Clinical nurses are often intimidated by nursing theory. Facilitating connections among theory and practice eliminates barriers and fosters innovative advances in patient care and nursing. Empowering nurses through nursing theory applications provides solid foundations for practice.

When the phrase nursing theory is mentioned, it may elicit less than favorable responses from clinical nurses who remember the term being elaborated upon somewhere along the continuum of nursing school long ago, but to whom it has no relative impact on their view of practice today. It is important for nurses to understand the definition of nursing theory to apply it in practice and for it to make sense in their everyday nursing activities. According to CurrentNursing.com (2012):

“A nursing theory is a set of concepts, definitions, relationships, and assumptions or propositions derived from nursing models or from other disciplines and projects a purposeful, systematic view of phenomena by designing specific inter-relationships among concepts for the purposes of describing, explaining, predicting, and/or prescribing” (para. 3).

The establishment of nursing theory can be traced back to the times of Florence Nightingale, but it came to life during the 1960-1970s (Masters, 2014) with the brainstorming and critical thinking of early nurse theorists like Martha Rogers, Sister Callista Roy, and Dorothy Orem to name a few of the pioneers. Examples of nursing theories that emerged during this period were Roger’s Science of Unitary Human Beings, Roy’s Adaptation Theory, and Orem’s Self-Care Deficit Theory.

How Can Clinical Nurses Relate Nursing Theory to Practice?

Nurses, perhaps unknowingly, apply nursing theory in their daily practice. Below are a few short scenarios demonstrating how nursing theory undergirds everyday nursing practice.

Scenario 1:

A patient has recently undergone an appendectomy. On Post-Op Day 1, the nurse begins discharge planning and performs wound care and a dressing change. While there, the nurse educates the...
AMSNI Annual Convention:
Discover the Possibilities

AMSNI has a convention in October designed to inspire you personally and professionally. And better yet, it will happen in the desert oasis of Palm Springs, CA.

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Let’s Dive In

New this year is a free pre-convention workshop on Thursday, October 12. This interactive session, “Prepared Nurses Protect Patients: Prevention Strategies for Healthcare-Associated Infections and Emerging Infectious Diseases,” will include the latest information on infectious disease, disease transmission, and emerging threats, as well as evidence-based strategies.

The workshop is a collaboration between AMSNI, the American Nurses Association (ANA), and the Centers for Disease Control and Prevention (CDC). Register early because seating is limited.

The convention will officially begin later that day with Opening Ceremonies and an Opening Address by Sharon Cox, MSN, RN. Ms. Cox will explore ways to boost sagging morale and build an extraordinary practice environment in her session, “Staying Positive While Working with Pearl and Grumpy.”

Next, you’ll attend the Opening Reception, enjoy hors d’oeuvres, chat with exhibitors in the Exhibit Hall, and view innovative posters by your nursing colleagues.

The next day, Peter Buerhaus, PhD, RN, FAAN, FAANP(h), one of America’s best known nursing workforce experts, will explore “The RN Workforce – Relationship to the Medical-Surgical Nurse and Healthy Practice Environment,” for the convention Keynote Address.

On Saturday, be sure to attend the Town Hall, “Putting the Spotlight on You: Nurses as Leaders.” You can take the mic during the interactive discussion and share how you lead, mentor, and advance the nursing profession. Summer Bryant, MSN, RN, CMSRN, will be hosting the Town Hall, which is always one of the most popular events at the convention.

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Economic Implications of Creating a Discharge Nurse Role on a Medical-Surgical Nursing Unit

Kevin Shimp
Brett Neville

This article describes the impact of creating a specific discharge nurse role. Expedited discharge times, improved HCAHPS scores, and cost effectiveness are some of the positive outcomes resulting from having a designated discharge nurse.

The Patient Protection and Affordable Care Act (ACA) of 2010 introduced several provisions into the ever-changing environment of health care in the United States. These provisions call for reforms within the healthcare delivery system that expand coverage to more Americans, increase accountability from health insurance companies, reduce healthcare costs, and increase overall quality of health care in America (ACA, 2010).

Quality of care in hospitals is evaluated and reimbursed by benchmarked data, length of stay, unplanned readmissions within 30 days, and the occurrence of preventable, hospital-acquired conditions such as catheter-associated urinary tract infections, central line-associated bloodstream infections, and falls with injury. The measurable quality indicators, as well as the patients’ reported perception of their quality of care, present challenges. Patient satisfaction scores generally focus on the hospital discharges process, responsiveness of staff, pain management, cleanliness of the environment, and amount of wait time for a bed in an appropriate care environment. Therefore, there is an increased need for hospitals and healthcare facilities to operate differently. Hospitals are seeking safer, timelier, effective, equitable, efficient, and patient-centered methods in providing care. Several issues are identified in the patient discharge process.

Identifying the Problem

Hospitals frequently release patients with inadequate discharge instructions, limited coordination of care by the interprofessional teams, and minimal communication of community resources (Jeangsawang, Malathum, Panpakdee, Brooten, & Nityasuddhi, 2012). The role of Clinical Coordinator was created at a large urban hospital in an effort to facilitate patient flow and improve discharge outcomes. This role was designed to improve identified discharge deficiencies and improve the processes. As the inpatient census continued to grow over time, the hospital began facing limited capacity for admissions. This translated to patients’ limited access to necessary and appropriate care and lost revenue to diversion hours. When delays in throughput occurred on surgical units, patients were often detained in recovery areas and in operating rooms. This too limited patients’ access to necessary care and caused losses in revenue as surgical cases were delayed and/or canceled.

