I grew up hearing the phrase “have a blast” in the context of meaning to have fun. I remember as each school year winded to a close, the students would tell each other,”Have a blast on your summer vacation!”

Working as a clinical nurse on a bone marrow transplant unit, I quickly learned that the word blast has a different meaning for patients with cancer. Specifically, for patients with leukemia, the word blast has a very unfavorable and potentially devastating connotation. A blast is an undifferentiated leukocyte. The word undifferentiated can be interchanged with the word immature, meaning that these cells are not mature enough to provide the patient with a sufficient immune response against invading pathogens. Blasts in the peripheral blood can be an indication that disease is present or that the disease has relapsed if the person was previously in remission (Parikh, Kadia, & Jabbour, 2010). There are acute and chronic types of leukemia, which will be briefly discussed here. It is important for all medical-surgical nurses to feel comfortable and confident in caring for this unique patient population.

A Review of Leukemia

There are two main variations of leukemia: acute leukemia and chronic leukemia. The most common types of acute leukemia are acute myeloid leukemia (AML) and acute lymphoid leukemia (ALL). Ganzel and Rowe (2011) stated that age is the most important prognostic factor in both types of acute leukemia due to co-morbidities such as diabetes and hypertension, which statistically

continued on page 2
increase with age. Acute leukemias are generally more aggressive than the chronic variation. The difference between AML and ALL is in the cell line; AML is a blood cancer that stems from the myeloid cells, and ALL stems from lymphoid cells. A pathologist will make the determination because the treatment regimens used are different. Patients with acute leukemia are often brought to an inpatient hospital setting to receive induction chemotherapy. Patients seek support from family, friends, and health care professionals to help them cope during this complicated process (Meenaghan & Dowling, 2010).

The chronic leukemias can also occur in the two main white blood cell branches – lymphoid (CLL) or myeloid (CML) cells. The chronic forms are often more indolent and less aggressive. Although, with CML blast crisis can occur, making it behave much more like an acute leukemia. Sessions (2007) stated that chronic myeloid leukemia is a stem cell cancer and represents 15-20% of all adult leukemia diagnosed each year. Huge medical advances have been made in the treatment of CML. Many well-tolerated oral therapies can now be used to stabilize the disease for years.

Most individuals are between the ages of 50 and 60 years when diagnosed with chronic myeloid leukemia and may have multiple co-morbidities. Laboratory tests, specifically a complete blood count (CBC) with differential, are a must to monitor these patients. Patients with CML must always be aware of the potential for a blast crisis. Although technically, the blasts seen in the acute and chronic leukemias are different, it is important to discuss both situations. Blast crisis is only used to describe hyperleukocytosis in CML.

**Blast Crisis**

Calabretta and Perrotti (2004) discussed that chronic myelogenous leukemia has three clinical stages: chronic phase, accelerated phase, and blast crisis. The blast crisis phase is described as the rapid expansion of a population of myeloid blast cells. During a blast crisis, chronic leukemia patients will most likely be admitted to the hospital and given intravenous chemotherapy. They may need a specific type of apheresis, called leukapheresis, to help remove some of the excessive numbers of white blood cells from the blood stream. This process involves filtering and concentrating the excessive peripheral white blood cells and removing them from the blood, while infusing the other blood products back into the patient (Calabretta & Perrotti, 2004). It is important for the nurses to offer support and education to patients and their families during this trying period. Although patients can be treated for a blast crisis on a medical-surgical unit where nurses are trained to give chemotherapy, sometimes patients may need to be moved to the intensive care unit for closer monitoring. It is important to explain this to patients and their families.

**Regimens Used During a Blast Crisis**

Fruehauf and colleagues (2007) discussed the combination of mitoxanthrone and etoposide to treat a blast crisis. Cytarabine-containing regimens are often used as well. To administer these medications, it is important for the nurse to be aware of the side effects of each medication, such as cardiac toxicity, neurological alterations, and pancytopenia. Central intravenous access is needed for these chemotherapy infusions, and vital signs must be frequently checked by the nurses or nursing assistants. Fruehauf and colleagues (2007) noted that in the 16 patients enrolled in the study, the regimen was well tolerated; however, expected pancytopenia did present, requiring many of the patients to receive red blood cell and platelet transfusions. Strict hand washing and stringent central line care are also a must for these patients, as their white count drops between treatments and their risk of infection grows. Nurses play a huge role in the education and emphasis of infection prevention (Brown, 2010).
Blasts Seen After Treatment

