The Joint Commission National Patient Safety Goals encourage hospitals to reconcile medications and to involve patients in their care. A program entitled “Ask Your Nurse about Your Medication” is described as a successful strategy nurses can implement to achieve these goals.

The Institute of Medicine (IOM) report To Err is Human: Building a Safer Health System estimated that medical errors are the eighth-leading cause of death in the United States each year (IOM, 2000). Medication errors are the most frequent cause of these errors and account for 7,000 deaths each year (IOM, 2003, 2004). Hospital medication error rates can be as high as 1.9 per patient per day (Fontan, Maneglier, Nguyen, Loirat, & Brion, 2003). Given these statistics, The Joint Commission established the 2008 National Patient Safety Goals. At the University of Maryland Medical Center (UMMC), strict adherence to the goals is seen as an important step in ensuring safety, and staff are encouraged to incorporate them into daily practice. This article describes a program that was implemented at UMMC to address two of the safety goals: (1) reconcile medications completely and accurately on admission, during patient transfers, and at discharge; and (2) encourage patients to be involved in their care.

Partnering with Patients to Improve Medication Safety

Government agencies, health care providers, and purchasers of group health care (like The Leapfrog Group) are working to make health care systems safer through multiple initiatives. One such initiative is to encourage patients and families to participate in preventing medical errors by taking an active role as informed health care consumers. This participation is seen as a critical factor in improving safety and quality of care.

The Agency for Healthcare Research and Quality (AHRQ), a government agency charged with supporting research designed to improve the quality of health care and address patient

continued on page 13
First Things First: AMSN’s Priority Agenda

Setting priorities is an essential skill set of the medical-surgical nurse. Just as the bedside nurse identifies the sequence of activities, calculates the time, or assesses resources needed to best manage patient care, a professional nursing organization determines priorities within its strategic plan. Development of a priority agenda is the next step of AMSN’s new strategic plan.

A priority agenda is a document that provides a framework for the direction, message, and focus of AMSN. Our member surveys and interviews reflect that while medical-surgical nurses view their profession as a distinct nursing specialty, there is frustration with medical-surgical nurses not being recognized and respected outside of their specialty.

As part of the 2010 strategic planning process, AMSN’s priority agenda was developed. The priority agenda is a concise way of identifying what AMSN stands for and the key issues that AMSN cares most about. The priority agenda states AMSN’s position on each issue, why it holds that position, and the actions AMSN will take based on the agenda. This document addresses those cutting-edge issues that are at the heart of what AMSN stands for, what our members believe, and what is in the interest of excellent patient care.

While the word agenda is quickly associated with leading an effective meeting, in AMSN’s context, the word is broadened to include describing what medical-surgical nursing is and what AMSN is doing to advance the practice of medical-surgical nursing.

This priority agenda will be incorporated into all communications inside and outside of AMSN. The priority agenda is AMSN’s framework for accountability and provides focus for the allocation of resources (e.g., staff, volunteers, Volunteer Units, fiscal, programs, and initiatives). From the priority agenda, the board can determine which strategic alliances will further the agenda, which meetings leaders should be attending or presenting at, and other decisions about our strategic direction.

The AMSN executive officers and senior staff, along with consultation from strategic plan facilitators, drafted AMSN’s priority agenda, which can be found on p. 3.

On the topic of setting priorities, it is not too early to begin planning to attend AMSN’s 19th Annual Convention October 20–25, 2010, in Las Vegas, NV, at the Riviera Hotel.

Kathleen A. Singleton, MSN, RN, CNS, CMSRN
AMSN President

AMSN and the University of Phoenix have created an academic opportunity to benefit AMSN members and their colleagues. Any nurse who has earned continuing nursing education contact hours through AMSN may earn college credit toward the general education and elective requirements at the university (undergraduate only). To learn more about the nursing degree programs, visit www.phoenix.edu/amsn.
AMSN’s Priority Agenda

AMSN is the professional nursing organization of over 7,500 members dedicated to the specialty of medical-surgical nursing. AMSN’s mission is to promote excellence in medical-surgical nursing. Medical-surgical nurses comprise a majority of nurses working in hospitals and over 30% of the nursing profession (HRSA, 2004). As professional nurses, medical-surgical nurses belong to the most trusted profession in America (Gallup, 2009).

A majority of medical-surgical nurses practice in the inpatient setting. They specialize in caring for patients with acute illness, major surgery, and chronic diseases or conditions. Medical-surgical nurses also specialize in caring for patients in settings such as home health agencies, community health clinics, private practices, hospice, and schools of nursing.

The medical-surgical nurse manages care needs of patients from the surgical recovery area, emergency department, or those transferred directly from the health care provider’s office, the intensive care unit, or from a long-term care facility. They simultaneously care for several patients on a designated medical-surgical nursing unit, who are in stable condition, are at high risk for a rapid deterioration in health status, and who are not ready to return home or transfer to a long-term care setting. The medical-surgical nurse teaches patients and/or families how to best care for themselves and when to seek medical and nursing care upon discharge.

AMSN’s Agenda

Professional Development:

AMSN believes that medical-surgical nurses can better lead health care teams, grow professionally, and advance the art and science of medical-surgical nursing when they engage in education, certification, mentoring, and other opportunities to enhance their nursing and leadership skills. AMSN is committed to providing state-of-the-art, accessible, and relevant education, professional growth, mentoring, and certification opportunities. Examples of initiatives to address this priority include the following:

- Current Initiatives: Annual convention; Online Library with an array of continuing nursing education articles, recordings, and courses; Certified Medical-Surgical Registered Nurse (CMSRN) certification program through the Medical-Surgical Nursing Certification Board (MSNCB) along with many AMSN study resources; Hospital-based and online mentoring program, Nurses Nurturing Nurses (N3); and volunteer leadership opportunities.
- Planned Initiatives: Increase online learning opportunities and clinical resources.

