Certified nurses demonstrate higher levels of knowledge and skills. To improve medical-surgical nursing certification, nursing staff in an academic medical center developed and implemented an in-house certification review course. The methodology for program development and program outcomes are described.

The delivery of quality patient care is an essential component of the U.S. health care system and is directly related to the morbidity and mortality of patient populations. The Institute of Medicine (IOM) released *Crossing the Quality Chasm* (Committee on Quality of Health Care in America, 2001) to identify methodologies to enhance and support quality patient care. The report indicates there is an imbalance between the ability of health care providers to translate knowledge into practice in the constantly changing arena of health care. To bridge this gap, continuing education and professional training classes are essential for nurses and health care providers. Specialty nursing certification is one approach to validate the nursing knowledge and skills that support and enhance the provision of patient care (Wade, 2010). This article describes one hospital’s journey to increase medical-surgical nursing certification.

The American Board of Nursing Specialties (2005) defines certification as the formal recognition of specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty to promote optimal health outcomes. Empowering nurses through the attainment of knowledge from specialty certification also strengthens professional credibility and self-esteem. The World Bank (2011) states:

Empowerment is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. Central to this process are actions which both build individual and collective assets, and improve the efficiency and fairness of the organizational and institutional context which govern the use of these assets.
New Year’s Resolutions for the Med-Surg Nurse

I just love this time of year. I live in the north, where all of our big maple trees are turning beautiful colors of red, yellow, orange, and brown. The air is getting cooler and the days shorter. We’ve already had snow in the upper part of our state. Many of you living in the southern states are still enjoying perfect temperatures and may actually be feeling sorry for your colleagues up north who are freezing. But despite the temperatures or changing foliage, wherever you live, it’s the holiday season! The holidays are such a wonderful time of year to celebrate with family and friends, reflect on the year behind, and look forward to the new year with fresh goals and resolutions.

This year, as you are preparing for the winter and the holidays, I hope you also reflect on your role as a nurse and how you can use your kindness, care, compassion, and knowledge to continue to improve the health and lives of the people you care for. You will find some suggestions of how to do that in this issue of MedSurg Matters!

For example, as you are making your New Year’s resolution, consider developing a process to help some of your colleagues become certified as medical-surgical nurses. Or perhaps you could brainstorm strategies to improve post-mortem care on your unit so mourning families don’t have to worry about the appearance of their loved ones at the funeral home. What about a resolution to improve quality and outcomes where you work or ways to improve the nutrition status in your patients? Perhaps a goal to strive for in 2015 would be to become the expert on the Affordable Care Act on your unit, so you can explain the law and its implications to your colleagues, patients, and family members. Maybe it’s something as simple as being kinder and more understanding to travel nurses and newly licensed nurses to reduce the lateral violence that is reportedly so prevalent in nursing.

I certainly hope you’ll make it a 2015 goal to attend the 24th AMSN Annual Convention in Las Vegas. Whatever your plans are for this time of year and the holidays, remember to be thankful that you are a medical-surgical nurse and have the ability to touch and heal so many lives. I am thankful to be a part of this wonderful community of med-surg nurses. We are a talented and gifted group of professionals that have so much to give.

Along with the MSM Editorial Committee, I wish you a wonderfully blessed, restful, and happy holiday season and a very prosperous New Year.

Molly McClelland, PhD, MSN, RN, CMSRN, ACNS-BC
MedSurg Matters! Editor

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Acute Appendicitis: A Case Study Describing Standards of Care

Michael M. Evans and Marissa Curtin

Ms. F., 27, has had diffuse abdominal pain for 12 hours. As the pain worsens and vomiting develops, she goes to the local emergency department (ED). According to Ms. F., her only significant past medical history includes ovarian cysts and asthma. Current medications include an albuterol inhaler as needed (PRN). She also had a laparoscopic removal of a right ovarian cyst five years prior.

Ms. F. informs the ED nurse that the onset of pain has increased and became more severe over the past 12 hours; vomiting began about six hours ago and is described as bile in nature. She has taken no medication for her symptoms and has only used a heating pad to help relieve the pain in her abdomen. You instruct Ms. F. about not using a heating pad because she may have appendicitis and a heating pad increases the risk of perforation (Black & Hawks, 2009; Lewis, Dirksen, Heitkemper, Bucher, & Camera, 2011; National Digestive Diseases Information Clearinghouse [NDDIC], 2012). Upon exam, Ms. F. rates her pain at 10 out of 10 on the pain scale throughout her abdomen, with tenderness and guarding noted upon palpation. The patient also has positive psoas and obturator signs. She has hypotonic bowel sounds in all four quadrants. Ms. F. is febrile with a temperature of 101 degrees Fahrenheit tympanically, with a pulse of 120 and regular respirations of 24, blood pressure of 168/52, and SaO₂ of 98%. Lung sounds are clear to auscultation with some incisional pain noted intermittently; auscultatory effort noted. Peripheral venous access and labs are obtained.

Clinical Decisions

The patient is medicated with Zofran™ (4 mg IV) and morphine (3 mg IV) for nausea and pain. Based on the patient’s presentation and history, an ovarian cyst versus an acute appendicitis (inflammation of the appendix) is suspected. A stat ultrasound of the abdomen is ordered. It shows no free fluid in the abdomen, an ovarian cyst with no rupture, and is inconclusive for appendicitis. Following a discussion with the ED attending physician, a Computerized Axial Tomography (CAT) scan is ordered and shows an acute appendicitis. Lab work reveals a white blood cell (WBC) count of 22,000 k/ul with 7% bands and a potassium level of 3.3 mmol/L, consistent with a possible appendicitis and dehydration. Based on the findings, normal saline solution (NSS) with 20 meqKCL/L is started at 125 ml/hr; the patient is kept nothing per oral (NPO), and a stat surgical consult is obtained consistent with health care standards (Lewis et al., 2011; NDDIC, 2012; Van Leeuwen, Poelhuis-Leth, & Bladh, 2013).