After chemotherapy is completed, all leukemia patients must be closely monitored through bloodwork for pancytopenia, and blood or blood product transfusion may be needed during the patient’s nadir, or peak effect of chemotherapy on bone marrow production. This time frame can be very stressful to patients and their families and they will often ask for a copy of their CBC with differential. Seeing peripheral blast percentages on a differential report would make most patients concerned, but one group of authors notes that peripheral blasts can be seen after chemotherapy and go on to say that this “generally represents primary refractory disease and portends a poor prognosis, however this may not be true for all patients” (Parikh et al., 2010, p. 301). These authors are writing about peripheral blasts appearing on day 21 after induction chemotherapy and resolving without intervention at day 28. It is important that the patient is aware of this potential transient increase in peripheral blasts and that repeat blood counts will continue to be necessary.

Allogeneic bone marrow transplantation can be used when the patient with acute leukemia is in remission in an attempt to replace the patient’s hematopoietic cell line with new, healthy stem cells. Patients who have had a transplant may have blasts in their white blood cell count differential for a few days during the engraftment phase due to the transient increase in peripheral blast counts that resolves without intervention as discussed in the previous paragraph. This is often a very unsettling time for the patient because of the fear that the leukemia may not be gone. It is important to explain to these patients that in the post-transplant period, blasts may be reported, but it does not necessarily mean that they have relapsed or that graft failure has occurred. The post-chemotherapy increase in peripheral blasts can be generally applied to the post-transplantation laboratory results to reflect that as a patient’s new marrow (donor marrow) begins to produce white blood cells, sometimes immature or blast cells are pushed out into the peripheral blood as well. Continued follow-up of bloodwork, bone marrow biopsies, and other blood tests post-transplant are a must to determine if the transplant was successful (McAdams & Burgunder, 2004).

Summary

Farsi, Nayeri, and Negarandeh (2012) are nurse researchers who, at many times in their article on the coping process of adults with leukemia, reflect on the impact that nurses have in supporting patients and helping them express their fears and concerns. As a medical-surgical nurse, it is critical to have some baseline understanding of the acute and chronic forms of leukemia to be able to provide effective support and education to our patients. One important thing to remember when dealing with this unique population is the other meaning of the phrase “having a blast.”

References


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Understanding Celiac Disease: A Recipe for Nursing Care

Lisa O’Donnell

Celiac disease is a genetic, autoimmune disorder that is triggered by the presence of gluten. Patients with the disorder should adhere to a gluten-free diet. Because celiac disease has become so prevalent and its presentation is often puzzling, it is imperative that nurses understand the symptoms, screening, diagnosis, and treatment of the disease, as well as nursing implications.

Celiac disease is an autoimmune disease that is genetically linked and affects 1 out of 100 people worldwide. 2.5 million Americans are thought to be undiagnosed or are experiencing long-term complications from the disease (Celiac Disease Foundation, 2014c). The leading cause of celiac disease is the ingestion of glutenous products, which can cause damage in the small intestine (Celiac Disease Foundation, 2014c). Gluten-free products have become prevalent in the marketplace, restaurants, and food products. Patients diagnosed with celiac disease must adhere to a lifetime commitment of a diet that excludes wheat and other related proteins such as barley, rye, and oats. This diet is often difficult to sustain and the ingestion of gluten results in atrophy or flattening of the villi that line the small intestine, causing mucosal inflammation. The villi are responsible for the absorption of nutrients. Those who are susceptible to the disease have an autoimmune disorder in which the intestinal villi are destroyed, thus affecting absorption of vital nutrients (Boettcher & Crowe, 2012).

Pathophysiology

The pathophysiology of the disease is induced by dietary gluten in individuals who are susceptible to the disease. The ingestion of gluten results in atrophy or flattening of the villi that line the small intestine, causing mucosal inflammation. The villi are responsible for the absorption of nutrients. Those who are susceptible to the disease have an autoimmune disorder in which the intestinal villi are destroyed, thus affecting absorption of vital nutrients (Boettcher & Crowe, 2012).

