Mrs. G., age 60, had been complaining of severe peri-umbilical abdominal pain for 4 hours. As the pain continued to worsen and nausea, vomiting, and diarrhea developed, Mrs. G. went to the local emergency department (ED). According to Mrs. G., her past medical history included hypertension, Crohn’s disease (for the past 12 years), and gastroesophageal reflux disease (GERD). Current medications included Diovan® 320 mg daily, hydrochlorothiazide (HCTZ) 12.5 mg daily, atenolol 25 mg daily, Prilosec® 20 mg daily, and Humira® pen 40 mg every other week for her Crohn’s disease. She also had a past surgical history of an oophorectomy to remove her right ovary several years previously due to a large cyst formation, and a cholecystectomy in 1999.

Mrs. G. informed the ED nurse that the onset of pain had increased and became more severe over the past few hours. Additionally, Mrs. G. described nausea, vomiting, and diarrhea that began about 2 hours prior to arrival to the ED. The vomiting was described as bilious in nature. Diarrhea continued on page 11
Imagine this scenario: seven months ago, a unit in a prominent metropolitan hospital embarked on two major changes. The unit welcomed a new management model, along with new managers and a change in model of care for their patient population. The leadership team planned, organized, and prepared for working with the staff to facilitate a seamless transition utilizing Lewin’s theory for planned change (Shirey, 2013). Many committees were formed, the strong opinions of the team were gathered, and a well-organized plan for a change of this magnitude began. The problem was, not all of the leadership team believed in the new structure. One of the supervisors, who had doubts, continued on in her role from the previous leadership structure. The doubts did not result from a lack of evidence supporting the model of care, but in this leader’s fear of change and lack of knowledge of the fundamentals of the new care model. The leader’s fear was that the new model would no longer enable her to provide the same high-level care normally afforded in her professional practice.

Change in the health care environment is inevitable. Creating an environment that embraces change will ultimately result in greater staff and patient satisfaction. Hader (2013) suggests that seasoned nurses are resistant to change and goes on to state, “to facilitate and affect positive change, you must set the example of a change agent” (p. 6). The concept of continuing professional development, also known as lifelong learning (LL), is a requirement of the nursing profession, mandating 20 continuing education units (CEU) every renewal period for a registered nurse (RN) (Gopee, 2001). The American Nurses Association published their definition of professional development as “the lifelong process of active participation in learning activities to enhance professional practice” (Brunt, 2001). Hospitals seeking Magnet designation (or those already a recognized facility) are also aware of the requirement that “clinical nurses will gain new knowledge by evaluating and incorporating evidence-based findings into their practice” (Hitchings & Jones, 2015, p. 46). For veteran nurses resistant to change and new nurses coming into practice, creating an environment that embraces change and constant evolution in practice by continued lifelong learning will foster more positive outcomes as change occurs. In order to manage change now and in the future, as nurses we should model the behavior of LL in order to keep up with the rapid pace at which health care is evolving.

The definition of LL includes formal, non-formal, and informal educational opportunities (Gopee, 2001). The intent is to expand one’s knowledge on the selected topic and then apply that information to their practice. LL is “deliberate learning…for individuals and teams which meets the needs of patients and delivers the health care outcomes...enable professionals to expand and fulfill their potential” (Gopee, 2001, p. 608). A nurse who broadens his or her scope of practice and body of knowledge is one who develops wholly, both personally and professionally, ultimately strengthening his or her nursing practice (Davis, Taylor, & Reyes, 2014). It is a way for nurses to critically evaluate their practice and pinpoint how it can be improved (McCormack et al., 2009). LL does not end with development of clinical assessments or understanding of a disease process, but includes technological advances as well (Gopee, 2005). It is therefore necessary for health care organizations to instill a strong environment of sustained learning patterns while continuing to maneuver oncoming changes.

Modeling the Practice of Lifelong Learning in the Changing Health Care Environment

Cyndi B. Kelley
Stephanie Huckaby
As leaders, how do we incorporate the demand of assisting in growing our nurse’s professional practice during constant change? The answer is modeling desired behaviors. This means setting a precedence that includes not only the mandatory educational needs to fulfill licensure requirements, but also creating a culture of growth and constant change. Empowering staff to evaluate and incorporate findings into practices, processes, policies, and protocols regularly proves profitable in job satisfaction and allows a more graceful transition through major changes as they arise. McCormack and colleagues (2009) highlighted the importance of allowing staff to seize control of their practice, making active learning on the job a part of daily practice, and allowing staff to develop a new set of skills, knowledge, and methods of working lead to greater and more sustained change. LL and change are the responsibility of all healthcare teams, including administration, leadership, and the bedside staff. Modeling the behavior of embracing LL and being well prepared before change presents itself will provide a deeper satisfaction in job performance, improve the quality of care, and create greater overall outcomes.

References

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The Association Between Proton Pump Inhibitors and Clostridium Difficile Infection: Reducing Risk

Jane A. Frary
Rebecca P. Winsett

Clostridium difficile infection is associated with prolonged antibiotic use. Proton pump inhibitors used for stress ulcer prophylaxis alter the gastric pH and may also be a contributor to this condition. Knowledge of indications for prophylaxis may help prevent this infection.