Practice:

AMSN believes the medical-surgical patient receives better care in an environment that integrates evidence-based care and determines staffing reflective of the intensity of patient care needs rather than predetermining staffing or using fixed staffing ratios. AMSN is committed to helping assure these conditions become the standard of care for all medical-surgical patients. Examples of initiatives to address this priority include the following:

- Current Initiatives: Publications such as the Scope and Standards for Medical-Surgical Nursing Practice, Core Curriculum for Medical-Surgical Nursing, and MEDSURG Nursing journal; Evidence-based and research grants; Position statements on clinical practice issues affecting the workplace.
- Planned Initiatives: Online resources; create resources for sharing work environment challenges and solutions.

Collaboration:

AMSN believes the unified voice of professional nurses strengthens when medical-surgical nurses strategically collaborate with others. AMSN is committed to working with other organizations that share our patient care issues, values, and priorities. Examples of initiatives to address this priority include the following:

- Current Initiatives: Collaborations with the American Nurses Association (ANA), National Quality Forum (NQF), Nursing Organizations Alliance (The Alliance), and the Americans for Nursing Shortage Relief (ANSR) coalition.
- Planned Initiatives: Evaluate current and potential collaborators that further AMSN’s issues, values, and priorities.

The priority agenda is a resource for each AMSN member. AMSN’s priority agenda is used by the board, volunteer leaders, and staff who represent AMSN. It may also be used by members to articulate what AMSN is focusing on for the specialty of medical-surgical nursing.

AMSN’s priority agenda for practice, professional development, and collaboration will validate strategic linking with current alliances, as well as growing new alliances and relationships with other organizations outside of AMSN.

References


Note to Our Readers:

The AMSN Editorial Committee and Staff of MedSurg Matters! take great efforts to ensure that every article published in this award-winning newsletter is thoroughly edited. While grammatical errors are rare, mistakes sometimes happen. We acknowledge and appreciate feedback from our readers, and will continue to enhance and publish MedSurg Matters! as AMSN’s premier publication for association news and clinical content.
Should Family Members Have the Option to Be Present During Resuscitation Efforts?

You are a medical-surgical nurse with many years of experience. Imagine that your mother is in a hospital recovering from surgery without any complications. You have gone to the cafeteria to get something to eat. As you sit down, you hear “Code Blue” called to your mother’s hospital room. You race to the room to find it packed with nurses, doctors, and other hospital staff. They are performing CPR and defibrillation. An endotracheal tube is inserted and oxygen is being bagged through it. IVs have been started in her arms and medications are being administered. You are frantic and cry out, “What happened? What’s going on? Mom! Mom!” A doctor yells, “Someone get her out of here!” Grasping your arm, a nurse hurriedly escorts you to the waiting room. You say, “Wait, I’m a nurse!” The nurse apologizes since she must return to assist in the resuscitation of your mother. You are alone and afraid, and you feel helpless. You promised that you would never leave your mother when she needed you because she has always been there for you.

Do you think you would want to be present during resuscitation efforts of a loved one or family member? Do you think your family member would want you there? Would you like to have a support person there for you or other family members to explain things and answer questions? What if the hospital has a policy or a protocol that provides specific guidelines for allowing family members the option to be present during resuscitation efforts? A policy or protocol could result in decreased stress for medical staff and family members.

One of the authors, who has 18 years of experience in critical care, believed for many years that family members should not be present during resuscitation efforts. This author is now convinced that there are times when family members should have the option to be permitted at the bedside. This article will discuss the concerns and benefits of family presence; the education, policies and protocols; and describe the role of a family support facilitator.

Standards and Research That Support Family Presence

Family presence during resuscitation is a relatively new perspective. In November 2004, the American Association of Critical Care Nurses (AACN) announced a practice alert stating that “Family members of all patients undergoing CPR and invasive procedures should be given the option of being present at the bedside” (p. 1). This position is also supported by the American Heart Association (AHA, 2005) and the Emergency Nurses Association (ENA, 2005). Because these three professional organizations exert significant influence on facility standards, acceptance of family presence during resuscitation is growing (Laskowski-Jones, 2007).

Research has validated the belief that family members desire to be present and actually benefit from being present during resuscitation (MacLean et al., 2003; Meyers et al., 2000). AACN reported that “Research and public opinion polls have found that 60%-80% of consumers believe family members should be given the option to be present during emergency procedures or resuscitation efforts” (AACN, 2004, p. 1). However, the issue remains controversial, not just for family members, but also for health care professionals.

Concerns about Family Presence

Laskowski-Jones (2007) outlined several reasons why health care professionals disapprove of family presence. First, there are the concerns about potential liability and violations of confidentiality. If family members witness an error or misunderstand the interventions, they may lose confidence in the competence of the health care team or they may be more likely to file a lawsuit, especially if the patient dies. Second, they fear that family members will be traumatized by the sights, sounds, and odors. They may be unable to tolerate the graphic scene and thus faint and injure themselves. Third, some individuals cope with anxiety, fear, and grief through anger and violence and this creates danger for all involved. Fourth, there is concern that family members may interfere with patient care. They may distract health care professionals from patient care decisions and tasks, and possibly impede resuscitation interventions. Finally, health care professionals may have anxiety about their performance and may feel distress about not being able to keep professional distance.

Benefits of Family Presence

Laskowski-Jones (2007) also offered reasons for allowing family members to be at the bedside during resuscitation. Nurses and doctors may believe it is the right thing to do. The family member’s presence may increase the patient’s desire to live, and encouragement provided by a family member may stimulate the patient’s will to fight to live. Conversely, the family member may offer support and closure; thus, the patient may feel it is alright to die. Family members may also be able to answer questions about the patient’s medical condition or history. By observing the health care professionals’ intense life-saving interventions, family members may come to the reality of the seriousness of the illness and unavoidable death. Finally, family members can see that everything is being done and/or has been done for their loved one.

A final reason for permitting families to be present during resuscitation efforts is that their presence may inspire hope in the family and the health care providers providing the resuscitation efforts. Miller
argued that when family and health care providers believe a death was a “good death,” they leave feeling positive about the experience. When families see that “all was done,” they may thank the health care workers and leave with a sense of peace. Family members may feel they were there in the last moments and will carry these feelings with them. Health care workers may also feel inspired and renewed, knowing the family truly believed that “everything was done” and it was the patient’s time to die.

In order for family members to be present at the bedside during these critical times, it is essential to increase awareness of the new standard of care among health care professionals. Information about situations in which family members’ presence has been beneficial in other institutions may also promote comprehension and a more positive attitude.

