POI.
3. Describe how to implement a multi-modal management plan in your institution for patients undergoing bowel resection procedures to improve time to bowel recovery.

There were 64 attendees at the event and the evaluations of the presentation were positive. The nurses took away knowledge to help medical-surgical patients recover from bowel surgery.

In addition to the networking and educational event, this chapter participates in a community service project at each meeting. The organization feels strongly about giving back to the community. Medical-surgical nurses are always good at being strong community members.

Many new toys were collected for Angel’s Place, a local agency that provides support for family members of a child with a life-threatening event or a terminally ill child. Local nurse Anita Gilford founded the agency when her son, Mark, 11-years-old at the time, was diagnosed with cancer. Mark is a cancer survivor, and has been in remission for over ten years now. The members of the Deep South Chapter collected enough toys to fill two “Santa’s sleighs” (actually the back of an officer’s SUV) for the families.

Patricia Smart, RN-C, MN, CNE
Chapter #218 Past President

(Chapter) Breakfast of Champions

At the 2009 AMSN Annual Convention, the Chapter Officer’s Breakfast was recorded for those who could not attend. Chapters shared their success stories and great ideas at this breakfast, and now anyone can listen to them. It’s truly amazing to hear the achievements and events of AMSN’s Chapters. Go to the AMSN Online Library (www.amsn.org/library), and look for Leadership Sessions 2009 on the left. It’s free to listen. Take the time to use this resource. If you are a chapter officer, you will be inspired.

Annual Chapter Reports Due

Chapter reports are due **June 30, 2010**. All chapters must submit the annual report. To be considered for one of our 6 Chapter Achievement Awards, chapters must hand in the larger Chapter Achievement Report by June 30 as well. All chapters that win a Chapter Achievement Award will be recognized at AMSN’s Annual Convention. Check the Chapter Resources section of the Web site (www.amsn.org) for the up-to-date form.
The Greater Portland Chapter #410 participated in the Susan G. Komen Race for the Cure on September 20, 2009. Thirteen members of the chapter joined the team "Nurses for Knockers" and together raised $1,391! This was well over their original goal of just $500.

The chapter also held a “Preparing for Certification” course on November 6, 2009. Almost 50 nurses attended. Registration was $35 with half of all registrations earmarked for donation to the Oregon Food Bank. The chapter board decided to round the donation to a full $1,000.

Beth Norman, President of the chapter, quipped, “Pretty amazing stuff for a small chapter that has an even smaller number of active members!”

Welcome to Our Two New MSNCB Directors!

Mimi Haskins, MS, RN, CMSRN, is a Nursing Staff Development Instructor at Roswell Park Cancer Institute in Buffalo, NY. She received her BSN from D’Youville College and her MS as a Clinical Nurse Specialist from the State University of New York at Buffalo. Her 22 plus years of nursing experience have been primarily in the medical-surgical arena, but she also has critical care, case management, and research experience. Mimi retired from the United States Army Reserve, Army Nurse Corps, in 2001 after serving 27 years. She lives in Amherst, NY, with her husband, Guy. Their blended family includes 6 children, 17 grandchildren, and 2 dogs.

Mimi has been active in AMSN since 1999. She has been a local chapter president, board member, and a member of AMSN’s Clinical Practice Committee. She is currently the Research Project Coordinator for MSNCB’s Value of Certification Research Study, an AMSN N3 Mentor, and a member of the Chapter Development Committee.

Her goals for the MSNCB are to promote the value of certification and encourage medical-surgical nurses to obtain the CMSRN certification.

Karen Hein Gregg, RN, CMSRN, CBN, is a Patient Care Coordinator on a medical-surgical unit at St. Francis Hospital, Beech Grove, IN. Karen received her ASN at Indiana University and her BSN at Ball State University. Karen lives in Indianapolis, IN, with her husband, Steve.

Karen has been an active member of AMSN since 1993, serving in several positions for the Central Indiana Chapter. On the national level, Karen has served on the Program Planning Committee for three conventions.

Karen’s goals for MSNCB are to increase the bedside nurse’s knowledge on why certification should be important to them, specifically to promote themselves as quality patient care providers and increase their self esteem and satisfaction.

Member-Get-A-Member Program Benefits You

You know how beneficial AMSN membership is to you. Naturally, you spread the word to other med-surg nurses. AMSN wants to reward you for what you are already doing. If a nurse becomes a new member because you referred him/her, have the nurse let us know. There is a spot on both the paper and online application for any new nurse to list the AMSN member who recommended him/her to us. Each new member who gives us your name goes towards your tally for the year. If at the end of the fiscal year you have recruited five or more nurses, you receive a reward. It’s just that easy. Continue doing what you’re doing, and get rewarded!

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<tr>
<td>Hospital Group</td>
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AMSN just made it easier to invite colleagues to join. Look for "Invite a Colleague" on the Member-Get-A-Member page of the AMSN Web site, located in the Membership section. Complete the simple form and AMSN will send an email inviting all the member benefits from you to your colleague to join AMSN.

*AMSN gift certificates may be used for membership dues, convention registration fees, or to purchase products and merchandise. They are not valid for MSNCB’s CMSRN certification, recertification, or exam exemption fees.
An Ounce of Prevention: Best Practice Bundles

Preventing hospital-acquired complications has long been a focus of nursing care. Identifying methods to prevent and decrease the incidence of these problems has led the way for providing old and new nursing interventions and practices. Best practice bundles achieve this through development, implementation, and evaluation of interventions as a whole to produce better patient outcomes.

As a nurse, I have experienced changes throughout my career that focus on promoting the best possible patient outcomes, influencing the way I perform my duties. As a conscientious nurse, I always want to do what is best for the patient, and look to the current research to support these changes. You are likely familiar with the terms evidence-based practice and best practice, and may want to know more about how these methods influence your practice. You may also want to know how you can more positively affect outcomes for your patients. The Best Practice Bundles (BPB) achieve both of these goals.