A review of the autoimmune process of celiac disease by Peck and Meize-Grochowski (2011) indicated that it has genetic, environmental, and immunological components. The genetic component is the presence of an antigen that can be found in the...
blood, and the environmental component is the ingestion of gluten. The immunological component is a response that can be triggered by infection, injury, surgery, pregnancy, puberty, and many other possibilities. Both B-cells and T-cells (antibodies) are involved in the immunological process that recognizes gliadin and glutenin, the protein factors of gluten (antigen), as foreign substances that stimulate antibody production. Gliadin can cause the most trouble because it increases intestinal permeability, which allows it to pass into the intestinal mucosa. Enzymes and lymphocytes develop as a result of the cell injury from the foreign substance, causing the symptoms of celiac disease (Fasano, 2014).

**Symptoms**

According to the Celiac Disease Foundation (2014a), celiac disease can be difficult to diagnose because it affects people in many different ways. There are hundreds of known symptoms that not only occur in the digestive system, but other parts of the body as well. Even though some people with celiac disease have no symptoms, all people with celiac disease are still at risk for long-term complications (Celiac Disease Foundation, 2014a). Children exhibit digestive symptoms such as bloating, diarrhea, and constipation, and kids can exhibit other extra-gastrointestinal symptoms including failure to thrive and Attention Deficit Hyperactivity Disorder (ADHD) (Celiac Disease Foundation, 2014a). Adults exhibit fewer digestive disorders than children, and some of these symptoms include fatigue, arthritis, depression, tingling and numbness in the hands and feet, and a skin rash called dermatitis herpetiformis (DH) (Celiac Disease Foundation, 2014b). The latter presents bumps and blisters that resemble herpes lesions (Celiac Disease Foundation, 2014b). Of people ages 30-40 with no digestive symptoms, 15-25% exhibit DH; this is often misdiagnosed as eczema (Celiac Disease Foundation, 2014b).

**How is Celiac Disease Diagnosed?**

Celiac disease can be diagnosed by blood tests, an intestinal biopsy, and the presence of dermatitis herpetiformis (DH). People with celiac disease have higher than normal levels of certain autoantibodies that trigger the autoimmune response (Brown, 2013). In addition to the antibody testing, genetic testing can also be performed.

An endoscopy with a duodenal biopsy is often considered the most definitive method of diagnosing celiac disease and samples can be analyzed to measure the degree of atrophy of the villus or flattening (Brown, 2013). The presence of DH can also signify celiac disease. This skin disease can be diagnosed through blood tests and a skin biopsy. If the antibody tests are positive and the skin biopsy has the typical findings of DH, the patient has celiac disease. Patients do not need to have an intestinal biopsy if these tests are positive. DH responds to a gluten-free diet and recurs if gluten is added back into the diet (National Institute of Diabetes and Digestive and Kidney Diseases [NIDDK], 2014).

**Treatment and Nursing Implications**

Adhering to a gluten-free diet can be challenging for patients. This type of diet will usually reverse the course of the disease, allowing the intestines to heal and symptoms to subside. Nurses are at the forefront to help patients better understand the disease and how removing gluten from the diet is priority.

Nurses can begin teaching patients about the hidden danger of gluten in food products and other substances. Food labels are not required to indicate that products are “gluten-free,” so patients need to learn how to read nutrition labels. Also, some products with food ingredients do not list gluten directly, so gluten can be hidden. Gluten is also used as a stabilizer, emulsifier, and thickening agent in a vast amount of processed foods. Some of these foods are sauces, marinades, processed meats and meat substitutes, soups, and candies. Patients need to be educated about the possibility of gluten in those products (Celiac Sprue Association, 2014). Patient teaching about diet for celiac disease often includes a multidisciplinary approach. Nurses need to collaborate with a dietician to teach patients how to eat a balanced diet and adopt a gluten-free diet with little expense. Nurses should also teach patients to be aware of vitamins, supplements, and prescription and over-the-counter drugs they might take that contain gluten. Gluten can also be found in some nonfood products such as shampoos and lotions, and this can become problematic if ingested. Products such as lipsticks, lip balms, and oral and dental care products could contain gluten. Patients should be encouraged to read the ingredients carefully on these products (Mayo Clinic, 2015).

Nurses can encourage patients to ask about gluten-free choices when they are dining out, especially because many restaurants have these choices on their menus. Patients should be taught how to ask about cross-contamination during preparation of food, such as boiled pasta water and food prepared in oil (McCabe et al., 2012).