Immediate Interventions

To avoid perforation and sepsis, the patient is rushed to the operating room for an open appendectomy with the on-call general surgeon. The anesthesiologist utilizes general anesthesia. The surgeon removes the appendix to prevent future inflammation and infection, and Ms. F. spends two hours in the post-anesthesia care unit prior to being transferred to the medical-surgical unit. Upon receiving the patient, the med-surg RN completes an assessment, noting the surgical site dressing is dry and intact, and monitors vital signs every hour for the next four hours and then every four hours for the remainder of hospitalization. NSS with 20 meqKCL/L at 125 ml/hr is maintained and orders for Ancef™ (1 g every eight hours IV), morphine (2 mg IV every two hours PRN), Vicodin™ (1 tab PO every six hours PRN), Zofran (4 mg IV every six hours PRN), and Dulcolax™ (100 mg PO daily) are provided according to described standards of care (Black & Hawks, 2009; Lewis et al., 2011; Vallerand, Sanoski, & Deglin, 2011). In addition, thromboguards are prescribed to prevent deep vein thrombosis, to be worn while in bed. Ms. F. is educated on maintaining Fowlers position, the proper use of the incentive spirometer (I/S), and use of a pillow splint to cough and take deep breaths each hour. A complete blood count (CBC) and comprehensive metabolic panel (CMP) are ordered to be completed each morning while in the hospital.

Ongoing Interventions

Ms. F. is able to tolerate small amounts of water without symptoms of nausea for the remainder of Day One post-surgery and a soft diet is permitted the next morning. Ms. F. begins to ambulate 150 feet with assistance by the end of the day without discomfort after premedication. Day Two post-op, Ms. F.’s temperature is 99 degrees Fahrenheit tympanically, with a pulse of 88, and regular respirations of 20, blood pressure of 130/76, and SaO₂ of 98%. Lung sounds remain clear to auscultation with some incisional pain noted intermittently; bowel sounds are active. Lab work reveals a WBC count of 14,000 k/ul and a potassium level of 3.6 mmol/L. The surgical wound dressing has a scant amount of blood, and upon dressing change by the surgeon, the wound is well approximated. Medication orders are changed to: NSS at 50 ml/hr, Vicodin (every 4-6 hours PRN), Dulcolax (100 mg PO daily), and continue with current treatment with Ancef (1 g every eight hours IV). Ambulation as tolerated is encouraged with assistance at minimum twice per day and even shifts. Continued use of I/S, coughing and deep Breathing with pillow splint, and use of thrombo- guards while in bed are maintained. Ms. F. ambulates to a chair for meals and to the bathroom with assistance. It is noted that the patient has not had a bowel movement at the conclusion of Day Two, but the RN explains that this is an expected temporary outcome to both anesthesia and pain medication. The patient is encouraged to continue drinking fluids and ambulating to stimulate peristalsis per described standards of care (Black & Hawks, 2009; Lewis et al., 2011; Vallerand et al., 2011).

continued on page 15
Lasting Impressions: Using the Perspective of the Funeral Director to Guide Post Mortem Nursing Care Practice

Mikel W. Hand

This article shares key insights related to physical post mortem nursing care from the perspective of the licensed funeral director. The goal of post mortem care is to provide the best possible physical appearance of the deceased and to bring comfort to the patient’s family.

Death is a significant life event and one that occurs frequently in U.S. hospitals. As a result, the important process of providing post mortem nursing care becomes the responsibility of hospital clinical nurses. The policies guiding such care vary by institution (Smith-Stoner & Hand, 2012). Nurses frequently face this task with limited experience and education in the provision of post mortem nursing care. Nursing textbooks frequently dedicate very little space to this important topic. Lecture courses may or may not include content related to the proper care of a deceased individual. There are many publications that address the psychosocial and emotional aspects of death and dying. The purpose of this article is to focus on the physical post mortem nursing care of a deceased patient.

When speaking of the continuum of care of individuals, the licensed funeral director is typically the next professional to provide care for a patient after death. As such, he or she is in a position to provide valuable recommendations in terms of how nurses can more effectively care for the deceased and assist in the process of producing a better cosmetic appearance of the body for family and friend viewing, as well as for the funeral. Open casket viewing and burial continue to be predominant practices in the United States and as such, the physical appearance of the deceased becomes a primal concern (National Funeral Directors Association, 2014).

In addition to physical appearance, safety factors such as proper body identification, shrouding, and shielding must be considered. Funeral directors collect and transport human remains and are keenly aware of the potential consequences of inadequate barrier protection, shrouding, and improper identification. The recommendations included in this article are based on a descriptive phenomenological study (Hand, 2012) involving twenty licensed funeral directors in a mid-western state. Participants were asked to complete an open-ended, web-based questionnaire pertaining to various aspects of post mortem nursing care. The questionnaire required participants to describe what typical post mortem care practices they typically observe with the deceased individuals that they encounter, whether they help or hinder a desired cosmetic result with further body preparation, and what (if any) alternative recommendations they might make in relation to what they typically observe. The practice recommendations contained in this article reflect the results of this study.

There are many elements to consider when providing physical post mortem nursing care. The following items are considered key in terms of their relationship to the physical appearance of the deceased:

- positioning of the body after death
- use of ligatures and ties on extremities
- removal of intravenous catheters and lines
- removal of drains and tubes
- placement of dentures and partials
- cleansing of the body

Objectives

The purpose of this continuing nursing education article is to increase nurses’ and other health care professionals’ awareness of proper care of the remains of deceased patients prior to transfer to the funeral director. After studying the information presented in this article, you will be able to:

1. Discuss the safety factors nurses should consider in regard to handling of a patient’s body after death.
2. Identify the elements of post mortem care that can impact the physical appearance of a body prior to transfer from the hospital.
3. Explain each of these elements and discuss the proper procedure for handling a recently deceased patient in regard to the effects of each.

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

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Each of these will be explored in greater detail with discussion of specific care recommendations. Safety and shrouding of the body and proper identification are also important aspects of post mortem nursing care and will be discussed in the article.