The role of the Clinical Coordinator is a resource that can improve quality and patient satisfaction during specific times of the day that are especially turbulent with admissions, discharges, and transfers. Decreased operating room hold times for patients boarding in recovery areas leads to decreased diversion hours and increased surgical volumes, which influences financial success. Turbulent/high activity times on a unit can be assessed with an intensity rating accounting for admissions, discharges, and transfers. The high activity of a unit is not reflected in the midnight census, foregoing consideration of the turnover of patients throughout the shift. These turbulent times are not captured in census...
A cute C are Surgery is a 28-bed, fast-paced surgical nursing unit, which averaged 125 discharges per month and 4.8 discharges per day over the last five years. Responding to the call for improved outcomes in care delivery, the leadership team planned to pilot the implementation of transitioning the Clinical Coordinator role to an admission and discharge role. The three existing Clinical Coordinators would continue their administrative role seven days per week, and the new admission and discharge role five days per week, thereby remaining budget neutral. The plan focused on transitioning the role of the Clinical Coordinator on high volume days to facilitate admissions and discharges. This new role was called the admission/discharge nurse.

Success of the project was measured by increased patient satisfaction scores and decreased hours of the discharge order entry time to the time of actual patient departure. Decreasing the time by one hour for each patient would allow Acute Care Surgery to generate 62.5 additional patient days per year, resulting in a potential revenue increase of $187,500 in additional room and board charges.

## Intervention

The pre-intervention data supported the need for a pilot. This data was presented to the Acute Care Surgery frontline leadership team to discuss commitment, buy-in, and establish guidelines for the pilot. The Clinical Coordinators agreed to the guidelines of sharing administrative resources and admission/discharge role. If the pilot proved to be successful, their hours would be split between serving as the administrative/resource Clinical Coordinator and the admission/discharge nurse.

The workflow of the admission/discharge nurse included the following:

- Ensure a provider entered a discharge order into the patient’s medical record.
- Collaborate with the bedside nurse caring for the patient to coordinate teaching and final preparations.
- Provide instruction and teaching to the patient and family.
- Assess for and remove invasive lines and catheters as ordered for discontinuation.
- Secure patient belongings and discharge medications.
- Facilitate safe transportation to discharge location.

For admissions, the admission/discharge nurse collaborated with the hospital, sending units such as Post Anesthesia Care Unit or Emergency Department, to ensure a safe nursing handoff. After handoff was completed, the patient was transported to the unit, where the admission/discharge nurse provided a focused admission screening and performed an in-depth skin assessment. These focused assessments were designed to help raise awareness of skin injuries and invasive devices present on admission. One result of collaboration between other units was the primary nurse and admission/discharge nurse increased effective interprofessional communication and quality of care as evidenced by unit benchmarking. The workload burden of the direct care nurse was decreased during the turbulent times, allowing for a decrease in patient assignment adjustments that often occurred three times a day.

## Results

The pilot was conducted in April and May 2014, and the admission/discharge role officially started in June 2014. Figure 1 illustrates the increase in discharges from 2013 to 2015 for both medicine and surgical service patients on Acute Care Surgery, allowing for a rebound in a decreased year of discharges as seen in 2013. Figures 2 and 3 illustrate that success was achieved as evidenced by an increase in medicine patient days when compared to surgical patients and an increase in the Case Mix Index (CMI). CMI is a form of measurement used to demonstrate the acuity of patients (Centers for Medicare & Medicaid Services, 2016). The business days with the most discharges were validated consistently since the start of the process and continued to have...
the highest amounts of discharges and correlating admissions. An increase in patient satisfaction associated with the discharge process was not anticipated, but embraced. As noted in Figure 4, the three specific measurements that address the discharge process within the Hospital Consumer Assessment of Healthcare Providers (HCAHP) surveys post-op are: discharge information (represented in green), help after discharge (represented in blue), and symptoms to monitor (represented in yellow). The dotted red line represents the linear progression since the start of the process through March 2015. The quality of bedside nurses’ communication during patient interactions addressing discharge-learning needs is a significant predictor of the patient’s perception of readiness to go home (Nosbusch, Weiss, & Bobay, 2010).

The most exciting result for the team was the creation of additional hospital beds. Capacity and throughput have been a focal part of the Clinical Coordinator role since inception, with previously minimal results. The use of the new Clinical Coordinator role as an admission/discharge nurse influenced discharges, being completed earlier in the day, allowing Acute Care Surgery to demonstrate its impact on hospital-wide diversion as depicted in Figure 5. The staff of Acute Care Surgery immediately talked about how they could get the discharges executed prior to noon when they saw these results.