**Education, Policies, and Procedures**

Documents that support this change in practice need to be developed and implemented. AACN (2004) has provided recommendations for policies, procedures, and educational programs for health care professional staff. These recommendations include the benefits of family presence for the patient and family, criteria for assessing the family to ensure that patient care will not be interrupted, the role of the family support facilitator, support for family members or patients who decide not to have family members present, and contraindications to family presence.

Mian, Warchal, Whitney, Fitzmaurice, and Tancredi (2007) offered general guidelines for developing standards for family presence during resuscitation or an invasive procedure:

1. The family support facilitator will remain with family members while in the treatment area, answering all of the family members’ questions and explaining the medical care.
2. Family may only be able to be present for a few minutes due to treatment activity. The family support facilitator or the team may ask the family to leave.
3. The family support facilitator will try to get family members as close as possible – to touch and talk to the family member.
4. The family members can leave any time they want.
5. The team is in charge of the treatment.
6. Only 1 or 2 family members may be in the treatment area at one time.

Note: Adapted from Mian et al., 2007.

Mian and colleagues (2007) recommended to be addressed in a policy.

**Family Agreement Tool and Family Support Facilitator**

Mian and colleagues (2007) noted that the policy or protocol should include a script for a “family agreement tool” which is enforced by the family support facilitator. The family agreement tool should state specific guidelines or rules to be followed in order for the family to be present during resuscitation efforts. These include how long the family may stay at the bedside, how many family members may be at the bedside at one time, where they may stand, and under what circumstances they will be asked to leave. It should be stressed that the patient’s health care is the greatest priority, and they will be asked to leave the bedside if they interfere or attempt to interfere with any interventions. A sample script for nurses to use as a family agreement tool is included in Table 2.

The family support facilitator should be present at all times. The facilitator may be a staff nurse, clinical nurse specialist, physician, chaplain, social worker, or other specially trained staff member who is assigned to support the psychological needs of the family, explain interventions, and answer questions. Given the responsibilities for family support, the facilitator

### Table 1. Recommended Guidelines for a Family Presence Policy

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<td>1.</td>
<td>Designate who will be the “family support facilitator.”</td>
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<td>2.</td>
<td>Screen and assess family members to ensure those who attend will be able to cope and not interfere with resuscitation efforts.</td>
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<td>3.</td>
<td>Request permission from the resuscitation team for family to be present.</td>
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<td>4.</td>
<td>Prepare the family members with what to expect, and inform them that the team’s priority is resuscitation of the patient.</td>
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<tr>
<td>5.</td>
<td>The facilitator should escort the family to the bedside and stay with the family at all times.</td>
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Note: Adapted from Mian et al., 2007. See AACN (2004) and ENA (2005) for additional recommendations.

### Table 2. Sample Script for a Family Agreement Tool

Mian and colleagues (2007) recommended that family members attending resuscitation efforts agree to all of the following before going into the treatment area. Keep in mind this is a “script” for the family support facilitator to use when talking with families – not a form for family members to sign.

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Note: Adapted from Mian et al., 2007.
should not be expected to participate in any aspect of the invasive procedure or resuscitation efforts. Additional responsibilities of the family support facilitator include assessing family members for comprehension of the situation, coping abilities, need or desire to be with the patient, and ability to leave or ask for assistance if unable to tolerate the situation. The facilitator should screen for family issues that would exclude them from being present at the bedside such as agitation, combativeness, extreme emotional instability, altered mental status, and intoxication (Mian et al., 2007).

After the family agrees to the family agreement tool, the family support facilitator should consult with the health care team and inform them of the family’s desire to be present. In addition, the facilitator should consider whether the time is appropriate, given unit activities or situations. Then the family should be prepared by the family support facilitator, who will explain the situation and what they may expect to observe as the patient is receiving treatment (Mian et al., 2007).

The family support facilitator should escort the family members to the bedside where the facilitator will remain to provide support, explain interventions, and answer questions. If possible, the family should be able to see, speak to, and touch the patient. After the “code” is over, whether resuscitation efforts have been successful or not, the family support facilitator should escort the family to a private area, provide clinical updates, and continue to offer emotional support to the family.

Debriefing for family members can provide an opportunity for them to discuss their perceptions of the situation, questions, and fears about the patient’s illness or lifesaving interventions (Mian et al., 2007). Debriefing will also be beneficial for the health care workers, especially if the patient outcome is unexpected or unfavorable. The health care workers can discuss, evaluate, and offer suggestions for improvement of the protocol as needed.

Family Presence May Inspire Hope

In conclusion, the AHA, ENA, and AACN recommend that the standard of care should be that families are given the option of being present at the bedside during resuscitation efforts. Further, there is evidence of positive benefits to family presence when the situation is appropriate. Resuscitation efforts are intense and stressful, but they may be more beneficial to the patient and family members than medical staff may actually comprehend.

As nurses, we recognize the importance of family relationships, particularly during potential end-of-life events. It is the obligation of health care professionals to ease the stress of these events whenever possible, and family member presence may provide a means to alleviate family stress.

References
Member-Get-A-Member

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Score valuable AMSN gift certificates by sharing the benefits of AMSN membership with your friends and colleagues through the Member-Get-a-Member Program.

Invite your colleagues to join AMSN by completing our online invitation form (www.amsn.org/MGM). We'll send your colleagues an e-mail highlighting the perks of being an AMSN member, and you'll start racking up the rewards!

**What kind of rewards?**

You’ll earn AMSN gift certificates that may be used for membership dues, convention registration fees, or AMSN products.* The more new members you recruit, the more you earn.

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<th>NEW MEMBERS</th>
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<td>5</td>
<td>Receive a $25 AMSN gift certificate</td>
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<td>Receive a $200 AMSN gift certificate</td>
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<td>30</td>
<td>Receive a $400 AMSN gift certificate plus $500 CASH†</td>
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**REFER YOUR HOSPITAL** to the AMSN Hospital Group Membership Program

Receive a $400 AMSN gift certificate

To be eligible for rewards, make sure your recruits list your name in the “Who referred you to AMSN?” section of the membership application.

