There are stories about groups (chapters, units, facilities, etc.) and their activities and success stories. The stories may be personal interactions with patients or colleagues.

We encourage you to submit stories, pictures, videos, and first-hand accounts of your experiences to share with the visitors of the AMSN Web site. Watch for chapter news, events, and service projects, unit and facility celebrations and achievements, even individual award announcements.

Below are the following featured areas showing “It’s All About YOU!”

- **AMSN Volunteers** – Tell us the story of your experiences as an AMSN volunteer. How has your involvement serving AMSN as a volunteer benefited you personally and professionally?

- **Healthy Work Environment** – Have you or your unit improved your work environment? Sharing your success story could inspire and empower other med-surg nurses to advocate for a healthier workplace in hospitals across the nation!

- **Member Achievements** – Have you or your unit received recognition or an award for a new patient quality initiative or excellence in patient care? Have you reached a milestone in your career? Tell us the story. We want to hear about your achievement! Your experience may motivate other med-surg nurses.

- **Nurses Celebrating** – Tell us the story of how your unit/facility has celebrated the compassion and commitment of medical-surgical nurses (e.g., celebrating Med-Surg Nurses Week).

- **Nutrition** – We’d like to hear your account of how nutrition intervention improved your patient’s outcome. We hope you will give us the story so that we can share the evidence with your colleagues!

- **Partnership for Patients** – Share YOUR story about how your hospital has supported the Partnership for Patients Initiative by making care safer and/or improving care transitions.

- **The DAISY Foundation** – Have you received the DAISY Award for providing outstanding patient care? Share your story to inspire your fellow med-surg nurses to go above and beyond.

Visit www.amsn.org to learn more and submit your highlights today!
Counting Down to Med-Surg Nurses Week

Medical-surgical nurses focus every day on caring compassionately for patients and families. The Academy of Medical-Surgical Nurses (AMSN) has designated a special week, **November 1-7**, to shift that focus to the nurses themselves.

How Medical-Surgical Nurses Make a Difference

- Build the profession of nursing and the medical-surgical nursing specialty
- Mentor and nurture each other
- Advocate for patients and families at the local and national levels
- Serve their communities through care and education
- Promote medical-surgical nursing certification, resulting in better and safer health care
- Improve patient care through evidence-based practice
- Speak, write, and conduct research to inspire and educate others

Find ways to celebrate and download or print our poster at www.amsn.org. Don’t forget to tell us how you celebrated! Send your stories and pictures to amsn@ajj.com.

One of Your Best Resources

The AMSN Online Library is your 24/7 learning tool, ready to help you get top-quality education at your convenience. Listen to convention sessions, browse poster presentations, or read articles. If you complete contact hours, your transcripts will be waiting for you when you are able to print.

Visit the AMSN Online Library at www.amsn.org/library
Bedside Reporting: Is it Enhancing Nursing Care?

In a healthy work environment (HWE), it is important that changes in health care be based on evidence and research. We don’t want change to occur just because someone says so. In a HWE, nurses should be sought out for their input on changes that impact their practice. They need a voice. Unfortunately, this is not always the case. As a nurse at a small community hospital, bedside reporting was introduced to us this year. As someone who questions change, I began to wonder what the evidence was behind this change in shift report, thus the following review of the literature will synthesize what is known about the topic.

Bedside Report – What the Evidence Shows

A literature review revealed that there is limited published information available on bedside reporting, and the literature that is available does not focus on nurses’ values and beliefs but rather just on patient satisfaction levels. With this limited view, one can argue that health care is looking at bedside reporting through a narrowed lens and not focusing on an important aspect of the process – the nurses who are doing the bedside reporting.

Standardizing reporting methods among health care professionals has been a goal of The Joint Commission (TJC) since 2006, and improving communication has been an initiative of theirs since 2000 (TJC, 2013). Improving communication and reporting methods have been shown to improve patient care and satisfaction levels while decreasing the number of sentinel events reported by hospitals (Haig, Sutton, & Whittington, 2006; Rush, 2012; Trossman, 2009). Therefore, many hospitals are moving to a standardized reporting system using the Situation, Background, Assessment, Recommendation (SBAR) framework, along with bedside reporting, where shift report is given in front of the patient. The literature shows that bedside reporting makes shift report more objective, concise, and relevant, and thus, financially beneficial as nurses are able to give shift report in a quicker time frame (Griffin, 2010; Tidwell et al., 2011).

However, as mentioned above, this does not come without challenges that impact nurses and patients. Patients are often disturbed by having their sleep or visits with their loved ones interrupted. In addition, one can argue that personal health information is violated through bedside reporting in semi-private rooms, which brings about ethical and HIPPA concerns (Griffin, 2010; Laws & Amato, 2010). Finally, various illnesses that require isolation precautions can make bedside shift reporting a complicated procedure when going in and out of “clean” and “dirty” rooms (Novak & Fairchild, 2012). This has all been observed by the author and thus has sparked his interest in the topic.

Conclusion

As one can see, the evidence is not clear that bedside reporting provides the best method for handoff communication. Thus, nurses need to continue to provide input on this matter. Nurse researchers need to conduct qualitative research to learn more about nurses’ perceptions and values regarding this phenomenon. Quantitative research needs to be done to look at outcomes to answer these questions: Are patient outcomes improved? Are there fewer nursing errors? Are there fewer safety events?

With more evidence, nurses would know the best way to provide handoff communication. We need be able to ensure that bedside reporting is providing everyone involved with a healthier and more productive work environment, or make changes to the process if needed.