Conclusion

Discharges and admissions may be positively affected when designated resources are allocated (Wong et al., 2011). Many facilities do not have additional resources to allocate for new roles; therefore, a better way to utilize existing roles is necessary. Understanding current full-time equivalents and assessing the ability to reallocate these resources or adjusting skill mix to meet the demands created by the high activity of a unit is an opportunity. Challenges of establishing an admission/discharge role include, but are not limited to, the creation of another handoff of care, which may increase risk. Evidence in the literature speaks to communication errors associated with handoffs in healthcare (Coleman et al., 2013). A decrease in communication leads to errors and poor patient outcomes. When patients are not clear regarding their discharge instructions, an increase in readmissions may result (Coleman et al., 2013). The exploration of the admission/discharge nurse role is warranted on units with high activity/turbulence created by the admissions, discharges, and transfers of patients.

References


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Healthcare Advocates in Nursing: Benefits and Burdens

Today, nurses are aware of the healthcare crisis and the need for change; however, few take the time to realize how the history of nursing has molded and contributed to the quandary that we face in today’s healthcare system. In addition, nurses need to demonstrate the will, time, energy, and political savvy needed to “play the game” to take on some type of advocacy role to influence a change in policies, laws, or regulations that govern our system and in their own facilities (Abood, 2007).

In 1976, Jo Ann Ashley wrote Hospitals, Paternalism, and the Role of the Nurse, in which she described the existence of hierarchical disparities among professionals in the hospital and the lack of respect toward nurses. Ashley wanted to give a voice to nurses. Ashley’s ideas are consistent with current analyses, as well as conventional wisdom, that exist in the United States and other Western countries, inherent systematic problems in healthcare practice and provision (Group & Roberts, 2001). Kendig (2006) stated every day, nurses are positioned to see not only the impact of health policy on individual patients but also the need for more comprehensive changes in the policies that address many health-related issues. In 2017, more than ever, nurses have an opportunity to assist patients in making a change to the healthcare system. Many Americans are not happy with how health care is being provided. Many nurses are still unhappy with constraints applied to professional practice. Both groups are begging to be heard. In the past, nurses considered whistleblowers put themselves at personal and professional risk.

As a whistleblower, the nurse assumes the role of a healthcare policy advocate. This type of advocacy necessitates stepping beyond our own practice setting and into the less familiar world of policy and politics, a world in which many nurses do not feel prepared to operate effectively (Abood, 2007). Ashley (1975) stated that nurses did not want to antagonize either doctors or hospital administrators. Ashley also felt that the lack of women in politics and presentation of sexism in the hospital family influenced the social conceptions regarding the perception of nursing (Ashley, 1976).

In 2017, there is more diverse representation than any time in history; however, more nurse representation is still needed. Given our history, most nurses are not surprised by discouraging news, such as highly variable quality of care delivered by a system that is poorly coordinated, thus driving up costs, and putting patients at risk (Schoen, Davis, How, & Schoenbaum, 2006). As challenging and time-consuming as it may be, accepting this responsibility offers nurses the unique opportunity to make a difference and to have the satisfaction of being part of bringing a better healthcare system into reality for themselves and their patients (Abood, 2007). Not only does advocacy add another dimension to our discipline, it provides us with the power bases to make changes in today’s healthcare system and have more control over patient care and outcomes (Abood, 2007).

To effect communication, negotiation, conflict management, critical thinking, and quality care, a personal and collective decision must be made to change our way of thinking. We need to focus on power and its relationship to freedom, choice, and action (Kagan, 2006). Jo Ann Ashley did not suggest that nurses were victims (Kagan, 2006). Ashley wanted nurses to embrace the fight against the issues that dominated sectors of health care (Kagan, 2006). Nurses who are willing to take the risk of being labeled a whistleblower by accepting the responsibility of a healthcare advocate will gain the satisfaction of bringing a better healthcare system into reality for themselves and their patients (Abood, 2007). Please join me in making your voice heard. Contact your local representatives, become involved in your nursing organization, and gain the satisfaction of knowing you made a difference in the healthcare system of today.

References

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Nurses Impact Quality of Care: That’s a Good Thing, Right?

Just when I figured that everybody involved in the delivery of and/or recipients of health care realized the positive impact that nurses have on safety and quality, the news comes out that nurses’ salaries dropped 3.1% in 2016 (Zolot, 2016). Few things will make the average person (nurse or not) crankier than a smaller paycheck. Despite an ongoing shortage of nurses, there seems to be a failure to grasp that the profession continues to believe itself over-worked and under-paid. The downtrend in salaries could be associated with any number of current factors: discontinuation of organizational bonus structures, retirement of seasoned nurses, newer nurses replacing seasoned nurses. Surely this is not the best strategy for encouraging a new generation to join the profession.

To figure out how we got here, we need historical perspective. The evolution to the modern nurse has been a slow and rather painful process. We are all versed in the angelic tales of ancient nurses: Florence Nightingale, the historic “Lady with the Lamp,” who transformed the quality and safety of nursing and hospital care by using the then fledgling science of statistics (Woodham-Smith, 1951); Clara Barton, the Civil War Angel of the Battlefield; and Margaret Sanger, the founder of Planned Parenthood; among many other practitioners who have paved our course.