**Body Positioning**

Although it is a common practice to place the body of a deceased individual in a flat lying position, this is typically not desirable. Blood may pool in the neck and ears, resulting in staining of the skin and subcutaneous tissue that may not be removable with the embalming process. Elevating the head slightly or using a disposable foam head block may be a viable option to prevent the skin on the head from being stained with pooled blood.

Placing the head in a central neutral position is essential as shortly after death as possible. Do not allow the head to lean to one side or the other. Muscle rigidity can develop and make this situation difficult if not impossible to correct.

Gently close the eyes. If the eye will not remain closed, do not attempt to use any means to physically close the eye. The funeral director will use a specially designed eye cap to close the eye and any aggressive attempt of eye closure may physically damage facial appearance.

Swelling of the hands and wrists commonly occurs after death. This condition worsens when the hands are placed in a dependent position beside the body. This can be severe enough to be disfiguring. Positioning the hands in an elevated position on the abdomen may be a simple and reliable strategy to prevent the development of dependent edema.

**Ligatures and Ties**

Ligatures and ties serve no relevant purpose in post mortem nursing care or in promoting a pleasant appearance of the deceased in the casket. If these are included in the facility post mortem care kit, they should be discarded. When ligatures or ties are used, there is a substantial risk that they will be tied too tight and leave disfiguring marks on the wrists and around the head. These may still be visible after the embalming process and potentially impossible to cover with the use of mortuary cosmetics.

**Removal of Intravenous Catheters and Lines**

The decision to remove intravenous catheters and lines is strongly dependent on the location of the device. If the line or catheter is inserted in a visible location such as high on the neck or in the dorsum of the hand, it would be appropriate to remove this due to the potential to leave disfiguring marks. If the catheter is in a non-visible location and your facility policy permits this, it would be appropriate to leave this in place. Lines and catheters that are removed leave holes in an otherwise intact vascular system. This may cause the body to leak during the embalming process and hinder the distribution of formaldehyde and other chemicals.

**Removal of Drains and Tubes**

The retention of surgical drains and tubes depends on their location. If the tube or drain is in a non-visible location, leaving it in place is ideal. This allows the wound or area to continue to drain in an enclosed system until the embalming process is complete and the funeral director cauterizes the tissue.

**Dentures and Partials**

Dentures and partial bridgework must accompany the deceased regardless of whether they are placed in the mouth or not. Further body preparation, including setting of facial features, closing the mouth with suture or wire, and embalming may occur within a short time after removal. Leaving them at the hospital would result in the need to fill in facial features with either cotton or a mouth former. The mouth is typically sutured or wired closed. If the dentures are received at a later time, they are typically placed in the casket with the deceased and thus serve no benefit to the cosmetic appearance.

**Cleansing and Bathing of The Body**

Nurses may be concerned that the deceased be clean and presentable for family and friends to say their final goodbye prior to removal from the hospital room. Simple and gentle bathing is adequate. Aggressive cleansing or attempts to disinfect the body are not necessary. It is important to note that the funeral director will thoroughly bathe the body again prior to embalming. In addition, the individual may also discharge bodily fluids during transport.

**Shrouding and Exposure Prevention**

Universal exposure prevention is an important component of physical post mortem care (Occupational Safety and Health Administration, n.d.) and attention to how the body is shrouded is important for the protection of all personnel involved in handling and transporting the deceased. Although it is still common practice to remove bodies wrapped in bed sheets, this is less than ideal due to the risk of blood and bodily fluid exposure leaking through the linen. An inexpensive body bag with a zipper is typically sufficient. If there is substantial blood or fluid flow from the body, a thicker body bag may be helpful. Some available post mortem care kits may contain plastic sheeting, but this method isn’t preferred due to the risk of fluid leakage and the potential of being wrapped too tightly around the body. Plastic sheeting that is wrapped too tightly may actually compress the nose, permanently bending it to one side and disfiguring the face.

**Proper Identification**

There are serious legal ramifications associated with improper identification and disposition of remains. It is imperative to assure that facility policies concerning identification of the body are adhered to. Wristbands, ankle bands, and toe tags must be double-checked to assure that these exactly match the release of remains form prior to the body being transported from the unit. Identification tags must
be attached to the body and should not be attached to any location, such as a sheet, where they are at risk of being dislodged or torn.

**Conclusion**

There are many aspects of physical post mortem nursing care to consider and this article has addressed several of these and included specific recommendations in terms of how to effectively carry out this care. Post mortem nursing care may also involve unlicensed assistive personnel, but any aspect of the care involving the need for assessment may not be delegated. For example, the decision to remove an intra-venous catheter or line is a decision involving professional judgment and should not be delegated (National Council of State Boards of Nursing, 2005). Nurses also need to be considerate of requirements for autopsy or coroners’ cases, which vary from state to state.

Post mortem nursing care must be considered as part of the overall plan of care, and as such must be individualized to meet individual patient/family needs and preferences. The recommendations made within this article should be adapted to address any cultural or spiritual needs or preferences that may differ from what is commonly observed.

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**References**


**Coming soon in...**

- Does the Associate Degree Nursing Education Curricula Prepare Nurses Adequately to Assume a Leadership Role In Nursing Practice?
- Substance Abusers Need Care Too: Ethics and the Undertreatment of Pain in Med-Surg Patients With Drug Abuse History
- Legally: What is Quality Care?
- Sustaining the Human Experience in a High Tech Environment Implementation of the Electronic Medical Record
- Educational Planning for Establishing a Health-Promoting Workplace
- Nutrition Supplements to Promote Wound Healing
- Nurturing New Hires to Safe Practices in a Caring Environment
- The Effects of Nurse Staffing on Quality of Care
- Current Trends in Stress Management
- Moral Injury is the Wound – Post Traumatic Stress Disorder is the Manifestation

**Quality Issues**

*Continued from page 16*

Six areas of nursing opportunity were identified:

- Ensuring that nursing education emphasizes patient engagement
- Amplifying the professional standing of nurses as champions for patient engagement
- Strengthening support for nurses as advocates in the care environment of patients
- Aligning payment incentives to encourage patient engagement
- Enforcing regulatory expectation and standards that support patient engagement principles in practice
- Intensifying efforts to conduct and disseminate research on patient engagement

AMSN serves the NAQC as an at-large member organization. National organizations focusing on Quality Care and Quality Measurement should be of interest to every nurse, as the recommendations from these organizations often impact the care that medical-surgical nurses deliver.