A bundle is a group of evidence-based best practices related to a disease process that when executed together, result in better outcomes than when implemented individually. The Institute for Healthcare Improvement (IHI) created the concept of best practice bundles in 2005 to provide a method of ensuring that patients receive the best possible care for their particular needs. These bundles are evidence-based, promote efficiency and patient safety, demonstrate quality care, are cost-effective and reason-based, and improve patient outcomes. More simply put, in the words of Benjamin Franklin, “An ounce of prevention is worth a pound of cure” (Independence Hall Association, n.d.).

One of the initial bundles, aimed at the prevention of Ventilator-Acquired Pneumonia (VAP), has met with great success. The basic interventions of elevating the head of the bed greater than thirty degrees, peptic ulcer prophylaxis, DVT prophylaxis, oral care, and assessing and weaning from the ventilator as early as possible, have decreased the incidence of VAP nationwide (IHI, 2006).

The American Association of Critical-Care Nurses (AACN) published a Practice Alert (2008), outlining the evidence and nursing practice interventions supporting the VAP bundle. By implementing these practices as a whole (i.e., bundle), two critical care units within Legacy Health System have decreased their VAP rates by greater than 50% within six months of the implementation of the VAP bundle, and two additional units have had no cases of VAP in two years (L. Staul, MN, RN, CNS, CCRN, personal communication, July 22, 2009). We anticipate that the implementation of additional BPBs will afford us with the same level of success.

The design of a best practice bundle is to prevent the most common complications associated with the problem it is designed around. Not all patient problems can be addressed with a designated bundle approach, although much of the care we provide is “bundled.” For example, when giving a bed bath, one collects all of the necessary supplies, prepares the patient, and performs the task. While bathing the patient, the nurse is also assessing the skin, assisting with or performing range of motion, providing tactile and cognitive stimulation, enhancing circulation, and so on. Without the correct supplies or missing one element of the bath results in the bath being incomplete.

The process of bathing the patient is very similar to the process for developing a bundle:

1. Identify a problem or need for improvement (hygiene and skin care).
2. Set goals to resolve the problem (provide bath).
3. Establish the necessary measures to achieve the goals (organize duties).
4. Utilize the necessary supplies (linens, cleanser, basin, water, etc.).
5. Plan the interventions (communicate with the patient).
6. Assess the interventions as you perform them (observe skin, apply lotion, etc.).
7. Evaluate the outcome (condition of skin).
8. Document the results (data collection).
9. Evaluate outcomes (skin intact).
10. Revise your interventions as needed.

The comparison of a bed bath to a bundle may oversimplify the process of developing a best practice bundle, but it does demonstrate the process on a familiar level. The IHI’s Model for Improvement (available at http://www.IHI.org) will provide you with the tools necessary to design a bundle that meets your clinical needs (IHI, 2008).

One of the key elements in BPB development is planning for staff education. Involving key staff nurses in the entire process is integral to the success of the bundles. Prior to implementation of each BPB, educational sessions should be provided outlining the rationale for each bundle, the evidence supporting the selected interventions, with training on implementing the interventions, documentation, auditing processes, and the plan for evaluation of outcomes. This plan includes sharing the data with staff, reviewing the outcomes, and revising the interventions as necessary to further improve patient outcomes.

Best practice bundles that have been implemented at Legacy Health System are: Catheter-Associated Urinary Tract Infection Prevention (CA-UTI), Pressure Ulcer Prevention (PUP), Central Venous Catheter Associated Bloodstream Infection Prevention (CA-BSI), and VAP (see Table 1). The Surgical Care Improvement Project (SCIP) contains bundles, or modules for care, of the surgical patient that have been implemented nationwide (Premier Inc., 2009).

CA-UTI includes assessing for alternatives to catheter placement, removing urinary catheters as soon as possible, keeping drainage bag below the level of bladder, placement of catheter
drainage tubing to avoid kinks and loops, and daily pericare. PUP includes risk assessment for developing pressure ulcers; full skin assessment on admission, each shift, and upon transfer and change in condition; skin care measures; positioning; use of appropriate pressure-relieving devices and surfaces; and management of nutritional status. Venous thromboembolism (VTE) prevention, as part of the SCIP initiative, is also a bundle. Interventions include risk assessment and communicating that to providers, as well as carrying out ordered interventions. Activity/mobility is incorporated into each of the bundles for the specific aspects of that bundle as it relates to activity and mobility in the prevention of complications.

For example, regular toileting increases mobility and helps prevent UTIs; regular ambulation, bed mobility, and range of motion contribute to prevention of VTE, PUP, and falls, and improve patient stamina and endurance.

Do these interventions sound familiar? They are all fundamentals of nursing care, which we learned as part of our initial nursing education. Somehow, much of the basics are forgotten in the rush to do our work, due in part to shorter lengths of stay, higher patient acuity, technological advances in health care, and a plethora of additional reasons for which we can all relate. The first step is to acknowledge these barriers; the next is applying the basics. Experiencing a decrease in UTIs, pressure ulcers, embolic events, and falls and improving mobility in our patients is our reward.

Education and implementation of best practice bundles will provide for better patient outcomes, a decrease in complications, and shorter lengths of stay. This is clearly evident by the decrease in cases of VAP since the implementation of that bundle.

By accepting these best practices and implementing them in all aspects of our work, our ounces of prevention may lead to no need for a cure.

References


Beth Norman, MS, RN, CNS, ACNS-BC, is a Medical-Surgical Clinical Nurse Specialist, Legacy Health System, Portland, OR. She is President of the Greater Portland Area Chapter of the Academy of Medical-Surgical Nurses (AMSN), and a member of the AMSN Clinical Practice Committee.
### CMSRN® and RN-BC: What’s the Difference?

There are two certification exams offered in the specialty of medical-surgical nursing. The Medical-Surgical Nursing Certification Board (MSNCB) provides this table of comparisons between the two certification programs to help you make an informed choice of which one is right for you.