References


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Acknowledgement: The author would like to thank Judith Hupcey, Ed.D, CRNP, FAAN, for her help and guidance in developing this article.
Peripheral IV Site Care: What the Evidence Shows

Jacklyn S. DelPrete
Michael M. Evans

Recommendations from the Centers for Disease Control and Prevention (CDC) state that peripheral IV catheters should remain in place for an average of 72-96 hours. However, current research suggests that it may be time to consider reviewing these recommendations.

Every year, there are approximately 30 million patients who receive intravenous (IV) therapy. Of those patients, about 850,000 develop catheter-related complications. The most common complications include phlebitis, infection, and obstruction (Bregenzer, Conen, Sakmann, & Widmer, 1998). It should also be noted that another common complication of infiltration could occur. These situations are completely preventable and can be very dangerous to the patient; however, there are conflicting views as to how to prevent these problems.

In 2011, the Centers for Disease Control and Prevention (CDC) released updated guidelines for the prevention of intravenous catheter-related infections. The recommendation that short peripheral IV catheter sites be rotated every 48-72 hour was changed to the following category 1b recommendation: There is no need to replace peripheral catheters more frequently than every 72-96 hours to reduce risk of infection and phlebitis in adults (O’Grady et al., 2011). Another issue in the 2011 guidelines is the rotation of sites in adults only when clinically indicated. The CDC has made no recommendation toward this issue and states it as “unresolved.” Another recommendation allows for the rotation of sites in the pediatric population only when clinically indicated, such as by a complication of infiltration, infection, phlebitis, or obstruction.

Also, the Infusion Nurse Society, the foremost professional organization for advancements in infusion nursing, has its own recommendations for changing peripheral IV sites. Every nurse should consider changing a peripheral intravenous catheter site only when clinically indicated. Deciding when to change the IV should be based on certain considerations such as: the patient’s current condition, IV site, vein and site availability, the type of dressing needed (including a stabilization device), and length and type of IV therapy to be initiated (Infusion Nurses Society, 2011). These considerations represent the newest recommendations from the Infusion Nurse Society for the standard of practice in infusion therapy. The policy and procedure manuals of most hospitals have a designated length of time a peripheral intravenous catheter may remain in place before needing to be rotated to a new site. This routine rotation may be anywhere from every 72-96 hours following the most current CDC guidelines from 2011. This standard rule is thought to prevent such complications as phlebitis, obstructions, and IV site infections. However, the repeated insertion of new IV catheters increases patient discomfort and health care center costs (Bregenzer et al., 1998). The reduction of required IV re-insertions, while maintaining reduced IV complications, could also lead to a significant cost savings for health care centers. One study realized as much as $6 AUD (Australian currency, about $6.19 U.S. dollars) in savings per catheter when sites were changed only when clinically indicated. That

Objectives
The purpose of this continuing nursing education article is to increase nurses’ and other health care professionals’ awareness of care of peripheral intravenous (IV) catheter sites. After studying the information presented in this article, you will be able to:

1. Discuss IV site care and CDC recommendations regarding routine changes.
2. Identify the benefits and complications associated with IV re-siting over different periods of time.
3. Explain suggested changes to IV care guidelines based on the results of this research study.

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

This educational activity has been co-provided by Anthony J. Jannetti, Inc. and AMSN.

Anthony J. Jannetti, Inc. is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nursing, provider number CEP 5387. Licensees in the state of CA must retain this certificate for four years after the CNE activity is completed.

Peripheral IV Site Care:
What the Evidence Shows

Deadline for Submission:
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2. Evaluations must be completed online by October 31, 2015. Upon completion of the evaluation, a certificate for 1.0 contact hour(s) may be printed.

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What the Evidence Shows

Peripheral IV Site Care:
What the Evidence Shows

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AMSNN1305

What the Evidence Shows

Peripheral IV Site Care:
What the Evidence Shows

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What the Evidence Shows
correlates to an 11% savings in IV catheter supplies (Webster, Osborne, Rickard, & Hall, 2010). This change in practice could add up to thousands of dollars being saved by an organization.

**Focused Problem**

What is the effect of changing IV sites when clinically indicated for cost savings, patient comfort, infection rates, phlebitis, infiltration rates, and obstruction as compared to the current practice recommended by the CDC?

**Methodology**

In order to find the most relevant and up-to-date information on the subject of catheter replacement, a literature review was conducted. Online databases were utilized, most commonly CINAHL, PubMed, and the Cochrane Library. The keywords that produced the most amount of relevant research included peripheral intravenous catheters, catheter-related infections, IV catheter replacement, clinically indicated catheter replacement, routine replacement IV, phlebitis, obstruction, and infection. After combing through research articles, a total of six articles met the criteria for relevant research. Only one article was more than ten years old, but has been cited consistently in other articles and appears to be a leader in the topic of changing peripheral IV lines. Overall, the studies suggest that clinically indicated catheter replacement does not produce any more negative outcomes or complications than routine replacement.