Patients with celiac disease often report symptoms that are vague and could be similar to many other diseases. Many patients seek medical advice from a wide array of medical providers with few answers and over a course of many months. Nurses can provide support to patients by listening and giving them accurate information and emotional support. Patients can be referred to support groups, which can be especially helpful to the newly diagnosed. Participants can support each other in transitioning to and maintaining a gluten-free diet, become educated about the disease, and share information on available resources. Nurses can also refer patients to health care providers who are knowledgeable about the disease and will perform a thorough workup, including a biopsy. The Celiac Sprue Association (www.csceliacs.org) can provide a list of centers that specialize in caring for patients with the disease and find centers close to home (McCabe et al., 2012).

Finally, in addition to the above nursing implications, patients must also continue to follow up with their health care providers. Because patients with celiac disease are at a
higher risk for other autoimmune diseases, it is necessary to teach them about yearly serologic testing to ensure that adhering to the gluten-free diet is effective. Some other testing could include bone-density testing, testing for nutritional deficiencies, and also for possible malignancies (McCabe et al., 2012). In 5% of patients with celiac disease, a refractory celiac disease develops. In this percentage of patients, the damaged villi in the small intestine do not heal from a gluten-celiac disease develops. In 5% of patients with celiac disease, a refractory celiac disease develops. In this percentage of patients, the damaged villi in the small intestine do not heal from a gluten-free diet, and all other potential causes of the damage have been ruled out (Celiac Disease Foundation, 2014a). Patients can be treated for this type of celiac disease by managing any nutritional deficiencies, possibly with total parental nutrition, and prescribing corticosteroids and immunosuppressants (McCabe et al., 2012).

Conclusion

The prevalence of celiac disease can result in long-term complications and if left untreated or misdiagnosed, can be detrimental to the health of the medical-surgical patient. Public awareness and education of the disease need to be elevated, as patients present with symptoms that are so common to other disorders that treatment becomes delayed. The average time from onset of symptoms to diagnosis for adults in the United States is 10 years (NIDDK, 2014). Although there are numerous signs and symptoms of celiac disease, a significant percent of patients still have no symptoms (The University of Chicago Celiac Disease Center, 2016). The diagnosis of celiac disease requires a permanent change in one’s lifestyle, and this can lead to psychological effects for the patient who would need to adhere to a restricted diet. Nurses need to provide support and concrete, helpful resources to the patient. Patient teaching related to diet is of utmost priority for the medical-surgical nurse. As nurses, we need to continue to educate lay people, health care professionals, and our patients about this disease, particularly the symptoms and treatment to improve their quality of life.

References


Suggested Reading


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Quality and Safety…
The Search Continues

Quality and safety matters to all of the stakeholders involved in health care delivery. The recipients (patients and their families) have a vested interest in receiving safe, high quality care. Organizations are reimbursed based on quality scores. Talented, dedicated care providers are attracted and retained by organizations that corroboreate and support quality nursing care. Payers have acquired an awareness that associating with organizations that provide high quality care reduces risk to patients, decreases admission recidivism, and results in increased client satisfaction. “Preventable medical errors persist as the Number 3 killer in the U.S.,” (McCann, 2014). Despite sharing the goals of providing the highest levels of quality and safety, achieving these goals continue to elude our industry.

Health care providers have been searching for mechanisms that will support the organization’s goals and facilitate the achievement of a culture of safety. In 2003, the Robert Wood Johnson Foundation (RWJF) funded a bedside nursing initiative of the Institute for Healthcare Improvement (IHI), Transforming Care at the Bedside (TCAB), with a “goal [that] was not only to make the hospital experience safer and more pleasant for patients, but also to free up nurses to spend more time in direct patient care, thereby increasing nurses job satisfaction and retention as well as quality of care” (RWJF, 2011, p. 1). RWJF collaborated with the other quality-focused organizations, schools of nursing, and nursing staff at pilot hospitals. Learning modules were developed and toolkits were created to help educate and support nurses in practice. Successes of the initiative include the development and implementation of Rapid Response Teams (IHI, 2015), discussions leading to enhanced communication and teamwork, and the acceptance of patient-centered care as a universal goal. Despite the positive reports, we have yet to be able to assure our patients that nirvana has been reached.

QSEN (Quality and Safety Education for Nurses) is the latest and greatest quality and safety initiative on our horizon…but is it really a new enterprise? Identified QSEN core competencies share a number of the same attributes as the foundational elements of TCAB (see Table 1).

Does this reiteration of initiative ingredients suggest a duplication or rehashing of nursing efforts? Will integrating yet another new program into practice take us to a tipping point that will serve to alter human behavior and break down barriers to safe, effective, high quality nursing care? Will starting with nursing neophytes (pre-licensure education) mean a better possibility of having the education stick? We’ll take a deeper look at QSEN in the next issue.