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<tr>
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#### Certification Eligibility Criteria

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#### Certification Exam

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<td><strong>Average Pass Rate/Last 3 Years</strong></td>
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<td><strong>Special Test Site at Your Facility</strong></td>
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#### Pricing & Discounts

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<td><strong>By Exam</strong></td>
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<tr>
<td><strong>Practice Hours in 5 Years</strong></td>
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<td>1,000</td>
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<tr>
<td><strong>Contact Hours in 5 Years</strong></td>
<td>90 CH</td>
<td>150 CH or 75 CH + academic course work, presentations, publications, preceptorship, or research</td>
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#### Pricing & Discounts

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#### Examination Prep Resources

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<tr>
<td><strong>Publications/Online</strong></td>
<td>Yes, many through AMSN</td>
<td>Yes</td>
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<tr>
<td><strong>2 Day Certification Review Course at your Facility</strong></td>
<td>Yes, Through AMSN $5,000 + faculty hotel expenses Unlimited Participants</td>
<td>Yes - $7,375 minimum of 25 participants; $295-$390 per participant after the first 25</td>
</tr>
<tr>
<td><strong>FREE Contact Hours</strong></td>
<td>Yes - with AMSN membership At least 18 free CH per year specific to medical-surgical nursing</td>
<td>No</td>
</tr>
<tr>
<td><strong>Web Site</strong></td>
<td><a href="http://www.msncb.org">www.msncb.org</a></td>
<td><a href="http://www.nursecredentialing.org">www.nursecredentialing.org</a></td>
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* AMSN dues = $84/year
** ANA dues = $290/year average
One of the questions that frequently comes up during the time of election is “what does the AMSN Board of Directors (BOD) do?” Yes, it is more than sitting on the stage at convention or occasionally posting information on the Web site. As members of the BOD, we are charged with setting the direction for the association, ensuring resources, and evaluating performance and outcomes of goals in relation to the values important to the membership (Hnatiuk, 2009). One of the most important activities is assisting members in furthering or advancing the practice of medical-surgical nursing.

While the day-to-day financial activities are handled by the national office staff, the AMSN BOD is charged with the overall fiduciary responsibility for the organization. Fiduciary responsibility can be viewed from a framework of duties owed to the organization. These are identified as the duty of care, the duty of loyalty, and the duty of obedience (Hnatiuk, 2009).

The duty of care involves the committed work of the board members. The BOD works best when all members of the group are active participants and communicate in an open fashion. In other words, the board functions as a team. The open dialogue, the give and take of an ongoing discussion, is key to a successful, functional board’s work. The BOD makes knowledge-based decisions and supports consensus as a framework for doing the business of AMSN. This type of decision-making and process requires active involvement of each member and commitment to participate.

The duty of loyalty is crucial not only to an effective BOD, but also in maintaining ethical standards for the association. This duty requires members of the BOD to seek the interests of the association over their own. This means members of the BOD must consider personal views as secondary in the decision-making process. This also encompasses the concept of conflict of interest. Every member of the BOD signs a conflict of interest statement upon election. The BOD must consider any potential conflicts that may be identified as discussions and decisions are made.

The final duty is that of obedience. Obedience in this setting means acting in accordance with AMSN’s mission, vision, policies, and practices (Hnatiuk, 2009). As a member of the BOD, group decisions are made and the member is duty-bound to support and uphold those decisions. The AMSN board works to make knowledgeable, evidence-based decisions through a consensus-building process. Once a decision is made, all members of the board are in agreement that they will live with and support that decision.

Fiduciary responsibility includes establishment and monitoring of the associations finances. The national staff is essential in assisting the treasurer and the board in creating and maintaining the association’s budget. The board examines activities and potential activities as to the financial risk and benefit to the association. There are times when tough decisions are made to not pursue an existing activity or to decline the opportunity to start something new because it doesn’t seem wise from a financial point of view. In hard economic times, these decisions seem more and more critical.

Ensuring the use of AMSN’s resources includes working with the members and volunteer groups to achieve activities of the strategic and business plan. The board works with the national office staff to provide services to the members. These activities include such things as: convention and meeting planning, AMSN publications, educational offerings, the AMSN Web site, AMSN NetWorks, Med-Surg Nurses Week, and supporting certification.

In setting the direction of the association, the BOD determines the policies and strengths that will lead AMSN into the future and the metrics that will measure the outcomes achieved. The board has to consider current needs and trends in health care and the direction it all appears to be moving. The board works to consider the organization a year from now, five years from now, and beyond.

As in all plans, it is important for the BOD to manage ongoing assessment of the strategic plan and activities of the association, volunteer units and services provided for the member. Volunteer units provide data as action plans are implemented and completed. Liaisons from the BOD serve as a vital link to the volunteer units. Assessment involves tracking the progress toward meeting the objectives of the strategic plan. The AMSN BOD gathers data from the membership through a variety of methods to seek input and determine value satisfaction.

Professional growth and refining/advancing the practice of medical-surgical nursing is an important goal of the BOD. The board works with various volunteer leaders to accomplish this. It is important for the BOD to stay abreast of issues facing the medical-surgical nurse. The BOD gathers information from its members, its leaders, and the national office staff. The board also seeks information and alliances with other nursing- and health-related groups. When necessary, the board responds to issues or makes plans for participation in activities in order to promote and protect the practice of the medical-surgical nurse.

To accomplish the work of the organization, the BOD meets four times a year – in the winter, late spring, and two times during the annual convention. Each member of the board works with various volunteer groups and leaders. The board reports on the activities of the group during monthly conference calls. While the board communicates monthly on the conference call, there is substantial work done several times a week electronically. Occasionally members of the board are called upon to

continued on page 15
Safe Use of Analgesia
continued from page 1

Features of a PCA Pump

A PCA pump has several different programming options. The pump can be programmed to deliver a basal (continuous) rate, an intermittent pre-programmed PCA dose, or both a basal rate and PCA dose. One of the safety features of this device is a lockout between the PCA doses. This lockout prevents the patient from receiving an additional dose until the first dose has had time to reach its maximum effect (Cranwell-Brace, 2009; Williams, 1996). Even though the patient may push the PCA button numerous times, a dose will not be delivered before the lockout has been reached. The pump also has either a one-hour or four-hour limit, which prevents the patient from getting too much medication in a specified time frame. It is important to remember that a patient can still be overdosed in spite of these safety features because of individual differences in metabolism and responses to medications.