**Literature Review**

Bregenzer and colleagues wrote one of the most commonly cited articles in the research area of catheter replacement in 1998. The article described an observational study conducted in a Switzerland university-affiliated hospital with 700 beds. In the clinically indicated group, catheters were changed when infiltration, phlebitis, and obstruction occurred. In total, the study involved 609 catheters. All catheter care and insertion techniques were the same for all of the catheters. All skin was disinfected with the same solution before insertion and the type of adhesive and the way in which the catheter was secured were uniform. The IVs were inspected daily for signs of complications such as infection, infiltration, phlebitis, or obstruction. After removal, all catheters were sent to the laboratory for microbial testing with cultures being done within two hours after removal. In this study, there were no specific controls or experimental groups. All catheters involved were in use until they showed signs of complication. No idle catheters (those used only intermittently, more commonly referred to as a saline lock) were used (Bregenzer et al., 1998).

The study by Bergenzer and colleagues (1998) concluded there was no increase in risk of complications from day to day after day two. About one third of the catheters were left in for more than three days, some up to ten days or more. Only four catheters demonstrated phlebitis and one became obstructed. Overall, the study may provide evidence contrary to the current CDC guidelines and suggests that it may be safe to leave IV catheters in place for as long as clinically indicated.

In 2008, Webster and colleagues conducted a randomized controlled trial looking into the incidence of phlebitis and infiltration in catheters routinely replaced compared to those replaced when only clinically indicated. The study was completed in Australia and included over 700 participants split into two groups: routine catheter replacement completed every three days and clinically indicated catheter replacement (Webster et al., 2008). In the clinically indicated replacement group, the catheters remained in place longer than the control group. Overall, in the control group, 33% of participants had catheters removed due to phlebitis or infiltration compared to 38% in the clinically indicated group. The difference between the two groups was not statistically significant. The study found an increased cost in the control group due to replacing catheters that were otherwise working properly. In conclusion, clinically indicated catheter replacement does not increase the risk of catheter failure due to phlebitis and infiltration (Webster et al., 2008). Therefore, if the IV catheter shows no signs of malfunction or infection, it may be safe to continue use.

In 2010, another article was published describing the incidence of complications in IVs re-sited every three days as compared to when clinically indicated. The study was conducted as a randomized controlled trial in a teaching hospital without a designated intravenous therapy team. Regular medical staff and nurses managed all IVs on 362 patients, totaling 603 IVs (Rickard, McCann, Munnings, & McGrail, 2010). The result of this study concluded that it might not be necessary to routinely rotate IV sites every three days. “All IVDs [intravenous devices] will fail eventually, but this study shows that artificially shortening the lifespan of individual catheters does not reduce the overall complication rates over the course of therapy” (Rickard et al., 2010, p. 6). Statistical analysis showed no significant difference between the numbers of complications in routine re-site versus clinically indicated IV site changes (Rickard et al., 2010).

Finally, a systematic review, conducted by the Cochrane Collaboration, investigated randomized controlled trials to determine the significance of routinely changing catheters versus when clinically indicated. A broad range of participants and interventions were included, such as any person requiring the need for a peripheral IV for greater than three days. The studies reviewed included all types of IV catheters with or without any type of coating and any style of site dressing. The settings included hospitals, nursing homes, and other community settings. Six trials met
The Cochrane review concluded that there was no greater risk to patients when IV catheters are changed on a clinically indicated basis versus routine re-site. The outcomes measured were rates of phlebitis, infiltration, bacteremia, and obstruction. Between both groups, the incidence of bacteremia was less than 0.6%. There was not a significant increase in the amount of phlebitis between the control and intervention groups. Moreover, there was a higher cost savings in the clinically indicated group (Webster et al., 2010).

**Risks and Benefits of Changing the Recommendations**

The risks associated with changing IV site rotation guidelines would be minimal according to the literature reviewed. The benefits of changing the IV catheter when clinically indicated could be a decrease in the number of IV re-sites per patient, reducing patient discomfort and increasing patient satisfaction, therefore also decreasing costs for the facility. Removing an IV catheter that shows no signs of complication, other than that it is greater than 72-96 hours old is not necessary. The current guidelines should be reviewed for the better interest of patients and economics.

**Summary and Conclusions**

Frequent and unnecessary re-siting of peripheral IV catheters can be very painful for patients and costly for the health care center. Based on a review of evidence, removing an IV catheter between 72-96 hours old that shows no signs of complication is not necessary. Therefore, the writers of this article suggest the current CDC IV replacement guidelines should be changed to the rotation of short peripheral catheter sites in adults occur only when clinically indicated. The adoption of this new evidence-based practice could significantly improve patient satisfaction, decrease patient discomfort, and improve cost savings for health care systems. If this was to become the new guideline and standard, patients can be saved from many unnecessary re-sites and new catheters, and health care institutions can realize dramatic cost savings. Hospitals and other health care facilities, including the nurses and administrators, should be properly educated on intravenous therapy and the appropriate policies should be reviewed for change.

**References**


Rickard, C.M., McCann, D., Munnings, J., & McGrail, M.R. (2010). Routine resite of peripheral intravenous devices every 3 days did not reduce complications compared with clinically indicated resite: A randomized controlled trial. *Biomed Central Medicine, 8*(33), 1-10.


**Additional Reading**


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**Health Care Reform: A Call for Manuscripts**

*MedSurg Matters!* includes an ongoing column—“Health Care Reform”—which addresses the impact of the Affordable Care Act (2010) as well as the Institute of Medicine (IOM) *Future of Nursing* recommendations on health care and nursing.

Authors are needed for future columns, in particular to address IOM recommendations for nursing education. Manuscripts are sought on these topics:

- Life-Long Learning
- BSN Preparation
- MSN Preparation
- DNP and PhD Preparation
- Funding Sources for Advancing Your Education

The following are minimal areas to include when addressing education preparation for nursing: overview of the IOM recommendation for nursing education for the specific degree, benefits of attaining an advanced degree (professional, personal, and effect on patient outcomes), core courses, online versus traditional programs, and a list of the top 10 programs.