Rewards are calculated on NEW memberships from July 1 through June 30 annually. Rewards will be mailed in August of each year.

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www.amsn.org/MGM

*AMSN gift certificates are not valid for MSNCB’s CMSRN certification, recertification, and exam exemption fees.

† Introduce your hospital to the AMSN Hospital Group Membership Program and you'll be eligible for prizes AND a membership dues discount. Award is conferred when the hospital begins participating in the program.

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You’re a Medical-Surgical Nurse: You Can Do Anything!

Steps to Completing the Annual Chapter Achievement Report

You can manage helping post-operative patients control pain, hang numerous IVPBs, administer blood products, talk to pharmacy, call the laboratory for a stat collection, and communicate with physicians and families, all without breaking a sweat. How difficult could it be to complete the Annual Chapter Achievement Report? You can do this! You are medical-surgical nurse.

The completion of the report doesn’t have to be overwhelming. A helpful practice is to keep a copy of the entire chapter’s activities in a folder; it can be saved electronically or as a hard copy. The report documents activities completed from July 1st until June 30th. It must be submitted (via email) to the National Office by June 30th.

Thorough guidelines and the form can be found on www.amsn.org, under the Chapters tab. A recommendation is to have all board members work together to complete the report, as this will make the task more manageable. Just like we use teamwork to care for our patients, have the board involved with the process. Another recommendation is to have the President-Elect work with the current President in compiling the information; two minds are better than one.

The sections on chapter information, chapter officers, committees, and accounts can be brought to a board meeting in the spring. The information can be gathered at that time and the treasurer can fill in the section on the account and financial report. Because you have kept copies of your events and meetings, you can easily fill in the list of meetings, dates, and locations. (Hint: when you hold an event, remember to count the number of attendees.)

This report is the mandatory component that is required by AMSN to be re-chartered. This is similar to our mandatory requirements for CPR, renewing our RN license, etc. You don’t have a choice – just do it!

The Chapter Achievement Report also needs to be completed if your chapter wants to be recognized and possibly receive an award from AMSN. This is a step above, similar to obtaining certification for all you know and do. This section has seven different areas: Recruitment and Retention, Collaboration with Other Professional Organizations, Community Activities/Services, Political/Legislative Activities, Marketing Activities, Participation at the National Level, and Additional Activities. This is where you can brag about all the things your chapter has done in the previous year. Again, complete instructions for this section and ideas of things to be included are listed on the Web site. If your chapter participated in a walk for a charity organization, please include the number of members that walked and the mileage. In all of these areas, indicate if this is a maintained or new event.

You’re almost finished; don’t give up. You’ve almost finished your shift! The last area to complete relates to goals. First, you evaluate how the chapter did in reaching last year’s goals. Then as a board, decide what goals you will set for the next year. Specific measurable goals are the best. Some examples would be to increase membership by 10% or to collaborate with two additional professional organizations during the year. Go ahead and reach for the stars. We are nurses. We can touch the stars by using our angel wings.

The person who is completing the report needs to sign the form and send it to the AMSN National Office. No attachments are required or accepted (this includes agendas, flyers, or newsletters). Email your report to Maura King at kingm@ajj.com and you’re all done. Now wasn’t that easy?

Patricia Smart, RNc, MN, CNE
Chapter Development Committee Member

Chapter Event

North Carolina Triangle Chapter #234

The North Carolina Triangle Chapter #234 held an educational meeting on January 28, 2010. Dr. Francis Castiller, DRAH Intensivist, presented “My Patient is Crashing!” to 24 attendees, 15 of them students. President Kathleen Conn reported, “The lecture was excellent.” The chapter also used this time to collect canned goods for the Raleigh Food Bank.

Attendees of the North Carolina Triangle Chapter’s educational meeting in January enjoyed an excellent lecture.

Members of Chapter #234 gathered for an educational event. (l-r): President-Elect Kathy Chiulli, presenter Dr. Francis Castiller, and President Kathleen Conn.
Citing In-Press Articles

When constructing the reference list in a manuscript written in APA style, remember that your readers have only one means by which to locate the sources you are including. Therefore, it is important to format your material carefully and with attention to detail, especially when citing an article that hasn’t yet been published.

If you’re adding an article to your list that has been accepted for publication in a periodical, but hasn’t yet been printed, your reference list entry should look like this:


The concept here is very similar to a typical journal-style listing. The difference is that the volume number, issue number, and page numbers aren’t yet known. If the periodical cited offers advance online publication prior to print, you should also include a direct link to where the article can be accessed on the Web. Your in-text citation would appear: (Kuruvilla, in press).

Do not use n.d. (no date) when referring to a source that hasn’t been published yet. Articles with no publication date (as are sometimes found online) are not the same as articles that haven’t been published yet. In press means the article has been accepted for publication in a future issue; n.d. means the article simply has no specified publication date. Articles in press are also different from those that are still in progress, out for review, or being revised. Check your Publication Manual of the American Psychological Association (6th ed.) for details on how to cite those items.

Even if you know how to craft your in-press entries, don’t forget to check your reference list multiple times before your article is printed. From the time of submission through publication and distribution, your in-press sources may have been published. Always make sure to include the most accurate, current information on each of your sources. A well-presented article with solid references will surely be considered a credible resource by your readers.

Katie R. Brownlow, ELS, is Managing Editor, MedSurg Matters!, Pitman, NJ. She may be contacted via email at katie@ajj.com.

Look for more tips on proper APA format in future issues of MedSurg Matters! Our next column will focus on citing contributions to meetings and symposia (such as paper or poster presentations).

Write for Us
If you would like to submit a manuscript on any of these or other topics, please contact the Managing Editor at msmnews@ajj.com.

We are more than happy to mentor novice writers!