Another safety feature of this delivery system is that the patient should be the only person administering the PCA doses. A patient will become sedated before respiratory depression occurs. If the patient becomes too sleepy, they will be unable to administer any further doses. The case study at the beginning of this article provides an example of possible consequences when someone other than the patient administers PCA doses.

Patients can deteriorate from over-medication quickly if too much opioid is administered. If someone other than the patient is chosen to administer the PCA doses (as in the case of a child), that person should be carefully selected and thoroughly educated about the use of the pump and the side effects of the medication. Only one person should be delegated the “PCA by proxy” person. Health care facilities should develop and adhere to a “PCA by proxy” policy and procedure in these instances.

Patient Selection

Patient safety can be compromised at several different phases associated with PCA therapy. The first area to consider is proper selection of patients for PCA therapy because this method of pain management is not appropriate for all patients. A patient must be able to understand the relationship between their pain, pushing the button, and the effectiveness of the medication. Patients need the ability to physically push the button and be willing to participate in their care and take control of administering the opioid.

Physicians should carefully screen patients not only for PCA appropriateness, but also for the type of therapy: PCA dose only, basal infusion only, or both PCA dose and basal infusion. Many common conditions have been assessed as high-risk for complications associated with opioid use (see Table 1) (D’Arcy, 2009; Hagie, Lehr, Brubakken, & Shippee, 2004; ISMP, 2009). Patients with a continuous opioid infusion are five times more likely to develop respiratory depression than those without a basal infusion (ISMP, 2009). Current recommendations include a basal infusion in opioid-tolerant patients only (ISMP, 2009).

Device Malfunction

Causes of device malfunction can include defective reed switch; defective motor, battery, or display board; or software problem and others. Of PCA events reported between January 1, 2002 and December 31, 2003, 79% were classified as possible device safety events (Hankin, Schein, Clark, & Panchal, 2007). It was confirmed that the device defects were likely to have caused the safety event in 86.8% of the pumps that were sent back to the manufacturer for inspection (Hankin et al., 2007).

Operator Errors

Operator errors are frequently cited as a cause of adverse drug events (ADEs) related to PCAs. However, during the survey period mentioned above, only 6.5% of errors were attributed to operator errors. Patient harm occurred in 63 cases, including six patient deaths (Hankin et al., 2007). Errors occurred first during the programming of the pump. It is imperative that the pump be programmed correctly to prevent over- or under-medication. Programming starts with an accurate review of the 5 rights of medication administration. This seems very basic, but cases exist in which the wrong medication, dosage, and lockout were programmed into the PCA pump. Consider the case in which the nurse selects a hydromorphone syringe instead of a morphine sulfate syringe or vice versa. A nurse may attempt to program a fentanyl PCA in milligrams instead of micrograms. A lockout can be set at one minute instead of ten minutes.

In order to prevent programming errors, many institutions require independent double-checks. This occurs when two practitioners separately check (alone and apart) each component of prescribing, dispensing, and verifying medication before administration. Independent double-checks should occur when the medication is first ordered, when a patient is transferred from one unit to another, when there is a change in the medication order requiring reprogramming of the PCA pump, and when a new syringe is inserted into the PCA pump. This check should include a simple check of the order and cognitive checks of the whole prescription (ISMP, 2008). An example of a cognitive check would be evaluation of the dosage of the medication or the questioning of the use of a basal infusion. It is believed that a few good double-checks are more effective in preventing errors than an overabundance of poor checks (ISMP, 2003). Operator errors include failure to clamp or unclamp tubing, pharmacy errors, and
improper loading of a syringe or cartridge (Hankin et al., 2007).

Patient Errors

Patients have been known to intentionally tamper with their PCA device, causing errors and potential harm. In the report by Hankin and colleagues (2007), there were 12 incidences of patient-related errors; eight of those errors were suspected to be a result of patient tampering. The other four events were attributed to family members operating the demand button.

Contributing Factors

Contributing factors, factors influencing the occurrence of an error but not directly causing the error, associated with PCA errors were discussed in a report by Hicks and colleagues (2008), which focused on medication errors. Two of the most frequent contributing factors were distraction and workload increase. There was no definition of workload increase in this study. Factors related to staff characteristics included inexperienced staff, agency, or temporary staff; insufficient staff; cross-covering staff; float staff; and shift changes. These factors accounted for 44.8% of 9,571 PCA-related medication errors reported over a five-year period (Hicks et al., 2008).

Nursing Care

The sequence of effects of opioids delivered via the PCA pump are: analgesia, sedation, and respiratory depression. Sedation is a sensitive indicator of impending respiratory depression (Pasero, 2009). Systematic assessment of sedation levels is key to the safe administration of opioids by PCA. Monitoring for sedation should be a routine and regular intervention for any patient utilizing a PCA. Nursing staff need to be attuned to the subtle changes in sedation levels and intervene by reducing the opioid dose and monitoring the patient frequently (Pasero, 2009). Nurses should utilize a simple and easy to understand sedation scale that provides clear direction to the nurse needing to intervene for the overly sedated patient (Pasero, 2009). An example of such a tool is the Pasero Opioid-Induced Sedation Scale (POSS) which links nursing interventions to the different levels of sedation (see Table 2).

A sedation assessment should include more than a patient’s arousal when touched. The nurse should assess how quickly the patient arouses and the patient’s ability to stay awake once aroused. Patients should be able to arouse quickly and answer a simple question without falling back to sleep (Pasero, 2009). A patient who falls asleep mid-sentence requires a decrease in the amount of opioid and more frequent monitoring (Pasero, 2009).