Queries regarding these and other related topics should be sent to msnnews@ajn.com. Suggested manuscript length is 4-6 double-spaced, type-written pages (2-3 newsletter pages). Download the Author Guidelines at http://www.amsn.org/newsletter and get started today!
**Clinical Research Abstracts**

**Medicare Nonpayment for Certain Hospital-Acquired Conditions Has Not Reduced Certain Infections**

In October 2008, the Centers for Medicare & Medicaid Services (CMS) discontinued additional payments for certain hospital-acquired conditions that were deemed preventable. A new study did not find evidence the CMS policy to reduce payments for central catheter-associated bloodstream infections and catheter-associated urinary tract infections had any measureable effect on these infection rates in U.S. hospitals. There were no subgroups of hospitals where patients appeared to benefit from the implementation of this policy change. The study was based on data from 398 hospitals in 41 states ranging from small, non-teaching community hospitals to large academic medical centers. The findings did not differ for hospitals in states without mandatory reporting, nor did they differ according to the percentage of Medicare admissions.


**Soap and Ointment Use Slashes Deadly MRSA Infections in ICU Patients**

Using germ-killing soap and ointment on all intensive-care unit (ICU) patients can reduce bloodstream infections by up to 44% and significantly reduce the presence of methicillin-resistant *Staphylococcus aureus* (MRSA) in ICUs. Researchers tested three MRSA prevention strategies and found using germ-killing soap and ointment on all ICU patients was more effective than other strategies.

A total of 74 adult ICUs and 74,256 patients were part of the study, making it the largest study on this topic. Researchers evaluated the effectiveness of three MRSA prevention practices: routine care, providing germ-killing soap and ointment only to patients with MRSA, and providing germ-killing soap and ointment to all ICU patients. In addition to being effective at stopping the spread of MRSA in ICUs, the use of germ-killing soap and ointment on all ICU patients also was found to be effective for preventing infections caused by microbes other than MRSA.

**Erratum**

An article by Beth Quatrara, “Malnutrition in Hospitalized Patients: Results of an AMSN Survey,” which appeared in the March/April 2013 issue of *MedSurg Matters*, contained erroneous figures depicting survey responses. The results shown in these graphics did not match the data provided in the article text. While the author reported the responses of in-patient hospital nurses, the figures reflected the responses of non-hospital nurses. The results also stated that 89.9% of respondents reported that nutrition was a moderate to high priority (Question #6), when it should have been 82.9%.

A revised version of this article is available in the issue archive at www.amsn.org.

To learn more, see Huang et al. (2013). Targeted versus universal decolonization to prevent ICU infection. *New England Journal of Medicine*, 368(24), 2255-2265.

**People with Disabilities Frequently Experience Pain and Fatigue**

Approximately 1 in 5 people in the United States have a disability. These individuals can experience a range of symptoms that in turn can affect their health status and physical functioning. In fact, a new study found diverse and significant symptom experiences among people with disabilities, with pain and fatigue being the most common symptoms.

In a study of 12,249 adults age 40 and older, more than a third (37.8%) reported a disability. Among nondisabled respondents, 67.4% reported excellent or very good health compared to only 24.7% of those with a disability. However, some persons with a disability reported very good or excellent health. For all participants, the top four most frequently experienced symptoms were joint pain, muscle pain, backache, and sleeping problems. A strong association was found between the reporting of symptoms and lower self-rated general health status, as well as poorer self-reported physical function.

For more info, see Patterson et al. (2012). Living with disability: Patterns of health problems and symptom mediation of health consequences. *Disability and Health Journal*, 5, 151-158.

**Coming soon in...**

- Caring for the Patient with Colorectal Cancer: Part II
- Novel Recovery Pathways to Prevent Postoperative Ileus after Bowel Resection Surgery
- Restructuring Orientation: Making It Meaningful, Relevant, Engaging, and Pertinent to Quality Patient Outcomes
- Deltoid Intramuscular Injections and Obesity
- Reducing Medication Errors by Educating Bar Code Technology
- Nutritional Needs of the Hospitalized Patient
- IV Therapies for Patients with Fluid and Electrolyte Imbalances
- Development and Implementation of a Patient Acuity Tool for a Medical-Surgical Unit
- A Successful Approach to Implementing Evidence-Based Practice
- Collaborative Learning: An Opportunity for Professional Growth of the Student Nurse while Caring for Local Community Residents
What is a Legal Nurse Consultant?

A legal nurse consultant is a registered nurse who reviews medical documents to assist with interpretation of medical terminology and assess for deviations from standards of care in medically related cases/claims. This specialty coordinates efforts with attorneys, health care facilities, insurance companies, and governing agencies to ensure the best outcomes for their clients.