**References**


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Healthy Practice Environments

Nurse Managers’ Expectations and Utilization of Travel Nurses

With increasing changes in the U.S. health care system, more demands are being placed to provide adequate inpatient nurse staffing, with an eye toward maximizing quality and minimizing long-term costs. While passage and implementation of the Patient Protection and Affordable Care Act (ACA, 2010) has provided more opportunities for nurses in a variety of non-hospital settings, larger and mid-sized hospitals continue to experience significant staffing shortages for reasons that include: inadequately trained newly licensed graduates, geographical restrictions of nursing graduates, retiring long-term employees, and high stress levels leading to rapid staff burnout (Gilmartin, 2013; Kovner, Corcoran, & Brewer, 2011). Currently, there continues to be a strong sense of uncertainty regarding the real effects of the ACA on hospital nursing practice (Krauskopf & Steenhuysen, 2014). In addition, traditional approaches to improve nurse retention have generally been unsuccessful in stemming the perennial problem of staff turnover (Gilmartin, 2013). To further complicate current staffing issues, health care reforms have resulted in overall reduced reimbursements, causing many facilities to cut back staff and benefits, shutter more expensive programs such as obstetrics and birthing centers, and begin considering cuts in hourly staff wages (Tozzi, 2013). Simultaneously, advances in technology and medicine have increased treatment options, creating a higher demand for more complex nursing skills in the inpatient setting. Some institutions are attempting to cut expenses by filling vacant full-time positions with more experienced float-pool or supplemental staff, while avoiding the hiring and orientation process of newly licensed nurses (Bhatt, 2012; Kurtz, 2013). This reduces costs for many medical facilities by eliminating training costs, reducing payouts for expensive benefit packages, and reducing paid leave costs. One popular approach to accommodate these staffing needs is the use of travel or contract nurses. According to the Professional Association of Nurse Travelers (2007), there are an estimated 25,500 Registered Nurse Travelers currently working in the United States.

Accreditation Process

There is a multitude of travel/contract nursing agencies providing supplemental staffing in the United States. A listing of these agencies can be found on a number of websites, which are generally industry-sponsored marketing sites and not data- or research-based. Three of the more popular websites include: Travel Nursing (http://www.travelnursing.com), Professional Association of Nurse Travelers (http://www.pantravelers.org), and Travel Nursing Central (http://travelnursingcentral.com). A common attribution expressed by many managers in the use of contract staff are questions about their ability to function independently and competently on the nursing unit, often referring to an older study by Blegen, Vaughn, and Goode (2001) showing higher rates of infections and adverse events with the use of contract staff. Unfortunately, there have been no recent, well-controlled studies in the nursing literature comparing high versus low contract staffing utilization in either medical-surgical or critical care units. It has been shown that years of nursing experience predict fewer adverse events and overall higher quality on nursing units (Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke 2006). More importantly, significant improvements and increased scrutiny regarding the training and experience of contract staff by staffing agencies has occurred over the past 10 years. For example, The Joint Commission (TJC, 2014a) now has a Health Care Staffing Services (HCSS) Certification Program that provides an independent, comprehensive evaluation of a staffing firm’s ability to provide qualified and competent staffing services. Health care staffing firms may apply for Joint Commission certification if they: (1) place temporary clinical staff in other organizations that direct or provide direct patient care; (2) place temporary clinical staff under the direct supervision of another organization’s personnel; (3) collect and present four months of data for each of the three standardized performance measures by the time of the initial on-site review; (4) place at least ten individual clinical employees on assignments by the time of on-site review (TJC, 2014a). TJC published the Health Care Staffing Services Certification Handbook which is available online in PDF format (TJC, 2014b), free of charge. This is a complete discussion of the review process for agencies as well as for customers to peruse. The one area of specific interest to managers utilizing staffing services is the Human Resources section. Here, standards are described for the hiring of clinical staff, methods for working with clinical staff, supervision, continuing education, and performance evaluation. Accreditations are bi-annual and occur via unannounced visits to offices of the agency to review quality data, performance trends and staff/contractor files. Managers and Nurse Executives should always select a Joint Commission accredited travel agency for any travel nursing needs.

Competency Testing

All accredited staffing agencies following TJC standards maintain thorough, up-to-date health records, drug screening information, and continuing education records, and will provide competency evaluations in the form of online testing via popular assessment and testing systems including: Prophecy Healthcare Testing (2014) and Cross Country Nursing Competency Assessments/Continuing Education (Cross Country TravCorps®, 2014). While Cross Country Staffing is a proprietary staffing company, it makes its testing program...
available to other agencies, for a fee. Both of these competency evaluation systems provide excellent clinical reviews of all areas of clinical nursing and rigorous tests of concepts and hands-on clinical knowledge for the clinical nurse. Clinical managers may wish to become familiar with the available tests from both of these companies as there are many different tests at varying levels of complexity specific to Critical Care, Telemetry, and Medical-Surgical Units. Managers can request certain passing scores on each test as a criterion for accept- ance of the travel nurse on their unit.

The Selection Process

After the manager chooses a travel nurse company accredited with “TJC Gold Seal of Approval;” the company submits viable candidates based on the needs that have been detailed. The next step is the interview, usually by telephone and sometimes by Skype or other video-conferencing when possible. Some of the important questions that must be asked include: years of total nursing experience, years as a travel nurse, and years of med-surg, telemetry, and ICU experience. Some managers become preoccupied with specific past training on one or another electronic medical record (EMR) system. After six years of travel nursing, I have learned that if the travel nurse has had experience on any of the top five EMRs, he or she can become proficient using an alternate EMR in 3-5 shifts, with a basic 1- or 2-day training course.