The incidence of respiratory depression associated with PCA ranges from 0.19–5.20% (Hagle et al., 2004). Respiratory depression can be defined as a decrease in the rate and depth of respirations from baseline (Hagle et al., 2004; McCaffery & Pasero, 1999). Nurses should perform a complete respiratory assessment on patients receiving PCA opioids. A simple count of the respiratory rate is an inadequate assessment. The nurse needs to include observation of the depth, regularity, and characteristics of the respirations. Listen to the sound of the respirations to detect snoring, which is considered an ominous sign (Pasero, 2009). Although snoring might be considered “normal” in a patient, it can progress into complete obstruction in a sedated patient. Repositioning and further evaluation is required (Pasero, 2009). Recommendations for a patient with a history of snoring include a sleep study, lower opioid doses, and continuous CO₂ monitoring using capnography (Pasero, 2009). Although pulse oximetry is often used when monitoring patients on PCA therapy, it is important to remember that oxygen saturation readings may be high in patients on supplemental oxygen, even though respiratory depression is present (Pasero, 2009).

The most dangerous time for the occurrence of respiratory depression is during the first 24 hours of opioid therapy (Pasero, 2009). Assessments for sedation and respiratory depression should occur every 1-2 hours during the first 24 hours of therapy and decreased to every 4 hours when the patient reaches a stable condition (Pasero, 2009). Continued on page 14.

### Table 2. Pasero Opioid-Induced Sedation Scale (POSS)

<table>
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<tr>
<th>Rating</th>
<th>Description</th>
<th>Intervention</th>
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<tr>
<td>S = Sleep, easy to arouse</td>
<td>Acceptable</td>
<td>No action necessary; may increase opioid dose, if needed</td>
</tr>
<tr>
<td>1 = Awake and alert</td>
<td>Acceptable</td>
<td>No action necessary; may increase opioid dose, if needed</td>
</tr>
<tr>
<td>2 = Slightly drowsy, easily aroused</td>
<td>Acceptable</td>
<td>No action necessary; may increase opioid dose, if needed</td>
</tr>
<tr>
<td>3 = Frequently drowsy, arousable, drifts off to sleep during conservation</td>
<td>Unacceptable</td>
<td>Monitor sedation level and respiratory status closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose by 25-50% or notify MD for orders; consider administering a non-sedating, opioid-sparing nonopioid</td>
</tr>
<tr>
<td>4 = Somnolent, minimal or no response to verbal or physical stimulation</td>
<td>Unacceptable</td>
<td>STOP opioid; consider administering naloxone; stay with patient; stimulate and support respirations as indicated; notify Rapid Response Team; notify MD; monitor sedation level and respiratory status closely until sedation level is stable at less than 3 and respiratory status is satisfactory</td>
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2009). It is important to remember that the nurse’s observation skills are more important in detecting changes in sedation level and respiratory status than mechanical monitoring. Applying pulse oximetry may stimulate the patient enough to take a deep breath, producing a false higher oxygen saturation reading (Pasero, 2009).

Other nursing care for patients with sedation or respiratory depression caused by opioids includes stimulation of the patient, decreasing or stopping the opioid dose, and reversal of the opioid with naloxone. Dilute one ampule (0.4 mg/ml) of naloxone with 9 ml of normal saline. Give 1 ml every minute until the patient is responsive (Eksterowicz, Quinlan-Colwell, Vanderveer & Menez, 2010). If reversal is necessary, it is important to remember that the patient may have repeated respiratory depression since the half-life of naloxone is shorter than hydromorphone or morphine sulfate. The patient still needs frequent monitoring after naloxone. It is evident that medical-surgical nurses play a key role in maintaining safe opioid therapy with frequent monitoring and appropriate interventions. Other recommendations that address PCA safety issues include: standardized order sets, prefilled syringes or bags, annual competencies on programming PCAs, and not allowing PCA by proxy (D’Arcy, 2009).

**Conclusion**

Every phase of PCA therapy needs to be evaluated critically in order to prevent errors and promote safe patient outcomes. Physicians, nurses, pharmacists, patients, and families need to be actively involved in these phases. Nurses need to ask patients about snoring and sleep apnea. Patient and family education should continue throughout the hospitalization. Physicians should consider comorbid conditions, previous use of opioids, and individual patient characteristics when ordering PCA therapy. The pharmacist should carefully review the order and patient profile to prevent errors. During PCA therapy, careful and frequent monitoring of sedation level and respiratory status are imperative. Cognitive checks assessing the appropriateness and effectiveness of the therapy should be conducted throughout the use of PCA therapy. Can medical-surgical nurses care for patients with PCAs safely? The author believes the answer is “yes” if the above recommendations are incorporated into practice.

**References**


PCa pump: Family member gave morphine dose, thought it was call light (2009). Legal Eagle Eye Newsletter for the Nursing Profession, 17(8), 7.

Study shows PCA results in more medication errors. (2009). Hospital Home Health, 26(1), 4-5.


Kathleen Lattavo, MSN, APRN, BC, CMSRN, RN, C, is a Medical-Surgical CNS, St. David’s Medical Center, and Faculty Member, University of Texas, Austin, TX. She is also Secretary for the Academy of Medical-Surgical Nurses (AMSN).

**Note:** A related article on the topic of pain management entitled, "Undermedication for Pain and Precipitation of Delirium," can be found in the April 2010 issue of MDSURG Nursing: The Journal of Adult Health, the official journal of the Academy of Medical-Surgical Nurses.