Nurses have, for decades, battled the paternalistic influence existing in health care. Envision the days of old when nurses got up from their chair so that the esteemed physician could rest his weary whatever. Think of the days when we were considered only in terms of stereotypes: Dickens’ boozy Sairy Gamp, the long-suffering handmaiden, the crone, the sexy nymphet waiting to marry the doctor, nurse ratchet, white stockings, and white polished shoes. We were paid little and asked to dedicate our caring souls to serving others. Angels of Mercy required few earthly possessions I suppose. Of course, in those days, there were few options for women to pursue when seeking a career opportunity – nurse, nun, teacher, prostitute, housewife; that was pretty much the scope of available career opportunities for women.

Today, our patrons of quality and safety include theorists aplenty, and the likes of Patricia Benner, Linda Aiken, and Loretta Ford. Benner is revered for her devotion to the education of nurses. Aiken has produced much evidence regarding the correlation between staffing, nursing education levels, and patient outcomes (Morin, 2012). The co-founder of the Nurse Practitioner movement, Loretta Ford, actually sought to expand the role of Public Health Nurses and well-baby care (Advance Healthcare Network for NPs and PAs, 2015). With the profession’s progression, better education, technology, a livable wage, and more respect, why are we still so under-valued? Maybe, because no matter what we want to think, nurses continue to sit at the back of the health care bus. A 2014 National Quality Forum (NQF) publication describing Person- and Family-Centered Care Core Concepts does not acknowledge the contribution nurses make daily, engaging patients and their families. Seriously, if the nation’s standard bearer in health care quality and safety cannot utter the words “Registered Nurse” as we work toward achieving the goal of engaging patients in their own care, then we must recognize the gap between public perception, colleague conceptualization, and the reality of the contributions made by the medical-surgical nurse in practice.

There was an old rhyme that my daddy used about his work, and I carried it with me when I first started nursing (back in the old ‘let me get the doctor’ era):

It’s not my job to drive the train
The whistle I cannot blow
It’s not my job to say how far
The train’s allowed to go
It’s not my job to blow off steam
Or even ring the bell
But let the damn thing jump the track
And see who catches hell
—Author unknown

If we remember that our system was designed to hold us responsible for outcomes but also to thwart our efforts to practice autonomously, then we understand not just this simple poem but also why nurses are often unnamed or simply part of the team and ambiguous hospital staff. “Nursing care is an integral part of patient care processes in the acute hospital environment. Research in the past decade has been undertaken to develop an evidence base for the relationship between patient outcomes potentially sensitive to nursing (OPSN) and nurse staffing in the acute inpatient setting” (Joint Commission, 2009, NSC-1-1). Nurse-sensitive care (NSC) performance measures include (but are not limited to): falls with injury, hospital-acquired pressure ulcers, restraints, central line-associated bloodstream infections (CLABSIs), and catheter-associated urinary tract infections (CAUTIs) (Joint Commission, 2009). We are charged with reducing patient readmissions, obligated to provide education and wellness counseling, and we own patient and family engagement as well as patient satisfaction. If we bear responsibility for outcomes, then we need to strive harder to achieve bedside leadership, organizational acknowledgement (that includes monetary recognition), and collegial acceptance for the role we play.

Practice ownership is essential to advancing personal, professional, and organizational goals. So what is the nurse to do?

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.
• Join a nursing organization or two.
  • Historically, nursing specialties with strong membership exert power. Have you ever wondered why ICU nurses care for two patients? The American Association of Critical-Care Nurses, founded in 1969 and now with over 100,000 members, has provided enough supportive evidence to maintain unit-based staffing levels.
  • Every nurse is at the core a medical-surgical nurse. The Academy of Medical-Surgical Nurses (AMSN) is celebrating its 25th year as a nursing organization. The AMSN supports safe, high quality patient care and professional and personal development.

• Earn your specialty certification.
  • Certification is a demonstration of the individual nurse’s commitment to lifelong learning and achieving acknowledgment by the certifying body as to clinical competence. Certification requires ongoing education for maintenance of certification, which encourages the sustentation of clinical excellence.
  • Earning certification reaffirms your commitment to nursing as a profession. Plus, it makes you feel great!

• Volunteer to serve your nursing organization.
  • Whether your volunteerism is at a chapter or organizational level, volunteers are essential to actualization of the organization’s stated mission.
  • Volunteer work is an opportunity to meet other like-minded nurses and expand the professional experience.
  • Volunteer for organizations to serve others.
    • The American Red Cross provides services to mitigate suffering post-disaster, as well as general nursing.
    • Some organizations, whether faith-based or globally developed, provide nurses the opportunity to render aid to the less fortunate.

• Continue education with vigor.
  • Get inspired by attending an education conference. An education conference is an opportunity to meet nurses with similar practice experiences across the country.
  • Advance your degree. Nurses returning to university need not commute to a brick and mortar campus. Online courses are available to earn a BSN, MSN, and NP, for instance.

• Become political. Ferret out issues locally and nationally that impact nurses and take a stand. Imagine what would happen if every RN in the United States, all 3 million plus, contacted their members in the House of Representative and the Senate and demanded that action be taken on existing bills regarding staffing levels (Bureau of Labor Statistics, 2015).
  • H.R. 2083 – Currently in the House Ways and Means Committee – Subcommittee Health (Congress.gov, 2015)
  • S.1132 – Currently in Senate Finance Committee (Congress.gov, 2015)
  • Only fourteen states have passed any type of legislation regarding nurse:patient ratios or nurse-driven staffing level (American Nurses Association, 2017)
  • Transformational leadership/clinical leadership are not just for nurses in organizational management.
    • Lead by example. Always do the right thing for the right reason. Don’t cut corners when nobody is looking.
    • Clinical leaders have an awareness of external forces driving health care, especially as they relate to direct patient care. Our health care environment is continually in a state of flux, which precipitates organizational changes. Cognition of the external factors that foment the internal care environment can help reduce stress by providing an understanding of the need for change.