Background

Gut flora and gastric pH play a role in maintaining the integrity of the gastrointestinal (GI) tract. Disturbances to the normal flora of the intestinal tract from disease or medications can lead to life-threatening diarrheal disease. Clostridium difficile (C. diff), under normal circumstances, does not cause harm, but when there is an alteration of the gastrointestinal environment, an overgrowth of the bacterium can occur, causing a serious condition known as Clostridium difficile infection (CDI). Maintaining normal gut flora and the normal acidic pH of the gastrointestinal tract are key in preventing the proliferation of C. diff and ultimate catastrophic infection. Ingested pathogens are eliminated or held in check from proliferation due to the high acidity (pH <4) of the digestive tract (Janarthanan, Ditah, Adler, & Ehrinpreis, 2012). With suppressed gastric acidity, or a pH above 4, C. diff can germinate and release toxins, leading to CDI (Rashid et al., 2012). In the United States, the rates of CDI have doubled from 2001-2005 (Lucero, Lake, & Aiken, 2010) and with an estimated 400,000 cases annually, accounts for 15-39% of antibiotic-associated diarrheas in the hospital setting (Viswanathan, Mallozzi, & Vedantam, 2010). The costs associated with this devastating infection are $3 billion/year (Viswanathan et al., 2010). One percent of the hospitalizations in 2009 that involved a primary diagnosis of CDI had an average cost of $24,000; this cost tripled when CDI was a secondary diagnosis or a doubled hospital length of stay (Lucado, Gould, & Elixhauser, 2012; U.S. Food and Drug Administration [FDA], 2012).

Symptoms of Clostridium Difficile Infection

Symptoms associated with CDI include mild to moderate diarrhea, fever, increased fecal leukocytes, abdominal cramping, and dehydration (Vaishnavi, 2009). Pseudomembranous colitis, colonic perforation, and toxic megacolon are some of the potential complications. These complications can present with severe abdominal pain, massive abdominal bloating, and fever, often leading to septic shock (Viswanathan et al., 2010).

Clostridium difficile is an anaerobic, spore-forming, Gram-positive bacillus and in the Western Hemisphere, one of the most common health care-acquired infections (Viswanathan et al., 2010). C. diff is a normal environmental organism that becomes an opportunistic pathogen when circumstances permit. There are now reports of community-acquired infection that are most likely due to medications that alter the gut pH or flora. The etiologic agent of CDI is the bacterial spore. Spores are formed as a result of the bacteria exposed to stress, where it creates a protective coating in order to survive. C. diff can lay dormant under highly acidic environments such as the human gut (Viswanathan et al., 2010). Hospitalized patients are inadvertently exposed to the bacteria as many antibacterial agents do not kill the spores. When conditions are ripe for the spore proliferation, such as long hospital stays or use of broad spectrum antibiotics, the GI flora is disturbed and the spores germinate and produce toxins that lead to CDI symptoms (Viswanathan et al., 2010). The toxins have potent enterotoxic and cytotoxic properties that are...
responsible for the diarrhea and colitis seen with CDI. Fluid secretion, inflammation, and mucosal damage leading to unrelenting diarrhea are caused by the destruction of epithelial cells in the colonic mucosa.

Susceptibility to CDI increases with prolonged use of antibiotics, immunosuppression for whatever reason (e.g., cancer, cancer therapy, organ transplantation, age), underlying gastrointestinal disorder, or a prolonged or previous hospitalization (Viswanathan et al., 2010). New factors are emerging that suggest that proton pump inhibitors may also be associated with CDI (Deshpande et al., 2012; Janarthanan et al., 2012; Kwok et al., 2012).

Proton Pump Inhibitors and Risk of CDI

Proton pump inhibitors (PPIs) are the most widely used agents for suppression of gastric acid in patients with erosive gastroesophageal reflux disease and erosive esophagitis. Approximately 80% of PPIs worldwide are now purchased over-the-counter (Heidelberg, Goldberg, & Inadomi, 2009). PPIs are the most commonly used medications for stress ulcer prophylaxis in the hospital, despite little evidence to support their use outside the intensive care setting (Heidelberg, Metz, & Yang, 2012).

Guidelines for stress ulcer prophylaxis by The American Society of Health-System Pharmacists (ASHP, 1999) do not recommend prophylaxis in patients at low risk for bleeding, such as the adult general medical and surgical patients with fewer than two risk factors. However, according to Heidelberg and co-authors (2012), in the non-ICU areas, 22-54% of patients were placed on proton pump inhibitors for ulcer prophylaxis and over one-half of these patients were discharged home on PPIs started in the hospital. In February 2012, the FDA issued a safety statement that cautioned the use of proton pump inhibitors as there is now evidence that there is an increased risk of C. diff-associated diarrhea with the use of these agents (Bavishi & Dupont, 2011; Deshpande et al., 2012; Janarthanan et al., 2012). PPI therapy was also shown to nearly double the likelihood of CDI in a recent meta-analysis that pooled 39 studies and 313,000 patients (Kwok et al., 2012).

Summary

CDI is a significant community- and hospital-acquired problem that is becoming more prevalent. Appropriate use of antibiotics and PPIs are important factors in preventing the disease. Currently, CDI is a legislatively mandated reportable disease in only six states. The Department of Health and Human Services Agency for Healthcare Research and Quality included C. diff in their 5-year target to reduce health care-associated infections by 30% (FDA, 2012).