Manuscript Wish List

- Process and effects of hospitals going green
- Cultural issues in nursing
- H1N1 influenza
- Health care reform
- Evidence-based care
- Stroke in young adults
- Heart failure
- Pain management for addicted/detox patients
- Care of aggressive/psychiatric patients
- Updates on wound care
- Transplants and transplant care
- HIV/AIDS and prevention
- Sepsis
- Assertive behavior and unsafe practice
- Pancreatitis
- VA care/war trauma
- Infection control
- Alcohol withdrawal syndrome
- Renal disease and peritoneal dialysis
- Musculoskeletal health
- Clinical leadership
- Respiratory topics
- Venous access devices (any and all types)
- End-of-life issues
- Stress response/management in acute and chronic disease
- Prevention of and injury from patient falls
- Recruitment and retention
- Toxic nursing work environments
- Nurse/physician communication
- Lateral violence
- Legal aspects of documentation
- Social health care disparities
- Lead placement
- Disseminated Intravascular Coagulation (DIC)
- Management in a culturally diverse workforce
- Interpreting the Nursing Code of Ethics
- Navigating HIPAA
- Mouth care for patients on tube feedings
- Managing chest tubes
“I Found It on Google – It Must Be Free!”

Copyright Permission and the Internet

Congratulations! You have written a manuscript for a professional publication, and it has been accepted by the publisher. You have decided to add a few finishing touches to your masterpiece, and you want to include a figure or table to enhance your article. In the world of high-tech, easy-access media, the first place you might run to is the Internet. A few keystrokes later, and your Google quest has returned hundreds of hits of your targeted image search, several of which you immediately capture as your own with a click of the mouse. You smile smugly and think, “Wow. That was easier than I thought!” There’s an old adage that states if it seems too easy or too good to be true, chances are, it usually is.

During the publication process, you may be surprised when the publisher or editor contacts you with questions concerning your submitted figures or tables. Reputable publishers and editors will (and should) ask you if you own the images, and if not, where you obtained them and if you have permission to use them. You think, “Hang on – I got these from Google. Google doesn’t own them, and everyone in the world can view them online already. Doesn’t that make them free?”

No. Not by a long shot.

It’s a common pitfall that has plagued novice and seasoned authors alike. What exactly is considered “public domain” (i.e., free for the taking) on the Internet? Millions of Web sites post photos, figures, tables, charts, graphs, and everything short of the kitchen sink. Regardless of where the hosting Web site obtained them, it doesn’t mean the images are free for the taking. Nor does it mean the Web site is even using them legally. The Internet, let loose to the world in August 1991, is still nothing more than a toddler, and laws governing “fair use” in cyberspace are still in their infancy.

It sounds complicated, but in reality, the truth is simpler than you may think: If you didn’t create it, it’s not yours, and if it’s not yours, you cannot use it without written permission from the original owner.

In this age of instant gratification, we trick ourselves into believing that all material found on the Internet is public domain. Some online entities state clearly that their images are not public domain. That is exactly what you are doing. The Internet and all of its content, public though it is, is not public domain.

Securing Permission of Online Images

How do you secure permission for that photograph you found online?

The first thing you should do is leave Google or whichever search engine you are using and go to the Web site hosting the image. Once there, check for a “Contact Us” link or a “Permission Requests” tab. Start by emailing someone connected with the Web site and asking who owns the image. A sample permission request email appears in Figure 1.

If you prefer (and if the contact information is available), you may call the organization or person who owns the Web site to establish initial contact. However, permission requests are generally handled via written correspondence. Should you receive permission from the original source, you will want more than a verbal response. If permission is granted, get it in writing (see Figure 2). Keep a copy for your own records and send a copy to your editor and/or publisher.

Occasionally, fees must be paid to the original owner for the use of the material. Fees can range anywhere from a nominal $10 or $15 fee to several hundred dollars. Be prepared for the owner to ask for payment for the use of the material and for a final copy of the article containing the reproduced item.
Figure 2. Sample Response to a Permission Request Email

Subject Heading: RE: Attention Department of Permissions/Reprints

Dear Ms. Doe,

Thank you for your email and your interest in Medical-Surgical Forums. Permission is granted to use the photo indicated in your email provided that the following stipulations are met.

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3. Please forward a copy of the published material to my attention at the address below.

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555-5422

Once you receive permission, you will want to request that the image be sent to you as a high-resolution JPEG or TIF file, at least 300 dpi (dots per inch). Images that look sharp and crisp on your computer screen may not be high enough quality for print publication. If this is the case, the image will reproduce poorly in print. Most publishers will not accept images under 300 dpi or 400 k.

Digging Deeper

If the hosting Web site does not own the image and is unable to provide you with the original owner’s name and contact information, you have two choices: 1) abandon this image; or 2) dig deeper in the attempt to locate the owner. What you must not do is assume all is well and use the image anyway. Not being able to obtain permission is not a license to proceed.

If your heart is set on using a particular image, and no other image will do, you could see if it appears anywhere else online. If so, contact those Web sites in the same manner as you did previously. You could also return to the Web site where you first saw the table or figure and make further inquiries: Was it copied from a textbook? Another Web site? A forwarded email? Anything that takes you another step closer in your search for permission will help. Remember the image didn’t create itself, so somebody, somewhere, knows something!

Finally, if all else fails, perform a search through the U.S. Library of Congress (www.copyright.gov). You can search using key words, titles, claimants, or authors. If necessary, the Library of Congress will perform a more extensive search for you for a fee.

If you’ve exhausted all your avenues and come to a dead end, you are left with the question, “Do I or don’t I use this image?” If you can prove you have done everything in your power to locate the original owner of the work and can provide written documentation of your search to an auditor and/or legal counsel, you may think now, finally, it is safe to go ahead and use the coveted material. However, do so at your own risk. Personally, at this point, my advice is to give up on the image in question and move on.

Conclusion

At the end of the day, not including one particular figure or table is not going to make or break your manuscript. However, using material that is not yours without permission is unethical and can be grounds for a lawsuit. This can damage your reputation as an author and cripple you with legal fees and lawsuit settlements.

Publishing your work can be a challenging and daunting experience, but it should also be a rewarding one. Seeing your name in print beside the title of your published work is cause for celebration. Don’t jeopardize your efforts and hard-earned accolades by not understanding the laws of copyright.