Nurses impact quality and safety. Nurses by nature are creative, imaginative, and motivated to provide excellent care. As we increase participation in the global essence of nursing, we feel more in control of our practice. Doors open beyond, which is opportunity. That’s a good thing!

References

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Joining Forces

A Smartphone App as Adjunctive Therapy to Help Veterans Cope with Suicidal Thoughts

Approximately 22 United States (U.S.) veterans commit suicide each day, totaling about 8,000 deaths per year (Veterans Administration [VA], 2016). Veterans account for 18% of all suicides in the country, yet they make up only 8.5% of the population (VA, 2016). Suicide is a complex event, and, in the veteran population, is often precipitated by wartime experiences, head injuries, and complicated survivor guilt. As some veterans struggle with depression and post-traumatic stress disorder, thoughts can turn to hopelessness and self-harm. There has been some success with talk therapy, specifically cognitive behavior (CBT), and dialectical behavior therapies (DBT). CBT taps into the veteran’s cognitive abilities to acquire new behavioral techniques to enhance coping when suicidal thoughts are present (Bush et al., 2015). DBT is more problem-focused and seeks to help the veteran develop a distress-tolerant approach to self-harming thoughts (Bush et al., 2015).

Talk therapy occurs within the therapeutic relationship in the clinical setting. The risk for veteran suicide during active talk therapy is less than when the veteran leaves the appointment and is on his/her own, whether with family or working, or just living life. It is during these times away from the therapeutic clinic setting that the veteran may experience negative thoughts, stress, and even suicidal thoughts and/or plans (Bush et al., 2015).

Prior to the digital age, some mental health therapists would help their depressed and/or suicidal patients develop a conventional hope box (CHB) (Bush et al., 2015). A CHB is a shoebox filled with items reminding the client why it was important to live rather than die. Such items might include a flower from a wedding, a meaningful photograph, a lock of hair from a child’s head, or a poem written years ago. Bush and colleagues (2015) remind us that depressed and suicidal people can name several reasons to die but find it difficult to recall even one reason to live.

In 2013, Bush and colleagues opened a randomized, controlled, 12-week study at the VA in Portland, OR, to test the hypothesis of a Virtual Hope Box (VHB) (VA, 2016). A VHB is similar to the CHB, but is available on hand-held electronic devices (ClinicalTrials.gov, 2013). The phone app was developed in conjunction with the Department of Defense National Center for Telehealth and Technology (Anderson, 2016). The study selected U.S. veterans who were in active talk therapy and who had been identified as being at risk for suicide. Veterans with dementia, terminal illness, inpatient status, or under guardianship were excluded from the trial (ClinicalTrials.gov, 2013). The purpose of the study was to provide participants with a customizable phone app consisting of icon selections similar to those categories found in the conventional hope box. The veteran could click the phone-based icons when self-harming or when suicidal thoughts occurred (Anderson, 2016). At the top of the app is a heading with support phone numbers for veterans to click when in crisis to connect with a trained mental health therapist (Anderson, 2016). The five main icons are: Remind Me, Distract Me, Relax Me, Inspire Me, and Coping Cards (Bush et al., 2015).

The Coping Cards function allows the veteran to rewrite positive mantras in response to negative thoughts. For example, if the veteran feels that a job is overwhelming and difficult, he or she can type something like, “vacation in 2 weeks,” “seeing my best friend on Friday night,” etc. Similarly, the Inspire Me icon can be preloaded with inspirational quotes, such as a cherished phrase from a loved one like, “Don’t give up, when a door closes, a window opens.” The Relax Me icon can be customized with deep breathing tools and muscle relaxation that allow the user to select the timing and duration for inhalation, holding, and exhalation. Importantly, goal-directed thinking demonstrates future planning, an important aspect of averting suicide, as belief in the future is an internal representation of hope (Sun & Shek, 2012). The Distract Me function has a place for an activity planner, which consists of a calendar for important future events such as “daughter’s ballet show.” The phone app does not require an internet connection to work and is encrypted at the military level to ensure confidentiality. Additionally, the app is meant to work as adjunctive therapy with talk therapy and not to be used as a standalone product (Bush et al., 2015).

The idea of the VHB is to provide veterans struggling with negative self-talk a way to quickly recall previous successes, positive life experiences, past successful coping methods, depictions of treasured relationships, meaningful music selections, and distraction activities. Cell phones are ubiquitous throughout American society, including with most veterans, making downloading the app simple for most. The clinical trial reported that the phone app helped veterans overcome disturbing thoughts and that the phone app provided a means of distraction, relaxation, and inspiration (Anderson, 2016). Various statistically reliable and valid tools were used to measure study outcomes including the Coping Self-Efficacy Scale, Beck Scale for Suicidal Ideation, and the Brief

If you have questions or comments regarding the "Joining Forces" column, or if you are interested in writing, please contact Column Editor Patricia J. Bartzak at patty@bartzak.com.
Reasons for Living Inventory (Anderson, 2016). Overall, the study showed that the phone app, when used as adjunctive therapy with talk therapy, was effective in helping veterans better cope with negative thoughts and stress (Bush et al., 2015). Veterans in the study commented that a limitation of the phone app was that it didn’t convey the same smells and textures as experienced with a CHB (Anderson, 2016).