With the mounting evidence associating PPIs with CDI, it is important to alter practice as well as inform the public on the relationship. As PPIs are available as an over-the-counter medication, community-acquired infections are on the increase. With the heavy burden of costs related to CDI, and the cost of the PPIs on the health care industry, the potential to decrease the use of PPIs will be beneficial in controlling this disease and associated health care costs.

Nursing Implications

As patient advocates, nurses can help reduce the severity of the disease, protect other patients from acquiring CDI, and play an integral role in preventing CDI. To reduce CDI severity, astute assessment of changes in bowel consistency may help ward off severe disease. Communicating early symptoms of watery diarrhea (particularly foul smelling), fever, and abdominal pain can lead to early treatment. A stool culture will provide definitive diagnosis, so early culture to early treatment is very important.

To protect the spread of the disease, use “contact precautions” for symptomatic patients and include all family members in these safety precautions. Contact precautions include: placing the patient in a single room or, after a definitive diagnosis, sharing a room with someone else who has CDI, and wearing gloves and a gown during care or contact. C. diff spores can survive on many surfaces for up to two years and many antibacterial agents used in the hospital do not kill the spores. Chlorine bleach is the only agent known to kill C. diff spores. Hand washing, preferably with soap, before and after entering a patient’s room is imperative to prevent the spread of C. diff spores. Alcohol-based hand rubs are often more accessible and distributed widely throughout the hospital, making this an acceptable alternative.

PPIs are used in the intensive care units (ICU) for stress ulcer prophylaxis. Patients on mechanical ventilation, coagulopathies, traumatic brain injury, burns, high-dose steroids, or other traumatic disease states place a patient at risk for gastrointestinal ulcerative bleeding, thus a need to reduce acid production to protect the GI tract during the stressful period. Current guidelines recommend discontinuing stress ulcer prophylaxis once the patient has less than two risk factors or is discharged from the intensive care unit (ASHP, 1999).

Reviewing the medication profile after ICU discharge is one way nurses can prevent CDI. The review reconciles what the patient has been taking with the current order; but in addition, the nurse can ask the tough question: Should my patient be on a PPI? What risks factors are present? When admitting a new patient from home, medication reconciliation can be used in the same manner to protect a patient from CDI. Many patients may be taking a PPI at home and, because several brands can be purchased over the counter, may not consider it a prescribed medication. Weighing the risks for GI bleeding and determining the continuation or discontinuation of a PPI may help reduce the patient’s risk for CDI.

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Joining Forces

PTSD: Stellate Ganglion Blocker as Potential New Treatment

In 1980, symptoms ascribed to post-traumatic stress disorder (PTSD) were first included in the American Psychological Association’s Diagnostic and Statistical Manual of Mental Disorders. PTSD is a psychobiological mental disorder associated with changes in brain function and structure, as a result of a person witnessing or participating in events outside the spectrum of normal human experience. Common symptoms of PTSD include intrusive memories, bad dreams, feeling on edge, and angry outbursts (U.S. Department of Veterans Affairs, 2014). Often there is an anxiety component to PTSD (Alino, Kosatka, McLean, & Hirsch, 2013) and a comorbid alcohol issue occurring in up to 50% of veterans who have PTSD (Lipov et al., 2013).

PTSD can occur in both civilian and military populations. Civilian PTSD, occurring as a result of trauma, violence, and natural disasters, affects approximately 7% of American civilians (Navaie et al., 2014). Military-induced PTSD occurs in about 20% of active duty troops, but increases to 35-40% of veterans, causing further mental disability over time (Navaie et al., 2014). Traumatic memory is encoded and consolidated in a similar fashion as non-traumatic memories, thereby activating symptoms of PTSD in response to memory recall and cue-sensitivity (Lipov, Kelzenberg, Rothfeld, & Abdi, 2012).

There is no consensus or gold-standard to treat PTSD (Lipov et al., 2013). According to Kime (2014), current treatments include selective serotonin reuptake inhibitors (SSRIs) and cognitive behavior therapy. According to Alino and colleagues (2013), SSRIs have a 30-60% discontinuation rate and efficacy is measured at about 60%. Veterans and civilians alike need a treatment that can provide relief from the debilitating and life-shortening sequelae of PTSD, including cardiovascular disease, dementia, substance abuse, and lack of employment (Navaie et al., 2014).

An old procedure with a new twist is now being reconsidered in some small studies as a possible treatment approach for PTSD. This treatment is called Stellate Ganglion Block (SGB). Originally described in the 1930s, this procedure was used to treat peripheral nerve injury and reflex sympathetic dystrophy (RSD) of the upper limbs (Gutierrez, 2015). The stellate ganglion is located in the front of the neck between the seventh cervical vertebra and the first thoracic vertebra (C7-T1) (Gutierrez, 2015). The stellate ganglion is a...
flat structure, approximately 1 cm in length that lies adjacent to the vertebral artery near the phrenic nerve (Craven, 2011). Typical indications for SGB include RSD, herpes zoster, post-radiation neuritis, and cancer pain (Gutierrez, 2015). SGB has also been used to treat schizophrenic hallucinations (Navaie et al., 2014).