Unfortunately, some travel companies allow nurses with less than two years of overall nursing experience to accept travel positions. In today’s work environment, managers can be more selective and may wish to set a minimum of three years total experience as acceptable for a Med-Surg/Tele unit and three years total with two years ICU experience for the ICU. The presence of clinical certifications and/or a Bachelor of Science in Nursing (BSN) is always a plus and should propel the candidate to the top of the prospect list, because it suggests that (in addition to years of experience) the nurse is committed to his or her specialty area. It is the experience of this writer that travel nurses with two years or less of experience often have difficulties mastering the clinical demands of the unit and frequently are not aware of common medication interactions/effects which cause adverse events resulting in Rapid Response Team (RRT) calls. For example, the blind administration of multiple blood pressure medications with borderline blood pressures and continuing with administration of scheduled insulin for patients with poor oral intake are two of the most common critical thinking errors this writer has observed in younger, inexperienced travel nurses.

Making the Experience a Win-Win Situation

The key to a positive and effective experience with the travel nurses selected is determined before they ever arrive on the unit. First, all travel nurses should receive a minimum of two days of general orientation as specified in TJC’s Certification Handbook for Health Care Staffing Services (2014b). After general orientation, including EMR use, the travel nurse should be assigned a mentor or preceptor to assist with basic unit orientation for a minimum of two shifts, which usually includes completion of a skills checklist. Finally, full-time RNs, nursing assistants, and unlicensed staff need a brief orientation meeting – while the travel nurses are going through their own orientation period – regarding the qualifications of the nurses selected to work with them. A brief pep-talk to both day and night staff, especially charge nurses, regarding the incoming travel nurses and referring to them by name gives the staff a sense that they are highly qualified nurses coming to help, assist, and teach. Travel nurses should be treated as colleagues. When this type of healthy practice environment is created, many travel nurses will renew their contracts multiple times, making the manager’s life easier while also elevating quality and patient satisfaction scores.

Conclusion

The use of travel nurses as supplemental staff can be a positive and rewarding experience for the clinical manager and the clinical nursing unit. Experienced travel nurses bring expert clinical experience, knowledge, and rapid critical thinking skills to the nursing unit. However, the selection of staffing agencies and travel nurse candidates, as well as their mentor- ing upon arrival to the unit, needs to be well-coordinated, well planned, and thoughtful in execution.

References

Explaining Health Care and The Law to Patients

Let’s face it, when patients or family members have a question about health care benefits, the first person they ask is the nurse. That being said, the new health care laws are very confusing. Being sick and trying to interpret the new laws can be very intimidating for our patients. Here are a few simple facts that will assist you with explaining these new laws to your patients and their families.

Congress passed the Patient Protection and Affordable Care Act (ACA) in 2010, and on March 23, 2010, the President signed it into law. On June 28, 2010, the Supreme Court rendered a final decision to uphold the health care law (U.S. Department of Health and Human Services [HHS], 2014a). The law put in place comprehensive health insurance reform that would be rolled out over the next four years and beyond. The Affordable Care Act (also referred to as ObamaCare) hopes to expand the affordability, quality, and availability of private and public health insurance through consumer protections, regulations, subsidies, taxes, insurance exchanges, and other reforms. ObamaCare was not designed to replace private insurance, Medicare, or Medicaid. The goal of ObamaCare is to give more Americans access to affordable, quality health insurance and to reduce the growth in health care spending in the United States (ObamaCare Facts, 2014).

What does this mean for patients and their families? Here is a quick list of different benefits, rights, and protections that went into effect on January 1, 2014:

- New Health Insurance Marketplaces are for all shoppers to compare health plans that include all new benefits, rights, and protections.
- Cost assistance is provided to individuals, families, and small businesses through the marketplace.
- Patients no longer have annual or lifetime limits on health care.
- Insurance companies cannot drop patients when they are sick or for making a mistake on the application.
- Patients cannot be denied coverage for pre-existing conditions.
- Patients and family members have the right to appeal any insurance company decision.
- Patients have the right to get an easy-to-understand summary about the health care plan’s benefits and coverage.

Young adults can stay on their parents’ plan until age 26.
Women’s health services were greatly expanded.
Senior care was expanded to provide better care and protection for seniors.
New preventive services are available at no out-of-pocket cost.
Essential health benefits are included on all non-grandfathered plans at no out-of-pocket limit.
Insurance plan costs cannot be increased based on health status or gender.
Americans who did not obtain insurance or an exemption by the deadline of March 31, 2014, will be charged a fee on their 2014 income tax returns.

As mentioned above, the ACA mandates that all qualified plans sold in individual and small groups must offer the Ten Essential Health Benefits as of January 1, 2014. In addition, all new Medicaid and Medicare plans must offer essential benefits starting in 2014. Grandfathered plans from before the law was enacted on March 23, 2010, don’t have to offer essential benefits. The Affordable Care Act’s Ten Essential Health Benefits (ObamaCare Facts, 2014) include:

1. Ambulatory patient services (outpatient care).
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health services and addiction treatment.
6. Prescription drugs.
7. Rehabilitative services and devices.
8. Laboratory services.
10. Pediatric services.

Essential Health Benefits include annual wellness visits and many types of preventive services including immunizations and screening at no out-of-pocket costs. The Affordable Care Act has a major focus on wellness and prevention to help increase early detection and catch sickness before it starts, increasing wellness and decreasing the need for costly treatments. There are no dollar limits on Essential Health Benefits to ensure that patients don’t have to stop treatment and/or go broke when they reach their dollar limit. The purpose of Essential Health Benefits is to prevent Americans from being denied treatment when they have hit a dollar limit. In addition, the Affordable Care Act creates a “single risk pool.” This means that regardless of what care is needed, all Americans share the cost and the risk. The goal is to allow insurance companies to cover men at that same rate as women and sick people at the same rate as healthy people. The single risk pool splits the costs of Essential Health Benefits so that all benefits are offered to all insured and so that pre-existing conditions are covered.