The VHB is based on a pre-digital age modality of a shoebox filled with personal items that help the depressed or suicidal person re-connect to the positive people and things in their life. The concept of a life’s collage, so to speak, even in its creation by the individual, requires thought and positive emotion. Such uplifting reminders help our veterans remember at least one reason to live — a pet, a grandmother’s favorite saying, sounds of the ocean, a photo of one’s child, or even a dog tag representing survival. When such ideas can quickly and easily be brought to the forefront of the veteran’s mind, as with the click of a phone app, then there is the opportunity to reshape thoughts, and ultimately, behavior; especially in the absence of a clinical therapy session. Hope is an elusive concept: powerful but difficult to operationalize. A Virtual Health Box is a new tool on the horizon to help augment mental health therapy to reshape thoughts to promote good coping skills in our nation’s veterans.

Though the VHB app is not currently available for widespread use, bedside nurses can view the prototype by viewing Dr. Bush’s slide deck (Bush, 2016). As bedside nurses deliver care, the principles of hope explored in this article can be shared within the context of the therapeutic relationship.

References

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Nurses as Second Victims: Peers Supporting Peers

According to a 2013 report from the Lucian Leape Institute at the National Patient Safety Foundation, in order to provide the safest and most effective care of patients, the healthcare provider must 1) feel safe from physical and psychological harm and 2) be able to find joy and meaning in their practice. While creating this culture is challenging at best, nothing is more detrimental to a healthcare provider than an adverse event, especially one that leads to litigation or a board complaint. In 2000, Wu contended that while a patient may be harmed with a medical error, the doctor is also wounded by the same error; they are the second victim. It is at this time in a person’s career that it becomes difficult to even function, let alone find any joy or meaning in one’s career. Most often, second victims experience feelings of shame, fear, anger, guilt, self-doubt, and isolation. These feelings can lead to emotional incapacity, depression, burnout, impaired clinical care, drug or alcohol use, and even suicide. Psychological symptoms and social avoidance are also possible. In cases of serious adverse events, the long-term consequences can even mirror post-traumatic stress disorder (Edrees, Paine, Feroli, & Wu, 2011).

In a survey of 3,100 physicians, 81% of those who had been involved in a clinical incident experienced some degree of emotional distress (Pratt & Jachna, 2015). This research led Pratt and Jachna to further define second victim as “any clinician who experiences significant emotional distress due to the course of clinical events” (p. 56). While much of the early research on second victim focused on physician colleagues, it was also found that nurses have a high risk for second victim-related harm because of the amount of time spent caring for patients and the number of medications administered (Quillivan, Burlison, Browne, Scott, & Hoffman, 2016). Medication errors are one instance of second victim-related harm experienced by nurses. Most authors agree that healthcare systems have a responsibility to care for second victims and that there are few structured emotional support services for care providers.

Early pioneers addressing second victim, such as Kaiser Permanente, found that the stigma attached to accessing Employee Assistance Programs and mental health services prevented care providers from utilizing those services (Van Pelt, 2008). Fears regarding poor performance appraisal, possible litigation, or a report to the licensing board may also prevent victims from seeking emotional support. Victims often did not know who it was safe to talk to and what they could discuss. Recognizing the needs and the barriers, health care organizations began creating innovative support systems for caregivers such as the Brigham and Women’s Hospital, where they formalized a Peer Support Team to pair second victims with a trained peer support person with a common clinical background (Van Pelt, 2008).

Stages of Recovery After an Adverse Patient Event

University of Missouri Health Care added two items to their internal patient safety culture survey to discover the needs of their organization in relation to second victim. It was found that 175 out of 1,160 respondents had experienced a patient safety event that caused personal distress. This was described as “anxiety, depression, or concerns about one’s ability to perform one’s job” (Scott, Hirschinger, Cox, McCoig, Brandt, & Hall, 2009, p. 325). In addition, 68% reported they did not receive institutional support with this stress. In follow-up qualitative interviews with nurses, doctors, and other caregivers, six stages of recovery were delineated after an adverse patient event (see Table 1).

Intervening

Early training for the Peer Support Teams was based on critical incident response and psychological first aid (Van Pelt, 2008). The team was taught to listen, assess, and when necessary, refer to the next level of care. Psychological first aid potentially decreases the risk of error through nervous system re-regulation after an unforeseen event. In addition, the ongoing peer support after a bad outcome, claim, litigation, or board complaint provides a confidential means to verbally process the event and its effects. Both support the provider’s inherent resilience (Trent et al., 2016).