To receive a SGB, the patient is placed in cervical extension position on a procedure table where local lidocaine is provided to numb the skin on the anterior neck (Lipov et al., 2013). Next, a beveled needle is placed at C6, either under fluoroscopy (Lipov et al., 2013) or ultrasound-guidance (Gutierrez, 2015). A small test dose of bupivacaine is injected, followed by approximately 5 cc of bupivacaine to administer the entire block (Lipov et al., 2013). Gutierrez (2015) suggests that the ultrasound-guided method is preferable, as this allows the practitioner to visualize vascular and visceral structures to minimize a puncture injury when placing the needle. The practitioner is able to determine adequate blocking by noting the presence of Horner Syndrome, which intentionally causes temporary damage to the sympathetic trunk (Lipov et al., 2013). Characteristics of Horner’s Syndrome or sympathetic blockage include ptosis, miosis, anhidrosis, and a slight increase in body temperature (Lipov et al., 2013) and nasal congestion (Gutierrez, 2015). The complication rate of SGB is 1.7 per 1,000 procedures, indicating high safety with low complications (Kime, 2014).

The pathophysiology behind SGB is that blocking the stellate ganglion tamps down the hyperarousal characteristics of PTSD (Kime, 2014). Emotional memory is activated by stress hormones in the amygdala, which are activated by the neurotransmitter norepinephrine (Lipov et al., 2012). SGB blocks the production of norepinephrine and the phenomenon of sympathetic sprouting, which enables the person with PTSD to maintain their recurrent hypervigilant manifestations. Essentially, SGB works as a temporary weed killer in the stellate ganglion, reducing norepinephrine and the perpetuation of the sympathetic ganglia. Navaie and colleagues (2014) suggest that SGB affects regional blood flow and improves the sleep-wake cycle, which can also produce positive effects in those suffering from PTSD.

Those who undergo SGB are evaluated using a number of statistically valid and reliable PTSD tools, including the Post-Traumatic Stress Disorder Checklist (PCL) (Alino et al., 2013). Approximately 75% of PTSD cases have shown improvement using the PCL a short time after the procedure (Navaie et al., 2014). Small studies with soldiers who have PTSD have been conducted at Walter Reed Army Medical Center and Tripler Army Medical Center with promising results; however, the studies suggest that long-term neuronal changes are unlikely (Alino et al., 2013). In some cases, patients were able to titrate off their SSRIs after receiving SGB therapy (Alino et al., 2013). Large, double-blind, placebo-controlled studies are needed to further quantify the efficacy of SGB therapy, though initial pilot results are encouraging.

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How Do You Eat an Elephant?

It was five years ago when AMSN leadership asked the MedSurg Matters Editorial Committee to add a series of articles on creating and sustaining healthy practice environments. I was extremely honored when the editorial team recently invited me to take over as the Healthy Practice Environments Column Editor. The first assignment I gave myself was to read all of the articles from the previous five years. What moved me the most was the commitment that this professional organization has to the success of the medical-surgical nurse. Not only are there tools to support your units and your organization, but also tools to help you as a bedside nurse. As a medical-surgical nurse, you are invaluable to vulnerable patients who require your skilled and compassionate care to safely make it through a very complex health care system.

The second thing that struck me while reading the healthy practice environments articles from the last five years was the immense amount of work that still needs to be done. No one person could accomplish a goal that vast, especially with all of the continually changing demands in health care today. So how do you eat an elephant? One bite at a time.

I am sure you are familiar with the acronym TEAM: together everyone achieves more. At no other time in history is that more important than in health care today. Each nurse brings value to an organization and an engaged staff is vital to an organization’s success. At one point, my organization decided to rename their clinical ladder ASPIRE – Achieving Synergy in Practice through Impact, Relationships, and Evidence. Instead of an hourly compensation, a sizable bonus was provided to staff or even supervisors that produced quality projects with measurable outcomes.

One nurse, Judy Joiner, BSN, RNC, MNN, observed the emotional stress and job dissatisfaction when the census on her unit was staying down, causing frequent floating of the registered nurses. She decided to complete an ASPIRE project to help. The biggest issues with floating prior to the intervention were the staff feeling invisible, not being acknowledged, and unfamiliarity with the work environment. In fact, 43% of nurses surveyed experienced significant or extreme stress when floating. The intervention, standardized expectations when a nurse was floated to another unit, included: to be welcomed, given a unit-specific template including a map with unit layout, unit routines, entry codes for locked areas, essential unit phone numbers (charge RN, pharmacy, etc.), and the name and phone number of an assigned buddy. After the intervention, staff that experienced significant or extreme stress when floating decreased from 43% to 23%. In addition, the staff felt welcomed and appreciated and experienced more job satisfaction. The pilot started on three units and was eventually rolled out to the entire 1,000 bed medical center (J. Joiner, personal communication, October 21, 2008).

Of course, that did not handle all of the nurses’ stress, but it did make one aspect of their job easier. By empowering your staff with both the knowledge of the quality improvement process and by providing rewards for their work, you can make eating of this elephant (the healthy practice environment) a more manageable task.

Successful organizations have the ability to develop and sustain high levels of staff engagement. So how do you foster nurse engagement? “Creating a culture of engagement invites staff members to participate in their work in ways that are meaningful to them” (Harmon, Sey, Hiner, Faron, McAdam, 2010, p. 47). In the example of Judy above, there is no way she could accomplish the goal of changing the floating process in a 1,000 bed hospital without help. She had to create a team. It is easier to recruit people who would also find the goal of decreasing the stress of nurses that float valuable. Unit-based or service line councils can also be an excellent source of team members for a project.