Carol M. Ford, BA
Director of Editorial Services
Anthony J. Jannetti, Inc.
Pitman, NJ

The Ideal Gift for a Med-Surg Nurse

Do you have a work anniversary gift dilemma? Don’t know what to get your nurses to celebrate their years of service in med-surg? AMSN can help! Make a donation to the AMSN scholarship and grant program in honor of a friend’s commitment. When you make your donation, tell us his or her name and years of employment, and we will print the name in a future issue of MedSurg Matters! and on the AMSN Web site. Proceeds will go toward AMSN’s grants and scholarships, which are awarded to med-surg nurses yearly. You can make your donation online at www.amsn.org. Not only will you be honoring your friend, you’ll be advancing the med-surg nursing specialty!
Advance your practice and prepare for certification with this new and updated resource!

Reorganized and expanded in response to requests from readers, the Core Curriculum for Medical-Surgical Nursing, 4th Edition, provides a comprehensive foundation of knowledge for medical-surgical nursing practice.

The enhanced 4th edition features:

- New and updated content, including chapters on mental health, infectious disease, and domains of nursing practice
- Integration of key regulatory requirements and evidence-based practice standards
- Revised chapter formats – find information easily!
- Increased emphasis on special populations, such as older adults and bariatric patients
- More than 550 pages!
- Continuing nursing education (CNE) credit and pharmacology minutes

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A Nurse-Patient Partnership

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safety and medical errors, developed a patient fact sheet called 20 Tips to Help Prevent Medical Errors. In this brochure, patients are encouraged to be active members of the health care team because it is the most important way to prevent errors (AHRQ, 2000). Patients are further advised to ask for information about medications in terms they can understand when they receive them. They are instructed to ask specific questions, such as those listed in Table 1.

Table 1. Specific Questions Patients Should Ask About Medications

- “What is this medicine for?”
- “How often am I supposed to take it, and for how long?”
- “What side effects are likely? What do I do if they occur?”
- “Is this medicine safe to take with other medicines or dietary supplements I am taking?”
- “What food, drink, or activities should I avoid while taking this medicine?”

The Institute for Family-Centered Care (1999) created a brochure entitled Your Role in Safe Medication Use: A Guide for Patients and Families in which patients and families are encouraged to ask questions about medications. The brochure emphasizes the need for hospitalized patients to know what their medication is for, to physically inspect all medications they are given for shape, size, and color, and to know how often the nurses will bring the medications.

In the American Hospital Association (AHA) initiative Improving Medication Safety by Partnering with Patients, patients are asked to share the responsibility for safe medication use (AHA, 2000). Health care professionals are encouraged to take the lead in helping patients learn as much as possible about safe medication use. To support health care professionals’ efforts to communicate with patients about appropriate use of medications, AHA’s Web site (http://www.aha.org/) has an area on medication safety that includes patient and consumer brochures and tools.

The National Patient Safety Foundation (NPSF) was founded to promote safer medical care through the prevention of medical errors and to improve health care systems for all patients. The NPSF released a document in 2003 entitled National Agenda for Action: Patients and Families in Patient Safety. It serves as a call to action for hospitals, health care systems, and health care organizations to involve patients and families in systems and patient safety programs. Hospitals are encouraged to establish educational programs that bring patients and professionals together. Patients are encouraged to safeguard their own care and partner with providers to create a culture of safety.

All of these programs call for greater participation of patients and families in efforts to improve patient safety. But can patients and their family members identify errors and injuries that result from medical care? Unfortunately, little is known about how well hospitalized patients can identify errors or injuries in their care. One study (Weingart et al., 2005) found that inpatients can identify adverse events affecting their care. After eliciting reports from hospital inpatients, adverse events and near-miss errors were identified and characterized. In this prospective cohort study of 228 adult inpatients on a general medicine unit, investigators found patients and families reported more problems, mistakes, and injuries than could be found in the medical record or hospital incident reporting systems. Almost half (49%) of the patients reported at least one incident. Problems with medication-related processes of care were implicated in the majority of incidents, including 70% of adverse events and 76% of overall incidents. In the majority of the incidents, a nurse was identified as the clinician being closely involved in the patient-reported incident. The results from this study indicate that patients and families can identify errors in care and adds credibility to best practice recommendations proposed by the AHA and NPSF that call for patient participation in preventing medical errors. Further studies are needed, but this preliminary study suggests that engaging patients as partners with clinicians to identify and prevent medical errors is a promising strategy to enhance patient safety. A nurse can administer up to 50 medications per shift and patients can receive up to 18 doses of medication per day (Marino, Reinhardt, Eichelberger, & Steingard, 2000). This places the nurse and the patient at the forefront of medication administration safety (Benner et al., 2002) and the perfect place to develop a partnership to do so.

Introduction of the “Ask Your Nurse about Your Medication” Program

These reports were the stimuli for the development of a task force at UMMC of medical unit nurses (two nurse managers and four staff nurses), who were charged with identifying ways to improve medication safety by partnering with patients. The task force agreed the medication safety partnership program should:

- Reduce medication errors.
- Be grounded within our nursing care delivery model, Relationship Based Care (Koloroutis, 2004).
- Complement the medication reconciliation program.
- Improve patient satisfaction.

Through a series of meetings over the course of several months, the task force developed a program known as “Ask Your Nurse about Your Medication.” The program was designed to enhance patient and family involvement in the medication regimen by providing them with an open forum to ask questions throughout the hospitalization. Through this program, nurses actively engage patients and family members in conversations about medications each and every time a nurse administers a medication to a patient. This conversation is initiated upon admission and continues through the discharge process.

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Upon patient admission, the nurse introduces the “Ask Your Nurse about Your Medication” program to the patient and family (see Figure 1). The nurse explains the program to the patient and family. Patients and families are encouraged to ask the nurse questions prior to taking their medications. When the nurse enters the patient room with a medication, the patient and/or family should ask questions such as:

- “What is this medication?”
- “What is the dose of this medication?”
- “Why am I receiving this medication?”
- “How often do I receive this medication?”
- “When will I receive it again?”
- “What are the side effects of this medication?”

After a few times, the patient should be able to state the answers to the questions. For example, after three days, the nurse walks into the room and the patient asks, “What is this medication?” The nurse replies, “This is your Lasix, Mr. Brown.” Mr. Brown should be able to state, “I am receiving Lasix to lose water so my heart can pump better. I should be getting 40 mg. I know I receive it twice a day and I expect to receive it again this afternoon around 4 p.m. I know Lasix causes me to lose potassium, therefore I need to eat food rich in potassium.”