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**Celebrate the Commitment Of a Med-Surg Nurse**

Do you want to honor a nurse for Nurses Week (May 6-12), but you aren’t sure how? AMSN can help! Make a donation to AMSN’s scholarships and awards program in honor of your friend’s commitment. When you make your donation, tell us your friend’s name and years of employment, and we will print it in a future issue of MedSurf Matters! and on the AMSN Web site. You can make your donation by visiting www.amsn.org and selecting Donation Form under Scholarships and Awards. Not only will you be honoring your friend, you will be advancing the med-surg nursing specialty.
Instructions For Continuing Nursing Education Contact Hours
Safe Use of Patient-Controlled Analgesia on a Medical-Surgical Unit
MSNN1002

To Obtain CNE Contact Hours
1. For those wishing to obtain CNE contact hours, you must read the article and complete the evaluation through AMSN’s Online Library. Complete your evaluation online and print your CNE certificate immediately, or later. Simply go to www.amsn.org/library.
2. Evaluations must be completed online by April 30, 2012. Upon completion of the evaluation, a certificate for 1.0 contact hour(s) may be printed.

Fees

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Objectives
The purpose of this continuing nursing education article is to increase the awareness of safe use of patient-controlled analgesia in nurses and other health care professionals. After studying the information presented in this article, you will be able to:

1. Discuss the types of errors or malfunctions that can occur when patient-controlled analgesia (PCA) is used in pain management.
2. Describe the features of a PCA pump and how they impact safety.
3. Identify the sequence of effects of opioids delivered via PCA methods and what interventions should be taken at each level of sedation.
4. Explain how nurses can ensure that PCA pumps are used safely on the medical-surgical unit.

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

This educational activity has been co-provided by AMSN and Anthony J. Jannetti, Inc. Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nurses, provider number CEP 5387. Licensees in the state of CA must retain this certificate for four years after the CNE activity is completed.

Anthony J. Jannetti, Inc. is accredited as a provider of continuing nursing education by the American Nurses’ Credentialing Center’s Commission on Accreditation (ANCC-COA).

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

The Work of an AMSN BOD Member
continued from page 11
represent AMSN at other national and regional meetings. Key to the role of a board member is the ability to communicate and function in a group setting. The board member must have daily access to email and be functional in electronic forms of communication. While not everyone is a computer expert, the board member must be able to function in that environment.

All of this sounds like a lot of work. Sometimes it is. However, in the process there is a tremendous opportunity to meet and work with nurses from across many geographic areas, practice settings, and points of view. Participating as a member of the BOD enhances your networking circle and knowledge base of medical-surgical nursing. AMSN board members have the rare opportunity of both shaping the future of the association and enhancing personal leadership skills. The work of AMSN and the BOD promotes excellence in medical-surgical nursing and has a positive impact on the entire nursing profession. This translates to improved patient care and outcomes.

Sandra D. Fights, MS, RN, CMSRN, CNE
AMSN Nominating Committee Chair & President-Elect

Reference

AMSN Corporate Members

Bon Secours Virginia Health System
8565 Magellan Parkway, Suite 900
Richmond, VA 23227
877-447-9342
www.bonsecours.com or www.bshr.com

Hill-Rom
1069 State Route 46 East
Batesville, IN 47006-9167
1-800-445-3730
www.hill-rom.com

Philips Healthcare
3000 Minuteman Road, Mail Stop 375
Andover, MA 01810
1-800-934-7372
www.healthcare.philips.com/us
Strategies for Nurse Educators

Priority Setting: A Clinical Exercise

The 2010 National Council of State Boards of Nursing’s RN test blueprint indicates 16-22% of the NCLEX-RN exam focuses on Safe and Effective Care Environments, which includes questions about establishing priorities under the subtitle Management of Care. Post-conference practice provides an opportunity for nursing students to apply prioritization principles to the patients they have cared for during clinical rotations, a time when they may not have had the opportunity to care for more than one patient at once.

Principles of Priority Setting

Priority setting is a learned skill that involves determining the order in which nursing actions are to be implemented throughout the nurse’s workday. This skill includes being able to make decisions about the order in which to see patients and the order in which to complete assessments, interventions, and all other aspects of patient care, such as teaching and medication administration. A nurse must learn to organize nursing activities from the most important to the least important to provide safe and effective care.

There are several methods to assist a nursing student in determining priorities of patient care. For example, Maslow’s Hierarchy of Needs, a common framework for prioritization, suggests ordering patient care according to physiological needs, safety needs, needs of love and belonging, esteem needs, and finally a person’s need for self-actualization. Another method is to incorporate the following principles into practice: prioritize care of a new acute injury/illness over the care for chronic illness, manage actual problems before potential problems, recognize and respond to trends, and recognize signs of emergencies and complications versus expected outcomes. Many nurses prioritize according to the ABCD method: airway, breathing, circulation, and disability (Norris, 2008; Wissmann, 2008).

A Clinical Exercise

My students have enjoyed the following activity during post-conference and state that this exercise provides them with an opportunity to “see” how patient assignments can be made and how a nurse would prioritize which patient to see first during initial rounds.

1. Divide the clinical group into two groups of students.
2. Have each student in one group give an end-of-shift hand-off report to the other group of students.
3. Pertinent information from each student’s report is posted on a flip chart or written on a white board for all students to see.
4. Discuss the needs of each patient and decide, based on priority principles, the order in which all patients will be seen during initial rounds.
5. Now let the second group of students present their patients and repeat the discussion.
6. Discuss what each group’s “assignment” would be like for the RNs caring for these two groups of patients. Does one assigned group of patients have more high acuity patients than the other assignment? Does one assignment have a lot of patients being discharged? Who could take the first admission? How could you make the assignment of these patients more equitable in acuity and work load for the RNs?

An adaptation of this exercise could include discussion about the expected outcomes for each patient and the identification of potential complications for each patient. Assisting nursing students in prioritizing nursing activities and evaluating patient outcomes will prepare them for the prioritization questions on the NCLEX-RN exam.

References


Janet E. Burton, MSN, RN, CMSRN, is a Clinical Nurse Specialist/Clinical Nursing Instructor, Columbus Regional Hospital, and a Medical-Surgical Nursing Instructor, Ivy Tech Community College of Indiana-Columbus, Columbus, IN. She is the Editor of MedSurg Matters!