Legal Nurse Consulting

Since the mid-1980s attorneys, governing agencies, insurance companies, health maintenance organizations (HMOs), and health care providers have utilized nurses to review medical records, understand medical terminology, health care issues, and hospital administrative issues to bridge the gap between the medical and legal worlds. This specialty is relatively new but is sanctioned by the American Bar Association (ABA) and recognized by the American Nurses Association (ANA). A legal nurse consultant (LNC) is a registered nurse who uses expertise as a health care provider and specialized training to consult on medical-legal cases and achieve the best results for their clients. Clients range from the hospital risk management department or nursing home medical review panel to the child of a young father who died during a routine cholecystectomy. Many agencies represent both defense and plaintiff clients, while some only represent one or the other. The plaintiff (the complainant) is the person(s) or organization(s) who’ve brought the action against the defendant, who is being sued or accused and is defending the action. The American Association of Legal Nurse Consultants (AALNC) promulgates a Code of Ethics for the Legal Nurse Consultant. While there are other LNC associations, AALNC is the only organization that offers certification credited by the American Board of Nursing Specialties. The AALNC (2012b) defines legal nurse consulting as the application of knowledge acquired during the course of professional nursing education, training, and clinical experience to the evaluation of standard of care, causation, damages, and other medically related issues in medical-legal cases or claims. This is accomplished by providing the following services:

- Preparation for and participation in client interviews
- Screen or investigating the case/claim for merit
- Identify, organize, analyze and summarize pertinent medical records
- Assess for tampering of medical records
- Assess for missing medical documents
- Assist with discovery of issues relevant to the case
- Define the applicable standards of care
- Define the deviations for the standards of care
- Prepare a chronology, timeline, or medical summary of the medical documentation provided by the client
- Assist with or conduct the medical research associated with the case
- Interpret the medical research
- Analyze the validity and reliability of the research
- Identify, screen, and facilitate key and expert witnesses
- Consult with the health care providers
- Serve as a liaison between the client and witness
- Draft and analyze medical portions of relevant legal documents
- Identify and evaluate the factors that caused the injuries/damages
- Educate agencies, attorneys, and clients regarding relevant medical issues
- Identify plaintiff’s future medical needs and associated costs

Table 1. Example of Deviations from Standard of Care

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Source</th>
<th>Provider</th>
<th>Clinical Events</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/12</td>
<td>Discharge</td>
<td>D/C Nurse</td>
<td>Patient given RX for meds. Told to call MD</td>
<td>This is a CHF patient. According to Core Measures Guidelines for CHF patients they must receive the following instructions upon discharge:</td>
</tr>
<tr>
<td>1430</td>
<td>Summary</td>
<td></td>
<td>for follow up.</td>
<td>1. Medicine side effects and precautions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Activity level</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Diet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. When to follow up with MD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. Daily weight</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deviation from SOC for CMS confirmed by lack</td>
<td>of proper discharge instructions documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>of proper discharge instructions documentation</td>
<td></td>
</tr>
</tbody>
</table>

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.
• Participate in case management and case strategy discussions
• Assist with preparation and attend depositions, trials, or Alternative Dispute Resolution (ADR)
• Review and summarize reports of depositions, trials, and ADR
• Serve as an expert witness
• Perform cost of care estimates for long-term care treatment and catastrophic case management scenarios; Life Planning
• Locate or prepare demonstrative evidence for trial
• Assist with preparation of witnesses
• Attend Independent Medical Exams (IME) and report/interpret findings
• Assist with coordination of focus groups for Mock Trials

Legal Issues Associated with Patient Care

Knowledge of how a medically related case/claim is reviewed by a LNC can assist the nurse to understand the necessary process required to ensure the safest delivery of patient care. Upon receipt of a chart, the LNC will organize the records in chronological order and determine if any records are missing or if there is evidence of tampering. The chart is then reviewed to determine if there are any deviations from the standards of care. The following is a list of some of the governing agencies referenced for standards of care:

• Department of Health and Human Services (DHH)
• Centers for Medicare and Medicaid (CMS)
• The Joint Commission
• Center for Disease Control and Prevention (CDC)
• American Nurses Association (ANA)
• American Medical Association (AMA)
• Agency for Healthcare Research and Quality (AHRQ)
• Food and Drug Administration (FDA)
• National Academies
• American Heart Association
• National Institute of Health
• National Cancer Institute
• President’s Advisory Commission Consumer Protection and Quality in the Health Care Industry

Every entry in the medical record is evaluated to determine if there are any deviations from the standards of care. If a deviation is detected, it is noted and referenced with the appropriate agency. Table 1 is an example of a chronological event with deviations from the standard of care (SOC). This case refers to a patient who took double his dose of medications upon discharge because he continued his old meds while starting his new medications.

By ensuring that the client received the best possible care, the LNC acts as the patient advocate. When a LNC rep-

continued on page 13

Sharing the Magic of AMSN at Magnet

The annual ANCC Magnet Conference (October 2-4, 2013) brought more than 7,000 nurses and nurse executives together in celebration of the Magnet Recognition Program® in Orlando, FL, one of the most magical places on earth. As the leader in medical-surgical nursing, AMSN couldn’t possibly pass up the opportunity to network with so many wonderful professionals! AMSN members and proud CMSRNs Ann DiAgostino, Deirdre Bauer, and Marlene Roman greeted attendees in the exhibit hall during their stay in the “Sunshine State.” Friends and colleagues visited our booth for complimentary copies of MEDSURG Nursing journal, as well as information on the AMSN PRISM Award, our FailSafe Certification Program, and the 2014 convention.

You care about your career.
So do we.

AMSN Career Center
The premier resource to find jobs online
Grow personally and professionally using the AMSN Career Center. It’s your online destination for finding your dream job or star employee.