Figure 1. 
Patients Are Encouraged to Ask the Nurse Questions Prior to Taking Medications

Engaging patients in questions helps them to learn through repetition. Often the nurse has to prompt patients on one or two points. In addition to enhancing patient education, engaging patients in these questions about their medications helps the nurse to complete one more safety check prior to medication administration.

Several strategies were implemented to encourage and remind patients and families to participate in the program. Every nurse wears a button that says, “Ask Your Nurse about Your Medication” and there are posters in each patient room as well as colorful banners located throughout the unit hallways (see Figure 2).

Prior to discharge, the nurse reviews the discharge medications with the patient and family. Together, they complete the “Home Medication List” card. Providing patients with a medication list has been shown to prevent drug dispensing and administration errors by ensuring correct drug, dosing, form, route, and administration time (Weingart et al., 2005). These cards are small and allow patients to carry the list at all times. The medications are listed in pencil so that when changes are made, the patient can update the card accordingly. Patients are sent home with a pencil or pen with the words “Ask Your Nurse about Your Medication” on it as well as a seven-day plastic pillbox to help with adherence and organization (see Figure 3).

Results

The program was implemented in six inpatient acute care medical units at UMMC. After providing inservices to all nursing staff over the course of a month, a “kick-off” celebration was held (see Figure 4). Nurses, nurse practitioners, physicians, house staff, hospital administrators, and pharmacists were invited.

Creative funding strategies were used for developing and implementing the program. The photography and design work was done by members of the team along with a hospital-based member of the graphics department. The six nursing units that participated in the program absorbed the cost of the patient...
supplies, posters, and banners into an operating budget in a sub-account that had a positive variance.

To evaluate the results of the program, nurses and patients were asked to complete surveys at several intervals during the implementation phase. Initially the nurses felt that the process was too time-consuming. The process changed from being one in which the nurse simply delivered and administered medications to one which required spending time educating and communicating with the patient, as well as encouraging the patient to ask questions. It took time for them to transition from a mindset that passing medications was just a task to complete. Passing medications in the new program had to be viewed as an opportunity to engage patients and family members in a conversation about medications and safety. The nurses expressed their amazement at how many patients, upon admission, did not know basic information about the medications they had been on at home. They noted that the intensity and complexity of the conversations they had with their patients about medications increased over time. The nurses saw this as a positive sign of the results of their teaching efforts.

The nurse managers and a team of Clinical Nurse Leader students conducted interviews with patients prior to discharge. Patients were overwhelmingly pleased with the program. They liked the openness the program encouraged and that the nurses did not feel threatened by their questions. Some stated that this openness allowed them to ask questions about other aspects of their care that they might not have asked otherwise. The nurse practitioners noted that patients were coming to the clinic for their follow-up appointments with the completed medication cards in their wallets. Several patients who were readmitted at later dates also had their completed medication cards with them.

There were patients who did not ask questions or did not appear to be engaged. However, the nurses still reviewed each medication with them. Additionally, the nurses completed the medication cards for patients regardless of their level of engagement. Overall, a significant decrease in medication errors was noted. An improvement was also seen in all units in relation to patient satisfaction, particularly in response to the following two questions: (1) Before giving you new medicine, how often did the nurse tell you what the medicine was for?; and (2) Before giving you new medicine, how often did the nurse describe possible side effects in a way you could understand?

**Conclusion**

Multiple national initiatives call for greater participation of hospitalized patients and families in improving patient safety. The “Ask Your Nurse about Your Medication” program is a successful way to involve patients and family members in medical care. Through this program, nurses actively engage patients and family members in conversations about medications every time they receive them throughout the entire hospital stay. Nurses involved in the program now view the process of medication administration as an opportunity to engage patients and family members in a conversation about medications and safety. Data revealed an increase in patient satisfaction as well as patient knowledge regarding medications and possible side effects, proving the program’s success.

**References**


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Instructions For Continuing Nursing Education Contact Hours

A Nurse-Patient Partnership Program To Improve Medication Safety: “Ask Your Nurse about Your Medication”

MSNN1003

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 June 30, 2012. Upon completion of the evaluation, a certificate for 1.1 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 the nurse-patient partnership in improving medication safety in nurses and other health care professionals. After studying the information presented in this article, you will be able to:

1. Explain why nurses and patients should logically be placed at the forefront of medication administration safety efforts.

2. Identify several examples of programs and handouts that are available to share with patients regarding the importance of understanding and being involved with their medication regimen.

3. Discuss the types of questions patients should ask the nurse each time they are given a dose of medication.

4. Describe the positive outcomes of the “Ask Your Nurse about Your Medication” program and why it increased satisfaction scores in both patients and nurses.

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

This educational activity has been co-provided by 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, AMSN Education Director. Accreditation status does not imply endorsement by the provider or ANCC of any commercial product.
New at the AMSN Convention: Grant Camp

The Research Committee of the Academy of Medical-Surgical Nurses is sponsoring a new pre-conference that can help you get started on writing a proposal for one of the AMSN research or evidence-based practice project grants. “Grant Camp” will be taught by the Chair and another member of the Research Committee and will provide time for discussing your own idea for a grant proposal. Even if you have never written a grant proposal before, this workshop will cover the basics of grant preparation. If you have written a proposal before but perhaps didn’t get funded, the speakers will offer ways to improve your chances.

Each section of an individual grant proposal will be presented, as well as tips on making your ideas clear to reviewers. The grant review process will be outlined and a critique of an example proposal will be shared. Workshop participants will have time to work up an outline of a proposal and receive feedback from the speakers. Detailed information on AMSN grants will be included, in addition to ideas of other grant mechanisms you might like to consider. Bring your research or evidence-based practice idea and join us at Grant Camp in Las Vegas this year!

Lynne M. Connelly, PhD, RN
Chair
AMSN Research Committee

Start Early – AMSN’s Pre-Convention Workshops

AMSN has four exciting pre-convention workshops at this year’s Annual Convention, including the Medical-Surgical Nursing Overview and Certification Review Course. The certification review course takes place on Wednesday, October 20 and Thursday, October 21. Participants will earn 13.75 contact hours for attending the two-day course.