References

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Join AMSN in Commemorating a Milestone

Look for announcements in the MedSurg Matters! newsletter, Med-Surg Nursing Connection e newsletter, the AMSN Hub, member email messages, and on the AMSN website for ways you can participate in the celebration.

If you have questions or comments regarding the “Quality Matters” column, or if you are interested in writing, please contact Column Editor Marguerite Windle at maggiedw@gmail.com.
As health care continues to evolve with technological advancements, complexity of patient prognosis, and competitiveness to provide the best care, there will be a demand for increased knowledge and accountability from providers. Nursing certifications recognize those individuals who demonstrate an advanced knowledge base, along with qualifications and skills within a particular specialty. Certification within nursing continues to advance, playing an essential part within the American Nurses Credentialing Center’s (ANCC’s) Magnet® Recognition Program for excellence in nursing services.

Research suggests that there is a strong correlation between certified nurses and job satisfaction, retention rates, patient safety, autonomy, and empowerment amongst peers. Evidence also supports intrinsic and external factors as the motivators that encourage practitioners to become certified within their nursing specialty. According to Schroeter, Byrne, Klink, Beier, and McAndrew (2012), “Certification represents a commitment to the leading edge in health care and professional standards and indicates to patients, employers, the public, and professional licensing bodies that the certified nurse is qualified, competent, and current in a nursing specialty/area of practice” (p. 36).

What is Certification and Why is it Important?

Certification is defined by the American Board of Nursing Specialties (ABNS) as the formal recognition of specialized skills, knowledge, and experience demonstrated by the achievement of standards identified by a nursing specialty to promote optimal health outcomes (ABNS, 2014). Certification in bedside nursing is a voluntary process undertaken by nurses, which includes completion of a nursing-specific exam in order for the public and peers to recognize quality nursing care (Shirey, 2005). Professional certification has been a measure of distinctive nursing practice since the 1970s and its criterion for meeting multiple standards with ANCC’s Magnet Recognition Program for excellence in nursing services (Haskins, Hnatiuk, Yoder, 2011).

According to ANCC, certification allows nurses to validate their knowledge while practicing in their specialty of expertise (ANCC, 2014).

Benefits

There are many benefits to certification within an organization. Literature suggests the primary benefits include personal achievement, validation of knowledge, access to job opportunities, financial incentives, and greater professional credibility through increased confidence in specialty skills and knowledge (Haskins et al., 2011). Certification leads to empowerment in nursing practice, professionalism, and higher retention rates, and can be driven by intrinsic and extrinsic factors.

Empowerment in Practice

Certified nurses feel empowered in their practice with the recognition and validation of surrounding peers. Empowerment from certification is a factor that also motivates nurses to climb the clinical ladder of expertise within their organization. Research suggests that if nurses achieve specialty certification, they remain in practice longer than non-certified nurses in order to apply advanced knowledge. Certification can increase a nurse’s informal power on a nursing unit due to the recognized knowledge and expertise in the specialty. Through certification, validation of qualifications and competency are demonstrated, as well as professional aspirations to improve quality of patient care and patient services (Haskins et al., 2011). According to a study on the views of
med-surg nursing, non-certified nurses and nurse managers have positive perceptions of certification (Haskins et al., 2011). Evidence also suggests there is an increased confidence in a nurse’s abilities, earlier intervention to prevent problems, and greater nurse/physician collaboration with certification. Autonomy in one’s profession and clinical expertise are only enhanced by certification, providing a means to practice with improved patient outcomes and patient safety as an end goal (Fleischman, Meyer, & Watson, 2011).

Professionalism

The National League for Nursing affirms that certification in any field is a mark of professionalism (Kaplow, 2011). Upon certification, the nurse perceives a sense of professional pride and achievement, along with a higher level of professional practice. One study revealed that certified nurses scored higher on total professionalism and autonomy than non-certified nurses (Kaplow, 2011). Certified nurses are more marketable during an interview or transfer process. They also have a greater chance for internal or external promotions. A study conducted by ABNS found that 86% of managers would hire certified nurses over non-certified nurses (Kaplow, 2011).