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Survey of Nurses’ Nutrition Screening and Assessment Practices in Hospitalized Patients

Malnutrition continues to be a problem in hospitalized patients in the United States and is associated with increased morbidity, mortality, and health care costs (Tappenden et al., 2013). Nutrition-related hospital structures and processes can impact malnutrition outcomes (Schönherr, Halfens, Meijers, Schols, & Lohrmann, 2012); however, little is known about the current nutrition-related structures and processes in U.S. hospitals. In order to better understand what is happening in hospital practice, it was recognized that a survey of the current practices for hospital nutrition screening, assessment, communication, and malnutrition diagnostic coding was needed.

A national interprofessional (nurses, dietitians, physicians, pharmacists) and intersociety (American Society for Parenteral and Enteral Nutrition [A.S.P.E.N.], Academy of Medical-Surgical Nurses [AMSN], and the Society of Hospital Medicine) survey was conducted to collect information on the structure and processes related to nutrition screening and assessment, communication, and malnutrition coding in hospitals. The objectives of the survey were to understand how malnutrition is handled in hospitals, identify who conducts malnutrition-related activities, and what tools/instruments are used in these activities. An improved understanding of how malnourished patients are currently identified and assessed in hospitals will enable clinicians to better meet the needs of these patients, ultimately improving outcomes.

Nutrition is not only a component of nursing care, but nurses are integral to ensuring the adequate delivery of nutrition to patients (Jefferies, Johnson, & Ravens, 2011). This article will focus on responses provided by nurses in regard to demographics, structural indicators, and nutrition screening and assessment processes. Findings will help nurses identify ways to improve nutrition screening and assessment processes in the hospital setting.

Methodology

A.S.P.E.N. led the design, validation, and implementation of survey activities. The survey was administered via the Internet using SurveyMonkey®. The collaborating organizations sent an email with the survey link to their members in November 2012 – January 2013. The 35-item survey included questions related to demographic characteristics of the respondents (6 items), structural indicators related to nutrition (4 items), and processes related to nutrition screening (7 items), nutrition assessment (15 items), and malnutrition diagnosis and coding (3 items). Structural indicators included items on nutrition support teams and implementation of the 2012 Consensus Statement of the Academy of Nutrition and Dietetics /A.S.P.E.N. concerning identification and documentation of adult malnutrition (White, Guenter, Jensen, Malone, & Schofield, 2012). Nutrition screening is a process to identify an individual who may be malnourished or at risk for malnutrition to determine if a detailed nutrition assessment is indicated (A.S.P.E.N. Board of Directors, 2012). Nutrition screening process indicators included timing of nutrition screens, use of validated nutrition screening tools, and communication of nutrition screening findings. Nutrition assessment is a comprehensive approach to diagnosing nutrition problems that uses a combination of the following: medical, nutrition, and medication histories; physical examination; anthropometric measurements; and laboratory data (A.S.P.E.N. Board of Directors, 2012). Nutrition assessment process indicators included the frequency to which individual components of nutrition assessment were performed, use of validated nutrition assessment tools, and the communication of nutrition assessment findings. Descriptive statistics were used to describe the subset of nurse responses to the survey items. The analysis of all survey items across disciplines will be published in a forthcoming issue of the Journal of Parenteral and Enteral Nutrition.

Results

Demographic characteristics. A total of 545 nurses completed the survey, and 6% were A.S.P.E.N. members. Nurse respondents practiced in a community or academic hospital (92%) with 100-500 beds (62%), and the majority (74%) reported the hospitals served adult, pediatric, and neonatal patients.

Structural indicators. While the majority of respondents (86%) reported having a nutrition support team at their hospital, only a few (6%) were familiar with the 2012 Consensus Statement (White, et al., 2012). Of the 439 nurses who responded to this item, only 9% were familiar with the Consensus Statement. Of those familiar with the statement, 63% reported their hospital is presently implementing the guidelines, and 13% reported their hospital is planning to implement the guidelines during the next year.

Nutrition screening processes. Almost all (85%) of the nurses reported that a nutrition screen is completed within 24 hours of admission. Nurses most often perform nutrition screening (see Table 1), and a validated screening tool is used by 42% of respondents. The most frequently
reported tools included Admission Nutrition Screening Tool (80%), Malnutrition Screening Tool (12%), Nutrition Risk Classification (12%), and Simple Screening Tool (13%). When a valid tool was not used, almost all nurses reported that screening parameters focused on trouble chewing or swallowing and weight loss history. The majority of nurses reported the findings from the nutrition screen are documented in the medical record and nutrition screening results in an intervention most of the time.

**Nutrition assessment processes.** The most frequently cited events that trigger a nutrition assessment were screening information documented in medical record (71.1%), automatic trigger from screening information (64.8%), and prescriber order (52.5%). Dietitians most fre-
quently performed a nutrition assessment (81%), followed by nurses and nurse practitioners (77%). Thirty-one percent reported using a validated nutrition assessment tool (see Table 1), which included the Mini-Nutritional Assessment (49.1%) and the Subjective Global Assessment (32.4%). Respondents were asked to identify parameters assessed for each component of a nutrition assessment (patient history, anthropometrics, physical exam, laboratory values, and functional performance). The most frequently reported items for each component were:

- **Patient history**: trouble chewing or swallowing and weight history
- **Anthropometrics**: current weight (96.5%), height (87.7%), and body mass index (67.5%)
- **Physical exam**: skin integrity (90.8%), edema (74.4%)
- **Laboratory values**: electrolytes (85.3%)
- **Functional assessment**: hand grip strength (94.0%)

While most nurses (54%) reported no barriers to completion of a timely nutrition assessment in their hospitals, 26% reported insufficient personnel as a primary barrier.