When looking at ways to improve engagement, consider the findings of 10 focus groups at Cleveland Clinic (Small & Small, 2011, p. 6):

• “Trust and listen to me,”

• “Understand the complexity of my work,”

• “Define roles and expectations,”

• “Simplify my work process,”

• “Keep me informed and engaged,” and

• “Do your job and let me do mine.”

If you just sat down with those six heartfelt requests of health care professionals and really looked at how you could truly honor those wishes, you would be moving toward processes that work and an engaged staff. I challenge you to take a few minutes and reflect on ways in which you were able to positively support each statement with your team members and ways in which you may not have been able to support each statement. A healthy practice environment starts with each one of us – one bite at a time.

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QSEN: Quality and Safety Education for Nurses

About a decade ago a small group of nursing academics, with funding from the Robert Wood Johnson Foundation, developed six quality and safety competencies that were to be integrated into nursing education programs. The goal of the effort has been to graduate clinically prepared nurses to provide safe care. These graduate nurses would start their careers with the knowledge, skills, and attitudes (KSAs) to be agents for quality and safety improvement in the rapidly changing health care system and organizations where these graduates work.

Experts in the education of nurses are supportive of the effort to profoundly alter curriculum throughout academia to provide consistent goals, a mutual language and cohesive core competencies. Patricia Benner, nursing theorist and academic, describes quality and safety education for nurses (QSEN) competencies in the 2010 fledgling stage, as a means to “demonstrate an integrative view of clinical performance rather than emphasize narrowly prescribed lists of elemental competencies” (Benner, Sutphen, Leonard, & Day, 2010, p. 83). The transition from didactic as foundational to learning in the clinical setting – which is the contextual environment for the development of clinical reasoning – is designed to enhance graduate nurse knowledge and capabilities and therefore improves patient outcomes.

The QSEN initiative is being partnered by nursing organizations and patient safety groups. To achieve the goals of the Robert Wood Johnson Foundation, grants of suffusing quality and safety regional training programs for nursing educators have arisen. Education modules and teaching resources for academics (pre-licensure and graduate programs) have been designed and are available via the QSEN Institute. Nationwide, academics are being trained to share their knowledge of QSEN with their colleagues, integrate QSEN to nursing curriculum, and imbue nursing students with safety and quality tenets.

Integration of clinical skills with the intellectual capacity to safely manage the complexity of nursing work is key to quality care in a time of diminishing resources. The message from nursing has, at times, been fractured and lacking in follow-through. As nursing continues through the development and implementation phases of QSEN, the feedback/response from experts in the field will exemplar the collaborative focus of the effort. QSEN competencies can help nurses integrate technology and practice while closing the gap in quality improvement and safety.

In upcoming issues, this column will explore the QSEN core competencies, which are designed to bring a revolutionary transformation to nursing care. We will discuss the use of QSEN Learning Modules in current nursing education. Most importantly, we will, as practicing nurses, explore the impact that QSEN will have on our day-to-day practice. As the health care practitioners who have largely been left out of the determination of quality decisions that directly impact the care we provide our patients (Ressler & Glazer, 2010), QSEN may be the far-reaching push that will place nurses at the forefront of quality and safety measurement decisions.

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Maximize Time: Maximize Outcomes

Precepting students can be time-consuming and overwhelming. After all, no one else is going to pass all those medications, ambulate and bathe patients, respond to new physician orders, console families, and answer call lights just because you are precepting a student nurse. However, evidence-based practice repeatedly states that expert clinicians precepting students positively impacts their role obtainment (McCarthy & Murphy, 2008). Therefore, there must be a way to be effective and efficient.

Preceptors have a great responsibility to serve as role models and facilitate clinical integration of theoretical knowledge (Carlson, Wann-Hansson, & Pilhammar, 2009). The classic “sink or swim” method is not a preferred choice to promote student success. Instead, try implementing these few steps in your precepting experience to be more effective and efficient.

Know Your Student

Get to know your student before the experience begins. Nurse preceptors are expert clinicians and are familiar with the flow of their unit, daily expectations, time frames, and methods used to stay on track. Before your first day of precepting, meet with your student. This can be accomplished in 15-20 minutes. Meeting with your student prior to the first experience enables you to predetermine some of your student’s abilities.

1. Introduce yourself and your experience through informal talking.
2. Find out the skill, comfort level, and experience of the student.
3. Give the student a tour of your unit, recognizing unit-specific policies/procedures.

Set Goals

Setting goals with the student at the beginning of a precepting experience will decrease frustration of the student and preceptor (Biagioli & Chappelle, 2010). Setting goals can be relatively easy and helps create accountability of the student. First, be sure you understand the goals and expectations of the precepting program. Review these expectations before encountering the student. Second, have the student create a list of goals and tasks he or she would like to accomplish during the precepting experience. The student can bring these on the first day. Third, review and revise the goals with the student to ensure they are appropriate for your unit and are within the nurses’ scope of practice. Lastly, to maintain a consistent flow of communication between the student and preceptor, provide reliable, non-biased feedback frequently (Rittman & Osburn, 1995).