The other three workshops will be held on Thursday, October 21. Five contact hours will be awarded for any of these sessions.

In the clinical pre-convention workshop “Defining Respiratory Concepts for Nursing,” participants will discuss oxygen delivery modalities, interpret ABGs, and update skills on tracheostomy care and chest tubes.

The topic for the research pre-convention workshop is “Grant Camp: From Idea to Research Proposal.” Participants should bring their ideas for a project to this session because they will have the opportunity to work in small groups with a mentor.

Our leadership pre-convention workshop entitled “Listen Up! Can You Hear Me Now?” Transforming Your Practice Through Skilled and Deliberate Communication” will provide attendees with the tools necessary to advocate for their profession and for patients.

AMSN’s 19th Annual Convention will be in Las Vegas, NV, October 20-25, 2010. For more information, please visit www.amsn.org or email us at amsn@ajj.com.
Since May 2003, the Medical-Surgical Nursing Certification Board (MSNCB) has always given the CMSRN® (Certified Medical-Surgical Registered Nurse) exam in one format only – paper and pencil (P&P). Every May and every October, the CMSRN exam has been administered at over 100 permanent and special sites nationwide. The P&P exam contains 175 questions (150 test questions and 25 experimental questions) and is 4 hours long.

In October 2009, MSNCB offered applicants the opportunity to take the CMSRN exam in a different format – computer-based testing (CBT). With CBT, candidates went to one of over 250 specified computer learning centers and took the exam on a computer at a set date and time. The CBT exam consists of 150 questions (with no experimental questions). Participants have 3 hours for testing, and there is a countdown clock on the screen as a reminder. Just like in the P&P exam, candidates are able to go back to check answers on previous questions at any time.

Since its implementation, CBT has been a huge success. Which format was found to be more popular? P&P or CBT? It was a tie! Of the applicants tested, 50% chose or changed to CBT, and 50% took the exam by P&P method. Because of its positive impact, CBT is here to stay!

Beginning in 2010, MSNCB will offer the test in CBT format throughout the year. After verification of eligibility, candidates will receive a letter containing instructions for scheduling and completing the exam during a 90-day window.

Need your medical-surgical certification by a specific date? Then CBT is the way to go. For those who would prefer to take the exam by paper and pencil method, the two P&P testing dates in May and October will remain a part of MSNCB’s offerings.

In 2010, become a CMSRN by taking the exam that best fits your needs – P&P or CBT. Visit www.msncb.org to learn more about the CMSRN exam, the only certification test endorsed by the Academy of Medical-Surgical Nurses (AMSN).

Noreen Dunn, BSEd
MSNCB Certification Service Manager

Member Benefit Enhanced: AMSN’s Career Center

The AMSN Career Center just got a make-over! The Career Center is the main resource to help you land your next job. And now, it’s redesigned to work for you more easily. As always, the Career Center offers job alerts on newly posted positions, resume assistance, and a personalized profile. Whether you are currently looking for employment or just browsing to see what’s available, the AMSN Career Center can help you find what you’re looking for. Go to the Careers page on www.amsn.org to get a jump-start on your next career move today!

What Nightingale Is Doing Next

2010 marks the 100th anniversary of the death of Florence Nightingale, founder of modern nursing. In the spirit of the first modern nurse, the 2010 International Year of the Nurse (IYNurse) was created as an initiative to recognize the contribution of nurses worldwide and engage them in promoting world health. The 2010 IYNurse seeks to involve the world’s nurses in making an impact locally and globally. AMSN is a proud co-sponsor of the 2010 IYNurse. Learn more about IYNurse at www.2010iynurse.net.
A MSN’s recent membership survey results describe our members and what they think the organization should focus on for the future development of the specialty of medical-surgical nursing practice. The 2009 survey, designed to guide the Board of Directors in its journey to create the new strategic plan, was completed by 674 (10%) of the 6,777 members who received it. The data collected clarified our identity as medical-surgical nurses and gave direction for AMSN’s future.

Who Are AMSN’s Members?

Forty-five percent of the respondents have been medical-surgical nurses for greater than 20 years; 31% have practiced in the specialty for less than 10 years (see Table 1). Over half of the respondents (61%) intend to still be working in medical-surgical settings in three years. The large majority (82%) of the respondents work in inpatient acute care settings. When asked which phrase best described the work they did, the membership overwhelmingly stated that “medical-surgical nursing” (80.4%; n = 514) better reflected what they did versus “adult health nursing” (19.6%; n = 125).

Where Should AMSN Be Going?

Respondents were clear in providing directions for the future. Greater than 90% of respondents indicated that medical-surgical nurses will need to be involved in bedside research and evidence-based practice in the next 3-5 years. Most respondents (81%) agreed that online continuing education will replace the traditional face-to-face educational forum.

Two questions focused on the membership’s vision of AMSN on a broader scope. Overwhelmingly, the membership sees the need for AMSN to achieve greater recognition at the national level. Ninety-three percent of respondents indicated that AMSN should provide national leadership in improving medical-surgical health care in America. Similarly, 92% of the respondents believed AMSN should be recognized by key health care decision makers as the experts in medical-surgical health care in the next 3-5 years. Finally, 98% of respondents voiced their belief that medical-surgical nursing should be recognized and respected as a distinct and vital specialty within health care (see Table 2).

A significant part of the survey included the question, “As you look ahead, what is the greatest challenge you anticipate facing in the next three years that AMSN could help you address?” Numerous responses (n = 478) were provided to this question. The responses centered on challenges such as work environment, the impact of health care reform, evidence-based practice, staffing and acuity, critical thinking, nursing shortage, technology, nurse retention, geriatrics, certification, leadership skills, and continuing education.

The data gathered from this survey was used to plan AMSN’s strategic direction for the coming year. AMSN members are the life of the organization and your input is so very important to the future of this organization. The AMSN Board of Directors thanks all members who participated in this survey. You will receive more information about the new strategic plan throughout the year.

Mary E. Grindel, BSN, MHA, RN, CMSRN
Director
Academy of Medical-Surgical Nurses
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.