**Discussion**

The Joint Commission (2009) mandates a nutrition screening using specific criteria within 24 hours of hospital admission and periodic rescreening. Nurse respondents reported 85% of the time this is completed within 24 hours. Nurses primarily perform nutrition screening, and our finding is similar to a survey of nutrition managers who reported that nursing staff members were primarily responsible for nutrition screening (Chima, Dietz-Seher, & Kushner-Benson, 2008). While the respondents to this survey report that many nurses participate in nutrition screening and assessment, it is often not clear about the validity of the screening and assessment tools used. Most nurses reported using an admission nutrition screening tool that is institutionally based and a component of the nursing admission assessment. Very few nurses reported using evidence-based, psychometrically reliable and valid nutrition screening tools even though nurses do use reliable risk assessment instruments in other conditions (e.g., Braden scale or Norton scale for pressure ulcer risk assessment) (National Database of Nursing Quality Indicators, 2013). These findings suggest that nurses need to incorporate reliable and valid nutrition screening tools in practice (Mueller, Compher, & Ellen, 2011). The most frequent parameter identified by nurses in both the screening and assessment processes is trouble chewing and swallowing, followed closely by weight loss history. This is similar to Chima and colleagues (2008) who reported the most common nursing admission nutrition screening criterion was history of weight loss and the fourth most common was chewing/swallowing issues.
While dietitians most frequently performed the nutrition assessment, 77% reported nurses and nurse practitioners also performed the assessment. A quarter of respondents noted insufficient personnel as a barrier to completion of a timely nutrition assessment. Once an assessment is completed, almost all of the time it is documented in the medical record, but only about one-third of the time does the assessor verbally report findings to the other clinicians. Standardized communication (e.g., Situation Background Assessment Recommendation [SBAR]) among members of the health care team is important for safe and effective care, including nutrition care.

While very few of the nurses were familiar with the 2012 Consensus Statement on Adult Malnutrition, an important component of the approach to defining malnutrition in this document is the incorporation of functional assessments—including hand grip strength measurements assessed with dynamometers (White et al., 2012). Dynamometers are not yet commonly used at the bedside, but 94% of nurses reported assessing hand grip strength during a nutrition assessment. A limitation to the survey is the question on hand grip measurements did not specify how the measurements were obtained (i.e., hand dynamometer vs. patient grasping examiner’s hand). Therefore, it is assumed that nurses regularly assess grip strength by having patients grasp their hand.

This survey demonstrates the critical role nurses play in nutrition screening and assessment of hospital patients. Recommendations for practice include incorporation of reliable nutrition screening tools, developing ways to effectively communicate nutritional recommendations with the health care team, and implementing current adult malnutrition guidelines.

References


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Legal Nursing
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represents a client in a workers’ compensation case, he or she can ensure that the client receives appropriate planning for future health care needs. In addition, LNCs ensure that non-meritorious cases are not filed and slow down our judiciary system. When representing the health care facility, they can recommend solutions to staffing issues, deficits in policies and procedures, and assist with adherence to standards of care. Another role of the LNC is to ensure coverage of an insurance agency for a client. For example:

- Durable Medical Equipment
- Chemotherapy
- Medications
- Therapy

The main role of the LNC is to educate, whether it be the facility, attorney, client, agency, HMO, settlement broker, or insurance company. Whatever role the LNC assumes, he/she is practicing a specialty of nursing that acts like a member of the litigation team whose clinical expertise is critical to achieving a fair and just outcome for both parties.

References


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The W.I.W.O. Initiative: Saving Lives Only Takes Thirty Seconds

“Hygiene is two-thirds of health.” –Lebanese Proverb

In the United States, hospitalized patients endure nearly two million hospital-acquired infections each year. That is about one infection per twenty patients (Centers for Disease Control and Prevention [CDC], n.d.). Hospital-acquired infections should be avoided at all costs because they endanger patients’ lives and put facilities and staff in compromising positions. The CDC reports that hand hygiene is one (if not the most important) way to prevent the spread of infections, including the common cold, flu, and even difficult to treat infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) (CDC, n.d.).

The health care team at Albert Einstein Healthcare Network (AEHN) in Philadelphia, PA, set out to stop the spread of disease and infection through their Wash In, Wash Out (W.I.W.O.) Initiative program created by the radiology department and piloted by the medical-surgical staff nurses of a 50-bed general medical-surgical unit. The radiology department initiated W.I.W.O. because they felt it was unprofessional to chastise one another in front of patients regarding hand washing. The W.I.W.O. Initiative was a strong reminder to all health care staff, patients, and families to wash their hands before entering a room and upon exiting a room. W.I.W.O. was initiated on May 5, 2012, World Hand Hygiene Day, established by the World Health Organization (WHO).

The goal at Albert Einstein Healthcare Network was to promote awareness about the spread of infection and encourage staff, patients, and their families to use hand hygiene to minimize the risks for infection.

Prior to the implementation of the initiatives, patients, families, and staff received education on proper hand hygiene. Patients and their families were instructed on a simple hand washing technique: washing hands under warm water and using soap for at least thirty seconds to lather the hands, as well as cleaning under nail beds. Instructions included washing hands before eating or using utensils and after toileting. Patients were instructed that hand washing can help prevent the spread of infection.