More resources continue to become available. In 2011, the World Health Organization published Psychological First Aid: Guide for Field Workers. In 2014, the American Association of Nurse Anesthetists published recommendations and resources for a critical incident stress management program that allows for support during and more importantly, for as long as necessary, after a critical adverse event. For those organizations wanting to create their own primary and secondary victim support program, Medically Induced Trauma Support Services has a toolkit that can be accessed at www.MITSS.org.

Evaluating the Effectiveness of Peer Support Teams

In 2016, Trent and colleagues published a qualitative study highlighting the benefits support participants received from the peer support program, “SWADDLE,” in the Baylor Scott and White healthcare system. In that study, the term health care adversity was coined and is defined as “difficult disclosures, depositions, claims, lawsuits, and licensing board/agency complaints” (Trent et al., 2016, p. 28).
Participants found it most useful to talk to respected peers with similar training who could really understand and give perspective to the experience of the event. The participants also reported it was useful to have preemptive education regarding risk management and the legal processes. Bad outcomes, with or without medical error, are open to litigation. Due to how the SWADDLE volunteers are selected and trained, the participants appreciated the fact that the communication is truly confidential peer support without records. The study also identified a need for further research in the area of board complaints and the effects on providers, particularly in those states that have seen a sharp increase in medical error, are open to litigation. One study (Lewis, Baemholdt, Guoefen, & Guterbock, 2015) found that giving support to RNs could be beneficial in preventing the emotional exhaustion and depersonalization. In another study of 358 nurses, Quillivan and colleagues (2016) found that a non-punitive response to error was significantly associated with reductions in several dimensions of second victim distress. The authors suggest that reducing punitive response to error and encouraging supportive interactions could lessen the severity of the second victim experience. A culture that looks at errors as learning experiences and provides supportive peer and management relationships could more adequately prepare and preserve the integrity of the nursing work force. While most state boards and organizations require documentation of errors, the conversation could be supportive and one that focuses on learning and professional growth, reducing the adverse effects of shame and guilt. Additionally, resilience training can improve the ability to bounce back after stressful or adverse events are encountered in health care. Building resilience will be discussed in the next “Healthy Practice Environments” column.

Supporting Each Other

While a formal peer support team is ideal, not all health-care providers have access to a formal program. Most authors agree that the first response would be to genuinely express care and concern by asking the person, “How are you?” Peers should be taught how unhelpful and insensitive comments can inflict further harm. Nurses frequently give each other psychological first aid. They talk to each other in the medication room, the break room, and in the parking lot, offering encouragement and support to each other. Simple, more effective communication tools can be taught through in-services and onboarding. Proper tools can improve the effectiveness of how nurses support each other through the stressful and emotional mine field that is today’s medical-surgical nursing unit. It is equally important to educate on “second victim” and provide numbers and resources available should emotional distress be encountered. Root cause analysis can also be used as an opportunity to identify potential second victims who might need attention.

Table 1.

<table>
<thead>
<tr>
<th>Stage 1: Chaos and accident response</th>
<th>In this stage, the victim may feel unable to think coherently and need peer support.</th>
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</thead>
<tbody>
<tr>
<td>Stage 2: Intrusive reflections</td>
<td>In this stage, the victim’s mind plagues them with re-enactments, “what if” questions, and feelings of inadequacy.</td>
</tr>
<tr>
<td>Stage 3: Restoring personal integrity</td>
<td>In this stage, support is sought out.</td>
</tr>
<tr>
<td>Stage 4: Enduring the inquisition</td>
<td>In this stage, there is fear about job security, license repercussions, and fear of future litigation. The person is still struggling with trust and what others think about them. This stage can be complicated with negative gossip.</td>
</tr>
<tr>
<td>Stage 5: Obtaining emotional first aid</td>
<td>Anxieties at this stage are about who is a safe person to confide in. Many felt that “where to go and what could be said” were never clear.</td>
</tr>
<tr>
<td>Stage 6: Moving on</td>
<td>Three pathways to moving on were identified: dropping out, surviving, and thriving. Dropping out is defined as changing either professional role or location or leaving the profession all together. Surviving is defined as doing alright, but still being plagued by the event. Thriving is when victims have had insights and feel they have become better people as a result of the incident.</td>
</tr>
</tbody>
</table>

Source: Adapted from Scott, Hirschinger, Cox, McCoig, Brandt, & Hall, 2009.

References


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**Building Bridges from Theory to Practice continued from page 1**

Patient about keeping the wound clean and dry. The nurse instructs the patient to breathe deeply, cough, and turn to prevent complications of pneumonia. The nurse assists the patient to the chair while making the patient’s bed. The nurse develops a plan with the patient that the patient will participate in the dressing change and move ‘from bed to chair’ on Post-Op Day 2. Which nursing theory can you think of that would support the nurse’s activities and patient interactions? This is a demonstration of Dorothy Orem’s Self-Care Deficit Theory. The nurse is moving the patient from a stance of dependence to one of more independence along the health continuum.