Adapt to the Student’s Needs

Adapting to the student’s educational needs will facilitate success (Biagioli & Chappelle, 2010). Although students in a precepting course have the same learner outcomes, they achieve the outcomes through a variety of learning styles. Preceptors can use observation or an “invisible presence” to assess the student’s ability. This not only provides a safety net, but also enables the preceptor to better comprehend the student’s strengths and weaknesses.

Adapting to the student is more than just observation. The preceptor must use multiple methods to accomplish the goals set forth. Helpful teaching strategies may include:

1. Reflective questioning – Preceptor utilizes open discussion to promote critical thinking of the student.
2. Situational feedback – Preceptor gives feedback while the student is performing a skill or task he or she has been trained to do. Often a simple sign to affirm the student is performing correctly can boost confidence.
3. Factual questioning – Preceptor questions the student for basic recall of previous nursing knowledge.
4. Demonstration – Student and preceptor perform a task together. This may be an interactive/collaborative learning process.
5. Observation – Student watches and listens to the preceptor as a role model. Used for a task never performed before (Carlson et al., 2009).
6. Self-direction – Students are encouraged to utilize clinical tools available to answer their own questions. Students will present the answers to the preceptor prior to acting on them. This may be used for patient teaching, review of diagnostic results, and is especially useful during down time (Biagioli & Chappelle, 2010).

Evaluate

Evaluation of the student is important to ensure progress and continued growth. Immediate feedback should take place at the end of each meeting between the preceptor and student, but can be more often. Encourage the student to reflect on his or her day (Carlson et al., 2009). Review the student’s reflection and provide feedback. Positive feedback and constructive criticism are necessary. Constructive criticism should not be thought of as punishment, rather your goal is to make the best new nurse possible. Patient safety should remain a top priority throughout the precepting process. Allow the student to reflect on the experience first. Use open-ended questions such as, “How do you feel the medication pass went?” Often students are able to pinpoint areas where they need more growth. Once establishing correct actions for the student, reinforce and praise the student when he or she completes the task correctly next time. If you are ever uncomfortable in providing negative feedback to the student, utilize your program faculty facilitator. A fac-
was described as liquid brown with some bright red blood noted. Mrs. G. admitted to being at a barbeque the evening prior and having consumed two pieces of corn on the cob. She had consumed no additional food since the party. Upon exam, Mrs. G. complained of a pain level of 10 out of 10 on the numeric pain scale throughout her peri-umbilical region with tenderness and guarding noted upon palpation. Hyperactive bowel sounds were noted in all four quadrants. Mrs. G. was febrile with a temperature of 100.4 degrees Fahrenheit tympanically, had a pulse of 124 and regular, respirations 28 per minute, blood pressure of 170/90, and a SaO₂ of 98%. Lungs sounds were clear to auscultation with a poor inspiratory effort noted. Peripheral venous access and labs were obtained.

Clinical Decisions

Based on the patient’s presentation and history, an acute exacerbation of the patient’s Crohn’s disease was suspected. Crohn’s disease is an autoimmune disease that causes chronic inflammation of the gastrointestinal (GI) tract (Crohn’s & Colitis Foundation of America, 2014). Therefore, a stat computerized axial tomography (CT) of the abdomen was ordered, which showed inflammation in the peri-rectal region and right side of the colon, consistent with Crohn’s disease. Following a discussion with the ED attending physician, lab work was obtained and revealed a white blood cell (WBC) count of 14,000 k/ul with 7% bands and a potassium level of 2.8 mmol/L, consistent with an exacerbation of Crohn’s disease and dehydration. Based on the findings, normal saline solution (NSS) with 20 mEq KCL/L was started at 125ml/hr, 40 mEq KCL in 250 ml NSS was ordered to be infused over 4 hours, Dilaudid® 1 mg intravenous (IV) as needed every 2 hours for pain was ordered, the patient was kept nothing per oral (NPO) except for ice chips, with an order to advance as tolerated. A stat GI consult was obtained, and the patient was admitted to the general medical-surgical unit. All diagnostics were consistent with current standards of care (Lewis, Dirksen, Heitkemper, & Bucher, 2014; National Digestive Diseases Information Clearinghouse [NDDIC], 2014; Vallerand, Sanoski, & Deglin, 2012; Van Leeuwen, Poelhuis-Leth, & Bladh, 2013).

Immediate Interventions

Upon arrival to the medical-surgical unit, a complete admissions assessment was completed by the RN. Mrs. G. was still febrile with a temperature of 100.1 degrees Fahrenheit tympanically, with a pulse of 98 and regular, respirations 24 per minute, blood pressure of 150/70, and a SaO₂ of 98%. Lungs sounds were clear to auscultation with a poor inspiratory effort noted. Hyperactive bowel sounds were
Ongoing Interventions

Mrs. G. was not able to tolerate anything other than ice chips for the first 24 hours; she did tolerate Boost®, a high calorie supplement drink, for all meals beginning on day two. Bloodwork was drawn in the late morning of day two, which indicated that Mrs. G. had an increase in her potassium 3.2 mmol/L. The NSS with 20 meq KCl was decreased to 75 ml per hour and oral potassium (k-dur) at 20 meq three times daily for one day was ordered.