Nurse Retention

Certification affects recruitment and retention rates, while increasing an organization’s ability to achieve Magnet designation through the ANCC Magnet Recognition Program. The desire to reach Magnet status puts more emphasis on the certification process. Certification has been shown to improve outcomes. For example, on one acute care medical unit at an academic facility, there was a 60% increase in certified nurses in one year that was associated with a decline in the rate of nurse turnover (from 16.7% to 8.1%), a decrease in vacancy rate (from 11.7% to 4.73%), and an increase in patient satisfaction scores (from 88.2% to 90.4%) compared to the previous year (Craven, 2007).

Certification allows employers to know that their nurses have the knowledge and experience to promote optimal patient outcomes, but certification also suggests a commitment to nursing quality and the profession. Nurses who take the time to get certified intend to remain employed in the area where their knowledge can be implied. According to a study correlating patient safety outcomes and certified nurses, findings suggested nursing certification may be a positive influence on outcomes in hospitalized older adults. The study also recommended that nurse certification is a worthy investment for hospitals in improving safety outcomes in hospitalized adults (Boltz, Capezuti, Wagner, Rosenberg, & Secic, 2013).

The ABNS believes employers should support and recognize individuals who seek certification, but also seek certified individuals to work with a current team of nurses. The board also encourages employers to inform the public about certification status within an organization and display these credentials. Celebrating certification in nursing and allowing credentials to be proudly displayed on plaques and name badges promotes certification within an organization (Shirley, 2005). Public recognition by the institution and administration adds additional support in the retention and recruitment of certified nurses. Certified nurses must maintain a certain number of hours in their specialty and must enroll in continuing education units to remain in good standing.

Motivators to Certify

Different factors motivate different individuals to pursue certification, but the two distinct classifications are intrinsic and extrinsic rewards. Intrinsic rewards are internal motivators that influence an individual to personally and professionally grow. Examples of intrinsic factors include feelings of personal accomplishments, personal satisfaction, validation of specialty knowledge, professional commitment, attainment of a practice standard, enhanced personal confidence in clinical abilities, evidence of accountability, and enhanced professional autonomy (Kaplow, 2011). Extrinsic rewards are typically motivators that are supported externally, including recognition of peers, marketability, recognition from other health care professionals, recognition from employers, increased consumer confidence, and increased salary (Kaplow, 2011).

Barriers

Promoting certification within a nursing environment can meet resistance even when the benefits outweigh the barriers. A survey conducted by the ABNS revealed that the major barriers to certification were cost of examination, lack of institutional support, and lack of rewards for becoming certified (Teal, 2011). Nurses, who have been out of school for years, fear the exam preparation process, especially when there is a lack of resources to provide review courses or supplemental review material. If an institution does not reimburse or compensate the exam fee, nurses find it difficult to spend their own money, especially if there is a lack of recognition upon completion. A study found that nurses who at one point in their career had been certified and failed to renew certification, contributed their certification expiration to the lack of recognition, lack of compensation to assist with the renewal process, and the lack of time to dedicate toward

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Continuing education due to professional and personal issues (Haskins et al., 2011).

Unit Example

Virginia Commonwealth University (VCU) Medical Center is an 800-bed academic, level I trauma medical center. As a Magnet organization, the health system supports and encourages nursing certification through incentives, acknowledgment, and reimbursement. Acute Care Surgery, awarded the Gold Beacon for Excellence, is a 28-bed unit consisting of general and intermediate level of care patients, composed of multiple surgical services including plastics, general and bariatric, surgical oncology, and urology. Over the last few years, the number of certified nurses at the bedside has grown exponentially, with certification as a milestone goal for clinical nurses at the bedside.

Acute Care Surgery Data

Currently, there are 50 registered nurses on the Acute Care Surgery unit at VCU Medical Center. Of the 50 RNs assigned to the unit, 33 are certified; this equates 89% of eligible RNs certified on the unit. On the Acute Care Surgery unit, it is an encouraged action from administration and from peers to test for certification as soon as the two-year mark of employment approaches. Nurses value the evidence-based research surrounding certification and have seen a difference in their practices. Nurses on Acute Care Surgery are driven to become certified by the autonomy and informal leadership, a higher level of professionalism, and better patient outcomes associated with certification. With the support of peers and administration, as well as the recognition and celebration of certification, nurses feel empowered and accomplished as they are publicly recognized among staff and patients (see Figure 1). Certification is beneficial to a unit’s overall morale and professional practice.