**Scenario 2:**

A couple is vacationing at the beach with their 10-year-old daughter when she is attacked by a shark. Unfortunately, the girl loses her left arm in the encounter, but she survives a nearly fatal event. Surgical repair is required for the remaining bud of the limb. After several days of recovery, despite a traumatic event, the youth has a positive attitude and desires to begin ambulation by walking up and down the halls of the pediatric unit. The nurse recognizes that the patient’s balance may be altered and offers to accompany her. The patient ambulates very well without any instability of gait and ventures into the teen room to obtain some books to read. Which nursing theory would capture the overall patient scenario? Sister Callista Roy’s Adaptation Theory can be applied to this patient scenario. Roy’s theory stated that in order for a person to respond positively to environmental changes or challenges, adaptation must occur (Roy, 1984). The girl demonstrated positive adaptation to a life-changing event – the loss of a limb.

**Scenario 3:**

An older adult is diagnosed with stage 4 liver carcinoma. The family is in the room, and the atmosphere is solemn. The nurse comes into the patient’s room to see if anything is needed. The nurse feels that she would like to do something to change the energy in the room and thinks to herself, “What could that be?” She shares with the family that she can bring several recent comedy DVDs into the room for the patient and family if they would like to watch movies. The patient perks up and states that he would like to see some movies. Suddenly, the room feels like a cloud has been lifted; the energy has changed. When talking about energy, Martha Roger’s Science of Unitary Human Beings may come to mind. Everything has a pattern, and interactions are patterns in and of themselves. Through the nurse’s interaction, the environmental pattern changed to a more positive one (Newman, 1999).

As exemplified in these scenarios, nursing theory does indeed weave into the activities of everyday nursing practice. The question that remains is: How can we bring the awareness of the underpinnings of nursing theory to the forefront so that bedside nurses can become inspired and build upon the theoretical knowledge of the nursing theorists?
Empowering Clinical Nurses with Theory

Framing nursing theory and conveying its applicability to daily nursing practice facilitates the engagement of bedside nurses. One way to accomplish this is to present opportunities where nurses can experience for themselves the benefits of theory in practice. Many institutions have adopted nursing theorists’ conceptual frameworks and integrated them within their foundational philosophies. An example of nursing theory being introduced into operations of the nursing department occurred when “Senior nursing executives in a Chicago-based healthcare system comprising eight hospitals decided that a new standardized nursing philosophy would be adopted for use by all facilities” (Rosenberg, 2006, p. 53). The nurse executives conceded that “…nursing theory should be part of the nursing philosophy and determined that the organization’s mission and core values were congruent with Watson’s Theory of Caring” (Rosenberg, 2006, p. 53).

Building Theoretical Models That Help Guide Practice

Encouraging clinical nurses to participate in theory building through developing theoretical models is an innovative and exciting modality to gain interest, support, and contributions from nurses who apply critical thinking skills, clinical reasoning, problem-solving, and high-level communication skills in every activity they do. Linking the connections between practice and theory will provide opportunities for bedside nurses to recognize the value of theory and its vital role in advancing both patient care and nursing science. An instrumental example of how theory building can impact nursing and patient care in a transformational manner is the ACE Star Model of Knowledge Transformation (Stevens, 2004). According to Stevens (2013), the model was “…developed to offer a simple yet comprehensive approach to translate evidence into practice.” As explained in the ACE Star Model, “one approach to understanding the use of EBP in nursing is to consider the nature of knowledge and knowledge transformation necessary for utility and relevance in clinical decision-making” (Stevens, 2013). Additionally, theory building provides an avenue to empower nurses within the profession to acquire a ‘sense of accomplishment’ from an activity once viewed as negligible but which now has the potential to provide connections for an infinite number of applications in nursing.

In conclusion, nursing theory is essential to the discipline of nursing. Nursing theory serves as a foundation to build upon institutional missions and core values (Rosenberg, 2006). Increasing the value of nursing theory facilitates empowerment for clinical nurses in the profession. Procurement of new theories benefits patient care and professional nursing.

References


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Nutrition to Improve Outcomes

Malnutrition in the Hospitalized Patient: Helpful Resources

While many of us are planning picnics or backyard barbecues, our patients are missing the nutrition needed to fully heal and recover quickly. They are continuing to experience longer lengths of stay, higher costs, additional complications, and an increased risk of death as a result of being undernourished. An Agency for Healthcare Research and Quality initiative mined data from a 2013 national inpatient repository to evaluate the “Characteristics of Hospital Stays Involving Malnutrition.” The resulting Healthcare Cost and Utilization Project (HCUP) Statistical Brief confirms that malnutrition is adversely influencing patient outcomes (HCUP, 2016). The data also reveals that the most prevalent form of malnutrition (protein-calorie malnutrition) is associated with a higher average cost of hospitalization ($25,200). As clinicians, we have an opportunity to use this data to improve our care. By targeting the most nutritionally at-risk (those who are 85 years or older, black, low income, or rural), we can begin to reduce these numbers and provide a healthier future for our patients. Through early assessment and intervention, we can develop nutritional plans to meet their needs and bridge the gap to establish a firm plan for nutrition care upon discharge.

Efforts to eliminate hospital-based malnutrition and change these startling statistics begin with cohesive interprofessional initiatives. Teams are encouraged to explore the toolkit available at the Malnutrition Quality Improvement Initiative (MQii) website (mqi.defeatmalnutrition.today). The resources are free and designed to meet the needs of all team members.

Much like mapping out your favorite picnic or barbecue menu, taking time to map out a strategy to defeat malnutrition will be incredibly meaningful to those you serve. What’s your summer strategy?

Reference

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