If you have any questions or comments regarding the “Legal Nursing” column, or if you are interested in writing, please contact Column Editor Helen P. Neil at hpneilm@cox.net.
According to HHS (2014b), medical expenses are the number one cause of bankruptcy in America. The new health care law attempts to make health insurance available to most uninsured low and middle-income individuals through a health insurance exchange system known as the Health Insurance Marketplace. Health Insurance Exchanges opened in October 2013 and ended on March 31, 2014, for 2014 benefits. The next open enrollment period begins November 15, 2014, and ends on February 15, 2015, for coverage in 2015 (ObamaCare Facts, 2014). Americans can use the exchange depending on their state regulations. There are three types of cost assistance offered through the Health Insurance Marketplace (ObamaCare Facts, 2014) to those who don’t have access to employer-based insurance:

- Medicaid/CHIP for those making less than 138% ($5,347 per household member) of the Federal Poverty Level (about $88,000 for a family of four).
- Help with out-of-pocket costs for those making up to 205% ($8,241 per household member) of the Federal Poverty Level.
- Premium tax credits to reduce monthly premiums for those making up to 400% ($16,080 per household member) of the Federal Poverty Level.

Federally regulated, subsidized private health insurance plans must provide one of four levels of benefits, named:

1. Bronze – 60% coverage
2. Silver – 70% coverage
3. Gold – 80% coverage
4. Platinum – 90% coverage.

Each plan covers an average according to their “actuarial value” until they reach the out-of-pocket maximums, then the plan covers 100% of their extra costs. In general, the higher the metallic level, the more the plan will pay toward individual health care expenses, but will result in higher monthly premiums (ObamaCare Facts, 2014).

**Exceptions and Limits on Essential Health Benefits**

There are some exceptions and limits on Essential Health Benefits. They are:

- Insurance companies can still put a yearly dollar limit and a lifetime dollar limit on spending for health care services that are not considered essential benefits.
- Some health insurance plans may have received a temporary waiver from the rules on yearly dollar limits. Yearly limit waivers end with plan or policy years beginning in 2015 (2014 in some states).
- Health plans can still, however, set limits on the number of times you can receive a certain treatment.
- Large group markets and self-funded plans don’t need to offer Essential Benefits.

Here are some common myths about Essential Health Benefits and ObamaCare to share with your patients.

**MYTH:** There are no dollar limits on health care.

**FACT:** Dollar limits still apply to non-essential treatments; essential benefits are covered at no dollar limits and must have reasonable out-of-pocket maximums.

**MYTH:** All Essential Health Benefits are free.

**FACT:** Only some preventive services have no out-of-pocket expenses. Other benefits may have reduced or no out-of-pocket expenses, depending on the plan. Even a “free” service still comes with the cost of the monthly premium.

**MYTH:** Abortions have to be provided on demand at public cost.

**FACT:** The ACA Sect 1303 explicitly prohibits abortion from coverage as an “essential benefit.”

**MYTH:** Paying for care I “don’t need” means higher premiums.

**FACT:** In order to make insurance affordable for all Americans, a single risk pool was created. Because all insurers share the risk, premium prices reflect not only the risk, but the benefits, rights, and protections offered by the ACA.

In summary, there are many new benefits for the health care consumer that went into effect on January 1, 2014. More is invested in primary care, all Americans are provided with access to health insurance options, adults 18-26 can be covered by their parents, women services are expanded, and pre-

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In-House Certification Review Course

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Nurses certified in their specialty practice have higher perceptions of empowerment for their nursing practice, resulting in increased nursing knowledge, expertise, and self-confidence, as well as increased recognition as formal and informal leaders due to the formal recognition by their national certifying organizations. Potentially, this improves nurse retention rates and decreases nursing turnover in health care organizations (Piazza, Donahue, Dykes, Griffin, & Fitzpatrick, 2006). Development of a hospital-based certification review supports the practice of nursing by increasing nursing certification and supports a health care facility’s mission of providing expert health care (Blair, Hill, Walters, Senn, & Brockopp, 2011; McCarthy, 2010). Recognizing the importance of med-surg nursing certification, the clinical nurse specialists and a nurse coordinator at a hospital in the Midwest developed and implemented an in-house Medical-Surgical Nurse Certification Review Course.

Problem

Traditionally, emphasis has been placed on specialty certification in areas such as critical care, perioperative services, and oncology. However, the specialty practice of medical-surgical nursing is the foundation of nursing and is generally the largest group of practicing health care professionals, serving in such diverse areas as inpatient care units, home health facilities, and clinics (Academy of Medical-Surgical Nurses [AMSN], 2014). Unfortunately, motivating nurses to obtain their med-surg certification has been challenging for this facility. Nursing barriers to certification include: lack of local certification review courses, travel costs associated with attendance of certification review classes, examination fees, concerns about successfully passing a national certification exam, and lack of understanding of the professional and personal impact of acquiring a national med-surg nursing certification.

Methodology

Clinical nurse specialists and the nurse coordinator met to discuss establishment of a med-surg nurse certification review course for the 13 medical-surgical nursing divisions located within the hospital. Discussions were held to determine which national med-surg certification would best fit the nursing staff of the hospital. The Certified Medical-Surgical Registered Nurse (CMSRN) exam, offered by the Medical-Surgical Nursing Certification Board (MSNCB) and endorsed by AMSN, was selected to be the primary certifying exam. MSNCB is the only national nursing organization whose focus is purely on certification of the medical-surgical nurse. Additionally, the MEdSURG Nursing journal and the MedSurg Matters! newsletter provide current evidence-based information, which focuses on the multidisciplinary knowledge and skills of the med-surg nurse.

The Surgical and Medical Directors of the hospital purchased all the AMSN educational materials in preparation for development of the certification review course. Materials included the AMSN Core Curriculum for Medical-Surgical Nursing and the Medical-Surgical Nursing Review Questions. Clinical nurse specialists and the nurse coordinator served as course instructors based on their areas of knowledge and expertise. The clinical nurse specialist in charge of organizing program development served as course facilitator. Each instructor received the two AMSN books. After reviewing the information in both, the instructors elected to use the Core Curriculum for Medical-Surgical Nursing to develop the Med-Surg Nurse Certification Review Course because of the depth of information provided in the textbook.