Mrs. G. reported her pain level at this time was a 5 on a numeric scale from 1-10. The Dilaudid order was changed to every 4 hours as needed. The patient had three small bowel movements with a more solid appearance. By the end of day two, Mrs. G. was tolerating the high calorie supplement, and beginning on day three, she tried a soft diet starting with breakfast. On day three, Mrs. G. showed improvement and was considered stable with a temperature of 99 degrees Fahrenheit tympanically, pulse of 88 and regular, respirations 20 per minute, blood pressure of 130/46, and a SaO2 of 98%. Lungs sounds were clear to auscultation, abdominal pain was reported as a 2 on the 1-10 numeric pain scale, and bowel sounds normalactive in all four quadrants. She remained in the hospital for another 24 hours for observation and additional consults prior to being evaluated for discharge.

Summary

On the fourth and final day of hospitalization, a consult with a registered dietician was ordered. Due to the cause of her exacerbation, Mrs. G. needed more education regarding nutrition and the impact of her diet on Crohn’s disease. The dietician reinforced information regarding the need to eat the right types and amounts of fiber. Although fruits and vegetables are necessary for people with Crohn’s disease, there are certain foods that can cause a worsening of symptoms. For example, eating soft, bland foods, such as toast, and eating smaller meals throughout the day can increase patient comfort during an acute exacerbation of the disease (Lewis et al., 2014; NDDIC, 2014). Additional patient information included teaching the patient to avoid nonsteroidal anti-inflammatory drugs (NSAIDs) as they can irritate the stomach and small intestines, worsening Crohn’s symptoms.

Acetaminophen and stress management techniques can be good alternative therapies to reduce pain and stress in the patient with Crohn’s disease. Also, the use of over-the-counter (OTC) products can be tried for diarrhea when necessary. Maintaining adequate hydration must also be taught to the patient due to the risk of dehydration. The patient should also be instructed to check with their primary care provider (PCP) prior to implementing any OTC regimens (Lewis et al., 2014; NDDIC, 2014).

Finally, Mrs. G. was reviewed for discharge by the GI specialist. Morning CBC and CMP labs returned with normal values. Mrs. G. was given individualized instructions to prepare for discharge and was instructed to contact the specialist for a follow-up appointment within 5 days from the date of her release from the hospital. Mrs. G. was discharged from the hospital on a dose of oral prednisone 20 mg twice daily for 10 days and ordered to continue her current medications of Divan 320 mg daily, HCTZ 12.5 mg daily, atenolol 25 mg daily, Prilosec 20 mg daily, and Humira pen 40 mg every other week. Finally, Mrs. G. was instructed to maintain a soft, bland diet and low level of exertion until she was cleared by the specialist. Although there is not a known definitive cure for Crohn’s disease, medical-surgical nurses can play an important role in patient education to prevent exacerbation of symptoms and thus avoiding costly hospital admissions.

References


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Nurses like you save lives every day and use high level skills to educate patients and families.

“Clinical nurses are frontline providers who administer and coordinate direct care. Our roles have gotten broader and more urgent, so that means leadership skills are needed now more than ever,” said Jill Arzouman, DNP, RN, ACNS, BC, CMSRN, president of the Academy of Medical-Surgical Nurses (AMSN).

Recognizing this need, AMSN partnered with HealthStream, an industry leader that supplies workforce, patient experience, and provider solutions for the health care industry. Together, they launched the new Clinical Leadership Development Program (CLDP), a 10-module online course that empowers clinical nurses to enhance their leadership competencies in delivering evidence-based quality care and maintaining a healthy practice environment.

“This is the first leadership program designed for clinical nurses at the bedside. It is not designed for nurse managers, assistant managers, or supervisors,” Arzouman explained. “It provides the tools and knowledge clinical nurses need to hone their skills as a nurse leader, work with an interprofessional team, and be a force of change and inspiration at their facility.”

The program also identifies the dimensions of clinical leadership, and maps out the competencies – such as emotional intelligence and communication skills – needed to be an effective nurse leader at the bedside.

The impact of the program will be to:

• Inspire leadership development
• Facilitate changes that improve delivery of patient care services
• Improve outcomes (improve work processes, reduce variations in practice and enhance patient and organizational outcomes)
• Influence healthy practice environments

“Along with patients and facilities, nurses themselves will benefit from the program by reaping both personal and professional rewards,” Arzouman said. “They’ll have increased pride and satisfaction in their accomplishments and opportunities for career advancement.”

Nurses may earn 14+ total Continuing Nursing Education (CNE) contact hours for the program.

Purchasing Information

The CLDP modules may be previewed and purchased at store.healthstream.com (type “AMSN” in the search box). Nurses are encouraged to check with their unit manager or nurse educator before they buy to see if their facility has already purchased HealthStream programs. If not, nurses may buy the course as an individual.
Legal Nursing

Patient Education: Are Nurses Legally Responsible?

Last summer, an uncle of mine had bilateral knee replacements. As I was visiting him on discharge day, his nurse walked in to provide him with his discharge instructions. I was surveying his medication while listening to the nurse talk to her computer; she never once looked at my uncle. Upon completion of her presentation, I asked about his dietary restrictions. “Is he on Warfarin?” The nurse’s reply was, “Oh, yeah, well the printer is broken.”

Needless to say, I was not happy. After several failed attempts to obtain the information, I explained to my family members that I would educate them on his medications and diet restrictions. As I drove home, I was so appalled by the lack of concern for my loved one and very troubled by this nurse’s lack of responsibility for her patients. How could I explain that legally it is our responsibility to make sure our patients have the information to safely go home and care for themselves?