Conclusion

Nursing certification within a specialty area impacts a health care organization, clinical nurses, and patient outcomes. Nursing certifications recognize those individuals who demonstrate an advanced knowledge base, along with qualifications and skills within a particular specialty. It also demonstrates the willingness to devote practice within a specialty area as a certified nurse. Certification provides recruitment and retention for units, allows for autonomy in practice, sets a level of professionalism, empowers nurses, and improves interprofessional collaboration. The exemplar provided from the Acute Care Surgery unit supports the evidence that certification is important. Nurses value their certifications and as a result, prioritize professional practice. Each nurse demonstrates the knowledge to provide excellent care while creating a supportive environment that fosters certification excellence. Competency, validation of specialty nursing knowledge, and validation of clinical judgment and practice are all benefits of specialty nursing certification. Research suggests investment in the encouragement process and celebration process of certification must be held in order to achieve a level of excellence.

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Exploring the “Rewind Technique” to Alleviate PTSD

While the Joining Forces Initiative focuses on the war veteran, other people who have experienced extreme stress or a non-war traumatic incident can also suffer from manifestations of Post-Traumatic Stress Disorder (PTSD). The Diagnostic and Statistical Manual IV (DSM-IV) categorized PTSD on the anxiety spectrum (American Psychological Association [APA], 2013). The new DSM-V, released in May 2013, has re-categorized PTSD as a trauma or stress-related disorder, recognizing the impact of the individual’s experience with death, serious injury, or sexual assault (APA, 2013). The DSM-V now includes four diagnostic clusters of PTSD: re-experiencing, avoidance, negative cognition, and mood and arousal (APA, 2013).

PTSD affects between 13% and 17% of Iraqi veterans and about 10% of those returning from Afghanistan (Gray & Liotta, 2012). Approximately 40% of returning veterans don’t seek or receive treatment and continue to live in the silent anguish of PTSD (Gray & Liotta, 2012). Extreme trauma occurs around the world. In 1994, approximately 10% of Rwanda’s citizens were brutally murdered as an act of genocide, where “war rape” was a commonplace tactic (Utuzza et al., 2012). Even today, Rwanda is still recovering from this massive scourge of lives.

Evidence-based, efficacious treatments for PTSD have been elusive. Current mainstream treatment modalities include non-specific beta blocker therapy like propranolol and cognitive behavior therapy (CBT), with mixed and limited results (Sharpless & Barber, 2011). Cukor, Spitalnick, Difede, Rizzo, and Rothbaum (2009) commented on a number of emerging treatments for PTSD, many of which are in need of randomized controlled testing to assess safety and efficacy. This is a niche for research-oriented nurses, especially those who work closely with veterans and/or trauma patients. Broad categories of PTSD therapies needing validating studies consist of seven major treatment areas: social and family-based, behavioral, imagery-based, distress tolerance, power therapies, technological-based, and pharmacologic treatments (Cukor et al., 2009).

As clinical nurses, we care for patients who could have a primary diagnosis of PTSD, although patients in the medical-surgical area are more likely to have a past medical history of PTSD. While we may be directing our care to their presenting problem, we must provide holistic care to our patients. As key members of the interprofessional team, we can suggest alternatives to help our patients who suffer in silence with PTSD. One particular “power” therapy to consider is the Visual-Kinesthetic Dissociation Protocol, also coined the Rewind Technique (RT) by Dr. David Muss in the United Kingdom (UK), where RT is a recognized modality in that country (Gray, 2010).

RT, developed in the early 1980s, emerging from the field of neuro-linguistic programming (NLP), is facilitated by a therapist who has been trained in the technique (Gray, 2010). Essentially, through brief and non-invasive questioning so that the patient does not relive the trauma, the goal of therapy is to re-classify the debilitating memory into one of three states, in which the memory is either transformed, inaccessible, or rendered non-traumatizing (Gray, 2010). RT has been in use for 25 years, though there have been just three scien-
tific studies, two reviews, and several mentions in the literature (Gray, 2010). There are anecdotal studies that suggest RT should be re-examined for possible use in the growing PTSD population.

The premise of RT is that traumatic memories are stored verbally and contextually (Gray & Liotta, 2012). When the memories are incompatible with the patient’s core beliefs that define their world (Gray & Liotta, 2012), the stage is set for the roots of PTSD to take hold. Healing is completed when both verbal and contextual memory are reconsolidated (Gray & Liotta, 2012). In psychology, there are the concepts of memory reconsolidation and extinction (Gray & Liotta, 2012). RT is a form of exposure therapy that reconsolidates, which is similar to de-classifying top secret information into the public sector, essentially de-toxifying the horrendous memory. Alternatively, extinction mechanisms can reactivate and spontaneously recover, necessitating further treatment (Gray & Liotta, 2012).