The content for the Review Course is based on the CMSRN examination blueprint, which includes physiological systems and domains of nursing practice. Presented twice yearly, the Med-Surg Nurse Certification Review Course is 16 hours long, consisting of 4 sessions, and provides continuing nursing education (CNE) contact hours. Each session occurs at three-week intervals, to allow nurses the time to review the content provided by each instructor and obtain answers to questions they may have from the course instructors. Review Courses are held in the hospital to promote collegiality and to encourage cohorts of nursing colleagues to take the review course together.

Upon registration to take the course, each nurse receives a Medical-Surgical Nurse Certification Review Packet. It includes the following: benefits of certification, overview of the CMSRN certification examination process, course curriculum, study guides, test-taking skills, eligibility, fees, information on hospital reimbursement for the CMSRN examination, recertification expenses, and contact information for the course instructors. Nurses are expected to attend all four sessions. However, if a session is missed, the nurse may contact the course instructors to arrange pick-up or delivery of the study materials. Additionally, the nurse may also arrange a face-to-face meeting with the course instructors to cover any areas of concern. To ensure the examination is taken following the completion of the Review Course, RNs must bring proof of exam enrollment prior to admittance into the second session as listed on the informational flyer.

Information on the Med-Surg Nurse Certification Review Course is presented at the hospital’s Patient Care Leadership Team Meetings, which are held monthly for nursing directors, clinical nurse managers, and lead charge nurses. Informational flyers are also emailed to the above individuals to post on their med-surg nursing divisions. The flyers include information on certification requirements as well as the requirements to sit for the exam, class dates, and exam fees. In addition, the course instructors actively recruit the nursing staff to participate in the Review Course. The hospital’s Chief Nursing Executive advocates for the Med-Surg Nurse Certification Review Course. She actively engages the Patient Care Leadership Team to increase staff nurse participation at each Review Course.

Outcomes

This course has been well received by all the nursing staff of the Med-Surg nursing divisions. A total of five Review
Courses (see Table 1) have been held over the past three years with staff participation from all the Med-Surg nursing divisions including the RN Float Pool. Prior to the conception of the Review Course, there were relatively few nurses with a specialty certification in medical-surgical nursing. The hospital now has 73 new CMSRNs. Additionally, the pass rate for the hospital’s review course is 96.5% (see Figure 1) compared to the national CMSRN pass rate, which has averaged 78% over the same three-year timeframe.

Responses of the nurses after Review Course completion and CMSRN exams are very positive. The nurses are very pleased with the course format, easy access to the instructors, and in-house location of the Review Course. Nursing comments included: excellent review for the exam, instructors made it easy to understand the material, instructors were knowledgeable and enthusiastic about the materials presented, and excellent delivery of material. There is no cost to the nursing staff for the Review Course.

The nurses are excited by the professional recognition received from their national certifying body as well as the hospital after successfully completing their CMSRN certification. Professional recognition includes certification credentials on hospital identification badges, use of credentials for advancement into the hospital’s Professional Nurse Development Program and entry into the annual Certification Nurses Breakfast. Personal benefits include the validation of knowledge, enhanced professional credibility related to advanced certification, and the personal satisfaction of achieving CMSRN designation. Benefits to the hospital include an increase in the number of certified med-surg nurses, which signifies nursing excellence and is a positive attribute for American Nurses Credentialing Center Magnet® designation (American Nurses Credentialing Center, 2012).

**Nursing Implications**

Implementing an in-house Med-Surg Nurse Certification Review Course demonstrates an organizational commitment to nursing excellence through specialty certification of its nurses. Additionally, increasing knowledge, improving skills, and enhancing collaboration with other members of the health team provide a pathway to enhance nurses’ work satisfaction and improve patient outcomes through the empowerment of nurses (Wade, 2010).

**Conclusion**

Specialty nursing certification provides nurses with clinical knowledge and self-esteem; hospitals with committed, expert providers; and patients with improved quality of care (Sy, 2010). Establishing an in-house Medical-Surgical Nurse Certification Review Course not only increases the number of CMSRNs in the hospital setting, but also establishes the importance of specialty certification for medical-surgical nurses. Key elements in implementing a successful in-house Review Course include committed individuals to serve as facilitators and instructors and an environment that supports the attainment of nursing certification as a marker of professional excellence in nursing care.

**References**


**Table 1. Med-Surg Nurse Certification Review Course Statistics**

<table>
<thead>
<tr>
<th>Date</th>
<th>Number Eligible to Test</th>
<th>Number Passed/Certified</th>
<th>Number Who Did Not Pass</th>
<th>Number Who Did Not Test</th>
<th>Overall Pass Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2009</td>
<td>18</td>
<td>15</td>
<td>1</td>
<td>2</td>
<td>93.7%</td>
</tr>
<tr>
<td>February 2010</td>
<td>18</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>88.8%</td>
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<tr>
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<td>0</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>February 2011</td>
<td>11</td>
<td>7</td>
<td>0</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>July 2011</td>
<td>15</td>
<td>14</td>
<td>0</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Totals</td>
<td>84</td>
<td>73</td>
<td>3</td>
<td>5</td>
<td>96.5%</td>
</tr>
</tbody>
</table>

**Figure 1. Med-Surg Certification Examination Pass Rate**
nursing

Suggested Readings

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vention is emphasized. According to Sarassohn-Kahn (2013), ObamaCare has led to more transparency in the health care market system. Senior care is improved and aims to fill in the doughnut hole for Medicare Part D prescription drug coverage. The ACA hopes to bolster the quality of medical services for all Americans. It’s America’s plan. Let’s help our patients understand how to utilize it in order to obtain the maximum benefits to meet their health care needs.