Second Module in Clinical Leadership Education

AMSN’s Clinical Leadership Task Force has released the second installment of a three-part series of independent study education modules on clinical leadership. The second topic is Delegating Effectively. The three modules, designed around a “Team Building” theme, are intended to help AMSN members stay current in leadership theory and continue to develop skills that will keep them on the cutting edge of the nursing profession. The first module, Effective Relationships, was made available in March 2009.

Visit the AMSN Online Library (www.amsn.org/library) to access the presentations for free and earn 1 continuing nursing education (CNE) contact hour by completing the evaluation online. These modules are listed in the Other CE Opportunities section under Clinical Leadership Series. You must be logged in to take the session evaluation. Setting up an account is free.
Award Recognition

Janet Burton, MSN, RN, CMSRN and Sandy Huntington, MSN, NPC, MBA, CRRN were recipients of the 2009 Commitment to Professional Development Award. This annual award honors a nurse or team who has exceeded expectations and supports lifelong professional learning and/or role development at Columbus Regional Hospital in Columbus, IN.

The peer nomination stated that Janet and Sandy work to ensure that the highest quality nurses graduate from the Ivy Tech Community College of Indiana-Columbus associate degree nursing program. The nomination also stated that Janet and Sandy continue to give staff nurses assistance and evidence of best practice when consulted about clinical situations.

Janet and Sandy are employees of Columbus Regional Hospital in Columbus, IN, with full-time teaching assignments at Ivy Tech. Janet is the Editor of MedSurg Matters!

YOUR Vote Counts!

It is very important for AMSN members to exercise their membership benefit of voting for the Board of Directors. In May, AMSN members will be asked to select two candidates to serve as Directors on the National Board of Directors for a term of office from October 2010 through October 2013.

“But I don’t know the candidates.” As requested, AMSN is changing some areas in this year’s election to help the members be more informed. Members will receive a link via email to access each candidate’s biography a month before we send the ballot. This will give the membership time to review the candidates and make an educated decision. We will also implement an “Ask the Candidate” question section so our candidates can reply directly to pressing questions from our members. A description of the role of Director can be found on page 11.

AMSN employs electronic voting for national elections. Nurses are professionals on the go. E-voting gives maximum flexibility in access to each AMSN member. On April 30, members will receive an email message from the AMSN Election Coordinator, AMSNvote@directvote.net. To ensure you receive this important email, please add this address to your address book or safe-sender list today. This message will include your member number, a passcode, and a voting link.

We require your current email address to send you a ballot. Please login into the AMSN Web site (www.amsn.org) as soon as possible to edit your membership profile to be certain we have your correct email address. You can also call us toll-free at 866-877-2676 and we’ll be happy to assist you.

AMSN values your privacy and will NOT give or sell your email address to others.

Look for instructions for casting your electronic ballot to arrive via email on April 30. AMSN is your specialty organization. Voice your opinion and vote!

Centenary Year Of Florence Nightingale

Florence Nightingale, the Lady with the Lamp and the Mother of Nursing, died on August 13, 1910. 2010 has been designated as the year to celebrate Florence Nightingale’s Centenary Year. Ms. Nightingale was a young lady of London society when she became dissatisfied with the lack of opportunities for females and began to investigate possible occupations for women. As Florence visited the poor and sick in London and other countries, a dream of making nursing a vocation for women was born.

We know Nightingale best for her work in the British military hospital during the Crimean War in Turkey. This work led to the opening of the first nursing school at St. Thomas Hospital in London. Her influence was far-reaching, as evidenced by the American and French governments seeking her advice during the American Civil War and the Franco-Prussian War. Her life was not without conflict as she fought to make nursing an honorable occupation for women, an effort that led to improved patient care.

There are many places to visit in England to commemorate Florence Nightingale’s life, from her homes in Lea Hurst and Emberly Park to the Florence Nightingale Museum in London. On her birthday, May 12, you can attend a commemorative evening service in the Westminster Abbey in London. You may also travel to Instanbul in Turkey for a tour of Scutari.

Tour opportunities may be found at:

- Jon Baines Tours – www.jonbaines tours.co.uk

Resources
http://www.spartacus.schoolnet.co.uk/RNightingale.htm
http://www.victorianweb.org/history/crimea/florrie.html

Janet E. Burton, MSN, RN, CMSRN
MedSurg Matters! Editor
AMSNN’s Convention Begins with Care

AMSNN’s 19th Annual Convention is starting on the right foot—talking about nursing care. The Opening Address and Keynote Address will both discuss nursing care in new and interesting perspectives. Anne Ryder, inspirational and motivational speaker, will be presenting “Caring Technology,” and Jean Watson, PhD, RN, AHN-BC, FAAN, will deliver “Returning to the Heart of Nursing.”

In her Opening Address, Anne Ryder will explore nursing care at a time when nurses are laden with technology. In this moving presentation, the journalist will journey through what happens when technology fails and nurses rely on “Calcutta” medicine. From Haiti after the earthquake, to the Albanian refugee camps, to her own bedside emergency, Ryder will take you through the profound difference nurses make through human connection. Join us for a session to make you reconsider the congruence of technology and care.

Jean Watson, recipient of the 2010 Anthony J. Jannetti Award for Nursing Excellence, will present the Keynote Address, sharing her work and describing the ethical scientific core of caring theory and caring sciences as the foundation for professional nursing. She will examine the latest theoretical-scientific perspective on Caring Theory, Caring Science, and Heart Science and explore the latest research in Heart Science and its intersection with Caring Science. Listen to this insight into both the art and sciences of nursing as we explore the field of caring science.

Don’t miss out on these sessions for an amazing two days of evaluating nursing care from the general profession to you individually. We’ll save you a seat! AMSN’s 19th Annual Convention is at the Riviera Hotel in Las Vegas, NV, October 20-25. For more information about the Convention, visit www.amsn.org.