RT places the patient in a virtual movie-theatre where the patient is in the movie room behind a glass window, watching themselves in the movie theatre seat as a movie plays with their trauma as the main feature (Gray, 2010). Just as the patient is becoming tense, the movie becomes black-and-white and shows the time from before to after the trauma, where both endpoints are safe places (Gray, 2010). The patient is dissociated from his or her body and is watching the black and white movie until able to do so without discomfort (Gray, 2010). Dietrich and colleagues (2000) suggested that RT be used with caution in patients with dissociative tendencies. The patient then reconsolidates with the body (Gray, 2010). Then, the trauma is played backwards in full color over a 2- to 3-second period of time, and the movie ends with the patient in a safe place in full, living color (Gray, 2010). RT preserves the memory but without the traumatic physiological and psychological manifestations.

RT has been used in a group setting in Rwanda, and the technique has been easily adapted to a different culture and language (Utuza et al., 2012), owing to the universality of trauma experience and sequelae. The pilot study in Rwanda suggested that most traumatized citizens benefited from the intervention (Utuza et al., 2012). As nurses who may be working directly with veterans on medical-surgical units or helping in disaster relief, there are opportunities to consider RT as nurse researchers or advocates for alternative therapies for PTSD.

References

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Improving Care Through Better Nursing Documentation

Elderly trauma patients have higher complication and mortality rates compared with younger victims with similar injuries. Gaps in the nursing documentation of measures to prevent hospital-acquired complications may be documentation-related, costly, and are probably preventable. The findings in this study highlight the importance of the relationship between nursing documentation requirements and the system used for the expedient documentation of nursing care.


Hospital-Acquired Conditions Reduced By 17% From 2010 to 2013

Hospital patient safety substantially improved from 2010 to 2013 with a 17% decline in hospital-acquired conditions (HACs), according to a final data synthesis from Agency for Healthcare Research and Quality (AHRQ). The decline translates to 1.3 million fewer incidents of patient harm, approximately 50,000 fewer patient deaths in hospitals and $12 billion in health care cost savings.


People With Arthritis Report More Limited Life Activities and Psychological Distress

A Centers for Disease Control and Prevention study of adults ages 18 years and older reported that having multiple chronic conditions was associated with poorer outcomes for important life domains (social participation restriction, serious psychological distress, and work disability). Having arthritis as one of those multiple chronic conditions made things even worse. Because arthritis is a common condition (affecting more than 1 in 5 adults) and often occurs with other chronic conditions, it is important to highlight the possible role of arthritis when discussing the negative effects of having multiple chronic conditions and the interventions needed to address those impacts.

To learn more, visit http://www.cdc.gov/features/arthritis-quality-life/

Comprehensive Prevention Program Effectively Reduces Falls Among Older People

Families and health care professionals have a new tool in the fight against falls — a comprehensive prevention program that reduces both falls and the resulting use of long-term care, such as nursing homes. The prevention program includes clinical in-home assessments of health, physical functioning, falls history, home environment, and medications to create customized recommendations. The program was developed by the U.S. Department of Health and Human Services.

For more info, see Cohen et al. (2015). Prevention program lowered the risk of falls and decreased claims for long-term services among elder participants. *Health Affairs*, 34(6), 971-977.

An Incentive Pay Plan for Advanced Practice Registered Nurses

Advance practice registered nurses (APRNs) are integral to the provision of quality, cost-effective health care throughout the continuum of care. To promote job satisfaction and ultimately decrease turnover, an APRN incentive plan based on productivity and quality was formulated. Clinical productivity in the incentive plan was measured by national benchmarks for work relative value units for non-physician providers. After the first year of implementation, APRNs were paid more for additional productivity and quality and the institution had an increase in patient visits and charges. The incentive plan is a win-win for hospitals that employ APRNs.


New Report: Assessing Progress on The Future of Nursing

The Institute of Medicine convened a committee to examine changes in the field of nursing since the release of *The Future of Nursing* report and to assess progress made in implementing the report’s recommendations. The resulting report, *Assessing Progress on the Institute of Medicine Report The Future of Nursing*, offers recommendations that provide a blueprint for the Campaign for Action and other stakeholders to accelerate implementation of *The Future of Nursing* recommendations.

For more info, visit http://iom.nationalacademies.org
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