References

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Celebrating Med-Surg Nurses Week
We hope you enjoyed Med-Surg Nurses Week (November 1-7) this year! AMSN welcomes your photos and recaps. Tell us how your unit/facility celebrated the compassion and commitment of medical-surgical nurses, and we’ll share your stories on our website. Visit www.amsn.org to see how other nurses celebrated and to share your own celebrations!
Nutrition TO IMPROVE OUTCOMES

“Feed the Patient” – A Barrier Removed

Feeding the patient is paramount to battling malnutrition in hospitalized patients. Although “feeding the patient” sounds simplistic, many complexities stand in the way of consistently meeting the nutritional needs of the patient. However, one of the hurdles in the path to proper nutrition was recently removed. Registered Dietitian Nutritionists (RDNs)* were granted the ability to prescribe therapeutic diets for nutritionally at-risk and malnourished patients. This prescribing authority provides Registered Nurses (RNs) with an additional pathway to facilitate “feeding the patient.”

The Centers for Medicare and Medicaid Services (CMS) issued a final rule enabling RDNs in the hospital setting the ability to independently order therapeutic diets effective July 11, 2014. Currently, this rule change only applies to hospitals and critical access hospitals, not long-term care facilities or other care settings. The Academy of Nutrition and Dietetics is working diligently with CMS to get nutritional prescriptive authority for RDNs expanded to these additional care settings. The specific CMS Condition of Participation is “Food and Dietetic Services (section 482.28)” (Federal Register, 2014). The new wording says, “all patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or other clinically qualified nutrition professional as authorized by the medical staff and in accordance with State law.” The rule allows qualified RDNs to write therapeutic diet orders. This includes enteral and parenteral nutrition, because CMS considers “all patient diets to be therapeutic in nature, regardless of the modality used to support the nutritional needs of the patient” (Federal Register, 2014). The finalized rule does include the ability of the RDN to order labs if the hospital’s governing body approves this. Because there will still be diagnostic tests or additional labs that are needed that the RDN is not priviledged to order, the RDN still needs to consult with other qualified health care providers in order to obtain such tests.

This new nutritional prescriptive authority of RDNs means that RNs have an enhanced opportunity to partner with other health care providers to provide optimal nutritional health for patients. Collaborating with RDNs on a daily basis and identifying nutritional needs can more readily convert into a therapeutic nutrition plan. Nurses have the opportunity to share weights, percent of meal intake, and overall nutritional status with RDNs in multiple venues. Capitalizing on huddles and care coordination sessions to communicate the patient’s tolerance of nutritional intake with insights into patient nuances creates the necessary team approach. Actively engaging RDNs in the plan of care will have new benefits. With additional health care providers available to prescribe nutrition, patients will be fed an appropriate diet sooner. Nurses will be able to help move patients toward wellness more quickly through this alignment. Increasing the likelihood of patients receiving therapeutic nutrition intervention within a shorter time frame removes an obstacle to “feeding the patient” and decreases malnutrition.

Reference


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Editor’s Note: In the May/June issue of MedSurg Matters!, we published an article, “New Safety Standards to Prevent Patient Tubing Misconnections,” which reported on new enteral connectors that were to be available this fall. The release of these connectors has been pushed back to January 2015. For more information, visit www.stayconnected2014.org.

* The Academy of Nutrition and Dietetics has provided the option for Registered Dietitians (RDs) to use the credential Registered Dietitian Nutritionist (RDN). These two titles are now synonymous and interchangeable.
Acute Appendicitis
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Summary
Ms. F. responded well to treatment and at 72 hours post-op, the IV of NSS was decreased to 10 ml/hr and maintained for antibiotic therapy. All other medication orders remained the same. The patient was tolerating a normal diet and drinking fluids. Lab results were within normal limits. Vital signs were stable and the patient’s pain level continued to decrease as expected. In addition, Ms. F. had a soft, brown bowel movement. She was reviewed and approved for discharge by the operating surgeon. Ms. F. was given individualized instructions to prepare for discharge and instructed to contact the surgeon for a post-op appointment in 7-14 days. She was to continue use of Vicodin, but instructed to try Tylenol™ (650 mg every six hours) as an alternative to the narcotic. Constipation and some nausea could continue, but the decrease in narcotics and continued ambulation and fluid intake would counteract this symptom. The incision was closed with dissolvable sutures and covered with steri-strips. The incision could form a hard knot beneath the skin and some bruising would occur, but this should subside. In the event that she noticed any areas of increasing warmth or redness, fevers, or chills, Ms. F. should call her surgeon immediately. It was recommended that she shower and not soak in a bathtub or hot tub until she is cleared in her follow-up appointment. With the approval of her surgeon, driving may only be resumed when off all narcotic pain medication and when she is able to turn and twist her body without hesitation (Black & Hawks, 2009; Lewis et al., 2011; NDDIC, 2012; Vallerand et al., 2011). Ms. F. was discharged to home with her mother, who picked her up.

References

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Is Your Unit Up to Date With Quality Issues?

The World Health Organization (WHO) purports that the starting point for quality improvement is a clear definition of quality. WHO uses the following terms to define quality: effective, efficient, accessible, acceptable/patient-centered, equitable, and safe (WHO, 2006). The Academy of Medical-Surgical Nurses (AMSN) recognizes the significance of quality outcomes. Involvement in quality organizations provides AMSN with a voice in the development of quality measures and process development.

What is the National Quality Forum (NQF)?

As a national non-profit organization, NQF focuses on finding ways to improve the quality of health care in the United States. Membership includes health care stakeholders physicians, nurses, hospitals, certifying organizations, patient representatives, and other quality improvement organizations.

The published mission of NQF (2014) is to improve health care in the United States by:
- Building consensus on national priorities and goals for performance improvement and working in partnership to achieve these goals.
- Endorsing national consensus standards for measuring and publicly reporting performance.
- Promoting the attainment of national goals through education and outreach programs.
- Developing and endorsing consensus frameworks for measuring and publicly reporting performance.
- Promoting the attainment of national goals through education and outreach programs.

What is the Nursing Alliance for Quality Care (NAQC)?

The NAQC (2014) is a national partnership of nursing organizations, health care consumers and other health care stakeholders with a stated mission to advance the highest quality safety and value of health care. The NAQC is managed by the American Nurses Association (ANA) and focuses on the advancement of high-quality, patient-centered health care.

In March 2013, the NAQC released Fostering Successful Patient and Family Engagement: Nursing’s Critical Role, which outlined the NAQC strategic plan for transforming patient engagement. These