Patients and families were introduced to the purpose and effectiveness of alcohol-based products. The CDC states hand sanitizers need to contain 60-90% alcohol to be effective in killing germs, and more than 20 published studies demonstrate that alcohol-based hand rubs are more effective than soap in reducing the number of bacteria on the hands (CDC, n.d.). In some cases, popular brands of hand sanitizer do not contain the adequate amount of alcohol and therefore, are not effective. Hand sanitizers are a helpful resource in fighting infection but do not eliminate all bacteria. Clostridium difficile (C. diff) is a spore that cannot be eliminated by alcohol-based hand sanitizers. Hand washing with soap and water must be utilized to combat the spread of C. diff (Mayo Clinic, 2010).

Samples of Avagardâ hand gel were given to participants in the initiative to raise awareness of hand hygiene and to make hand washing a routine practice. Patients and families were educated on the difference between simple soaps and alcohol-based hand sanitizers. AEHN solicited volunteers from various interdisciplinary teams such as nurses, physicians, managers, administration, and even office staff to monitor and assess hand-washing practices during the pilot on the largest medical-surgical unit of the hospital. The volunteers observed staff from the hallways to ensure hand washing was done before entering a patient room and again upon leaving a room. Avagard hand sanitizer dispensers were mounted outside every doorway and inside every room to make it easy for hand hygiene compliance by staff, families, and patients. As interdisciplinary team members approached a room to provide care for a patient, a volunteer observer greeted them with a simple, “Thank you for washing your hands and saving lives.” If any clinician, staff, or family member entered or exited a room without performing hand hygiene, a gentle reminder to wash his or her hands was given. Everyone understood the importance of this initiative after receiving education on the role hand washing plays in preventing infection, so a simple reminder did not prove to be offensive to anyone. Simple reminders to wash hands given to participants who failed to do so without prompting appeared to have been received as a non-offensive, unthreatening, valued reminder of the initiative.

The W.I.W.O. Initiative lasted for eight days around the clock for all health care staff, patients, and families on the medical-surgical unit where W.I.W.O. was trialed. At the end of each day, the staff and volunteer observers would regroup to talk about their W.I.W.O. experience and discuss stories, encounters, or any thoughts or feelings they had about hand washing. Debriefing sessions were held at the end of each shift during the pilot and were instrumental in discussing key elements contributing to risk of infections. Nurses and clinicians held roundtable discussions about contributing factors that could lead to the spread of infection, such as: hospital equipment, bedside tables, side rails, patient gowns, and helping patients with their activities of daily living. Volunteer observers shared notes they had taken throughout the day while monitoring hand-washing practices. Many of the responses were...
similar; nurses and physicians felt W.I.W.O. was a simplistic and cost effective way to ensure patient safety.

Following the trial on one med-surg unit, various other disciplines and departments became involved in the W.I.W.O. Initiative. The radiology department was excited to show off their creativity and entered a contest sponsored by 3M™, the makers of Avagard hand gel. The radiology department created a superhero named W.I.W.O. who used Avagard powers to fight many infections. Buttons, pins, and t-shirts were worn throughout the hospital to show unity and to remind staff, patients, and families how easy it is to stop the spread of infection and save lives. The radiology department was a runner-up in the 3M™ Innovation Award contest with the W.I.W.O. Initiative.

The AEHN’s network’s Internet homepage displayed the letters W.I.W.O. in bold and bright letters to ensure anyone visiting the Web site was aware of the steps the AEHN staff were taking in infection prevention. The Medical Director of Infection Prevention and Control at AEHN was featured on a Facebook page promoting W.I.W.O. and encouraging Einstein staff to join in this movement. Educational posters were displayed throughout the campus, and W.I.W.O. became second nature to staff.

It was apparent infection awareness was one of the staff’s priorities throughout their shifts. Patients would even remind staff, family, and friends to W.I.W.O. during visits. As a staff nurse, it was encouraging to see patients performing spot checks on staff during visits. Patients even checked to make sure staff were washing their hands in between patients. Patients felt empowered by this process because the health care staff encouraged them to have a voice when it came to their care. Patients were encouraged not to feel embarrassed or discouraged when a doctor or nurse did not wash their hands, but rather to kindly remind them to use proper hand hygiene. After all, it is the job of the health care team to keep patients safe.

AEHN recognizes hand hygiene is a fundamental and necessary tool to prevent contamination of the health care environment, prevent hospital-acquired infections, and promote occupational safety. The impact of hospital-acquired infections not only endangers patients and tarnishes reputations, but it also prolongs length of stay and increases mortality rates and health care costs. The lack of hand hygiene practice accounts for 90,000 patient deaths per year (and the cost of treatment for infected patients has skyrocketed to $4.5 billion per year in the United States alone) (CDC, n.d.). Hand hygiene compliance rates are at an unacceptable 40% average across the country (Hand Hygiene Resource Center [HHRC], n.d.). With the rising cost of health care across the country and insurance companies holding providers accountable for patient safety, nurses cannot afford to overlook hand hygiene when providing care. These numbers are startling, and the W.I.W.O. Initiative at AEHN is our way of making a stand, one unit and one patient at a time. AEHN encourages all facilities to monitor and assess hand washing because not only is it standard practice, hand washing also saves lives.

As nurses, it is our priority to educate and promote knowledge building; nurses are mentors, educators, and reliable resources who can bring about change. Nurses are the first line of defense in an ongoing fight to ensure patients are infection free, especially during their hospital stay.

References

Suggested Reading

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Write for Us

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

We are more than happy to mentor novice writers!

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