Submit Your Poster Abstracts For the 2010 Convention

AMSN is currently seeking abstract submissions for consideration for poster presentation during AMSN’s 19th Annual Convention, October 20-25, 2010, in Las Vegas, NV.

We are soliciting abstracts for poster presentation on creative nursing interventions, new models of services, education programs, or research projects. AMSN invites you to share your expertise with colleagues. Topics of interest related to the practice of medical-surgical nursing will be considered.

Forms are available from the AMSN Web site (www.amsn.org). They are located on the Resources page under Poster Presentations. You may also obtain an application by calling the AMSN National Office at 866-877-2676 or sending an email to amsn@ajj.com. Submissions must be received by May 15, 2010.

Now Accepting AmEx and Discover

I’ll Pay By...

We have added American Express and Discover Card to our line of credit cards for payment. Whether registering for the AMSN Annual Convention or the CMSRN exam, renewing your membership, or buying products, you have a wider selection for how you want to pay!

Nurses: Start the Celebration!

Nurses are among the most trusted professionals in this country. Celebrate the career of nursing with National Nurses Week from May 6-12, 2010. The annual weekly celebration always closes on May 12, the birthday of Florence Nightingale, founder of modern nursing. To appreciate nurses in your area you can:

• Host a reception.
• Have a recognition plaque/bulletin board.
• Create political awareness and positive media coverage.
• Give handwritten notes or photos of the nurse in action.
• Give out prizes or gift bags.

See what ideas you can come up with. Better think fast; May is just around the corner! Don’t forget to tell us how you celebrated. Send your news and photos to amsn@ajj.com.
President’s Message
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Strategies:
- Refine existing EBP/Research section of the Web site to integrate all AMSN resources.
- Develop content on Performance/Quality Improvement for the EBP/Research section of the Web site.
- Determine ways to promote EBP, Research, and Performance/Quality Improvement on the Web site.

Objective 2: Develop methods to support members in creating EBP/Research grants.
Strategy: Investigate resources and feasibility to support members in creating EBP/Research grants.

Goal 3: Professional Development
Goal: AMSN will foster learning and professional growth of medical-surgical nurses.
AMSN members feel that professional development is important and requested more opportunities for online education. The BOD determined that this goal is one of the top priorities of this strategic plan.

Objective 1: Increase online resources for leadership, professional growth, and education.
Strategy: Inventory existing AMSN resources.
- Increase awareness and accessibility of existing online AMSN education resources.

Objective 2: Implement online methods to address clinical practice issues.
Strategy: Investigate online methods for members to share clinical information.

Objective 3: Refine the AMSN mentoring programs for medical-surgical nurses.
Strategy: Evaluate the current Nurses Nurturing Nurses (N3) program.

Goal 4: National Leadership and Influence
Goal: AMSN will be the leader influencing decisions that impact medical-surgical nursing.
AMSN’s priority agenda for practice, professional development, and collaboration are outlined in the priority agenda document. This document will assist AMSN’s leaders by having a clear, concise message. The priority agenda guides AMSN in strategically linking with current alliances and growing new alliances and relationships with other organizations outside of AMSN.

Objective 1: Articulate AMSN’s priority agenda for leading the future of medical-surgical nursing.
Strategy: Draft priority agenda document.
- Determine ways to communicate and use the priority agenda internally and externally.
- Determine current and future goal of position statements.

Objective 2: Form strategic alliances/affiliations/relationships that are consistent with the mission and strategic direction of AMSN.
Strategy: Evaluate AMSN’s current alliances/affiliations/relationships for consistency with the strategic direction.

Goal 5: Promoting Organizational Health
Goal: AMSN will have a strong, distinct identity with systems that promote organizational vibrancy.
An overwhelming number of AMSN members responded that their professional identity is tied to the medical-surgical nursing practice setting. A clear and consistent identity is essential for the short and long-term visibility and growth of the organization. The BOD chose the objective to create a clear and consistent identity as its top priority for the new strategic plan. Operations and organizational health are essential components of the strategic plan. Thus, evaluation of all entities, including volunteer units and local chapter support, will be essential in order for AMSN to remain successful and continue to thrive.

Objective 1: Refine the identity of AMSN.
Strategy: Engage a consultant to assist the board in assessing and refining AMSN’s identity.

Objective 2: Align volunteer activities with the strategic work of AMSN.
Strategy: Evaluate current chapter structure.
- Assist volunteer units in identifying and accomplishing their work.

Objective 3: Implement a strategy for chapter support.
Strategy: Evaluate current chapter structure.
- Engage a consultant to assist the board in assessing and refining AMSN’s identity.
- Align volunteer activities with the strategic work of AMSN.

The BOD created an atmosphere of accountability by assigning a board member to champion each goal. The next phase of designing the strategic plan will be determining the volunteer skill sets and competencies needed to meet each objective. As the bedside nurse looks to innovative ways to balance the work environment, the BOD will be looking at ways to make the best use of each volunteer’s time and energy, while making a beneficial and meaningful contribution to their professional development goals and advancing the practice of medical-surgical nursing.

The BOD worked brilliantly and diligently to design a strategic plan tailored to its members, mindful of its most precious resource – YOU – and a plan that is easily and quickly adaptable to an ever-changing world. As Spring arises from the harshness of winter and the slush melts, so does the strategic plan spring forward after much hard work! Thank you to Sandy, Jill, Kathy, Cyndee, Denise, Mary, Linda, Jane, and Sue. Look for updates, as the strategic plan blooms, in MedSurg Matters!

Speaking of Spring – it isn’t too early to start planning to attend AMSN’s 19th Annual Convention October 20-25, 2010, in Las Vegas at the Riviera Hotel. Happy Spring!

Kathleen A. Singleton, MSN, RN, CNS, CMSRN
AMSN President
The mission of the Academy of Medical-Surgical Nurses is to promote excellence in medical-surgical nursing.

Medical-surgical nurses will use their powerful voice and focused action to continuously improve patient care.

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