Nurses as Educators

Teaching was recognized as a function of nursing when Florence Nightingale wrote her significant treatises on nursing in 1859 (Nightingale, 1992). Nurses have historically considered patient education one of their most important responsibilities (Freda, 2004). According to Margaret Comerford Freda (2004) in her article “Issues in Patient Education,” appropriate and comprehensive patient education has become more difficult to accomplish for many reasons, including:

- The huge influx of clients of varying cultures
- The lack of time available for patient education
- The dearth of educational languages other than English
- The need for training of providers that lack skill
- The lack of health education materials written at appropriate literacy levels
- The lack of reimbursement for time spent on patient education

An appropriate evaluation of each patient requires an accurate assessment of the strengths and weakness of the patient, as well as a determination of the family’s learning needs regarding the patient’s problems and his or her ability to meet basic human needs. Nurses are taught that it is imperative to include families in the teaching process in order to enhance cooperation with self-care issues and compliance with the medical regimen. Therefore, the family should also be included in the assessment of the ability to learn, retain, and implement health education.

In the case of my uncle, my aunt never left his side. Patient/family assessment and education should not have been an issue. During his discharge instructions, several close family members were present and willing to participate. Unfortunately, the nurse caring for my uncle lost a great opportunity to enhance the knowledge of the recovery experience, self-care issues, and medical regimen.

Legal Responsibilities

The American Nurses Association (ANA) supports the professional nurse’s responsibility to teach the patient and family relevant facts about specific health care needs and supports appropriate modification of behavior. The ANA (1999) identified 10 nursing-sensitive quality indicators that capture care or its outcomes most affected by nursing care. One of these identified indicators is patient satisfaction with educational information. The quality of nursing care can be measured in part by the quality of patient and family education provided (Rankin, London, & Stallings, 2005).

References to patient education are found in most facility’s policies, job descriptions, and the ethics codes of nursing organizations. Furthermore, the courts have consistently upheld the rights of patients to know about their health care issues, treatments, medications, and recovery participation. Patient education has become a professional expectation and a legal duty of nurses (Rankin et al., 2005). The Joint Commission (2001) states, “Patients have the right to receive appropriate education and to use the knowledge they gain to participate in decision-making. However, patients also have a responsibility to participate in their own decisions and care processes.”

Furthermore, Medicare developed a prospective payment system for education of all patients that must include learning the ability to recognize problems after discharge and make decisions that contribute to self-care management. The fastest growing segment of our society is the older population. They depend more heavily on health care services, particularly nursing care. More acute care is being provided in the home and in the discharge of patients from the hospital; sicker and quicker demands the provision of patient and family teaching and continuity with caretakers in the home (Rankin et al., 2005).

The following education topics are imperative to the safety of patients and are legally required upon discharge:

- Medication management
- Nutrition and hydration
- Disease/Illness

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 hpneilrn@cox.net.
• Treatments and symptoms
• Physician discharge orders concerning follow-up
• Support services needed and available
• When and how to seek appropriate treatment

In addition, the safest practice for the patient and nurse includes documentation of the educational topics covered, the patient/family response, and the need for further education. If the need for further education is recommended, a plan for the patient/family to obtain additional education must also be documented and communicated to the patient/family.

Conclusion

In summary, patient education is an ethical and legal responsibility of the nurse. Failure of the nurse to assess the learning needs or ability of the patient/family to learn, record the education process conducted, and log documentation of the education could (and should) result in legal intervention.

References

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Legal Nursing in 2016
Stay tuned for an upcoming “Legal Nursing” column on legal aspects of nursing and its impact on delivery of patient care. Nursing practice is influenced by many regulatory requirements; however, nurses are judged based on a legal definition for the standard of care for nurses. Don’t miss the upcoming discussion of the legal definition of the standard of care for nurses.

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* AMSN gift certificates are not valid for the MSNCB CMSRN certification, recertification, and exam exemption fees.
Bipartisan Senate NIH Caucus

One of the exciting topics on the hill is the launching of a bipartisan Senate National Institutes of Health (NIH) Caucus. On May 19, 2015, U.S. Senators Dick Durbin (D-IL) and Lindsey Graham (R-SC), co-chairs of the Senate's newest caucus, were joined by Dr. Francis S. Collins, Director of the NIH. “The goal of the NIH Caucus is to preserve our nation’s global competitiveness by highlighting the need for investments in cutting-edge research being performed by the NIH – the foremost biomedical research institute in the world” (Durbin & Graham, 2015).

The caucus will focus on NIH’s waning ability to fund research after losing 25% of its purchasing power since 2003. The senators attribute this to sequestration and flat budgets. “As a result of this decline, the U.S. is missing opportunities to discover cures for cancer, Alzheimer’s, heart disease, diabetes, and countless other diseases,” they wrote in a release (Ferris, 2015).

Funding for NIH will restore the purchasing power and provide steady, predictable growth for biomedical research in the future. This growth in funding is important to continue the monetary support for research from the National Institute of Nursing Research (NINR), which is a small portion of the greater entity of the National Institutes of Health (American Association of Colleges of Nursing [AACN], 2015). Contact your senators to increase awareness of this caucus and the importance of nursing research in improving the overall health of the nation.

References

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