Williams, Leslie, Leen, Mills, and Dobb (2013) discovered that nurses can improve the nutritional status of patients by minimizing unnecessary holding of enteral feedings and understanding endorsed guidelines in managing enteral feedings. Patients become compromised when they receive less than 65% of their recommended daily calories (Yamamoto Honda et al., 2013). According to Compton, Bojarski, Siegmund, and Van der Giet (2014), patients administered enteral feedings should reach a target rate of 25 kcal/kg/day. Algorithms prove instrumental in assisting nurses to manage enteral feedings to ensure optimal nutrition (Tume, Latten, & Darbyshire, 2010).

**Background**

During a morning communication huddle, a nurse reported that her patient’s tube feeding remained off during the night because of high residuals. A novice nurse asked a practice question, “What constitutes a high residual?” Differing opinions ensued from her colleagues. Answers ranged from 100 to 300 millimeters and included a physician who was unsure. The literature was reviewed and an evidence-based guideline for the management of enteral tube feedings was discovered from the American Society of Parenteral and Enteral Nutrition (ASPEN) (Bankhead et al., 2009). Bankhead and colleagues (2009) recommended continuing enteral feeding with residuals less than 500 millimeters. This volume did not increase the risk of regurgitation or aspiration if the head of the bed is greater than 30 degrees during enteral feedings (Guenter, 2010).

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25 Years of Volunteering for AMSN

Ambassadors for AMSN and MSNCB

Merriam-Webster (2016) defines a volunteer as a person who “expresses a willingness to undertake a service.” This service does not result in a prize or some form of recognition; the person providing the service simply knows he or she has the ability to make a difference and is willing to share time and energy to that end.

So it has been since the Academy of Medical-Surgical Nurses (AMSN) was founded in 1991. Volunteers have contributed their time and expertise to help the organization grow and meet medical-surgical nurses’ ever-changing needs, and they have helped educate them on evidence-based practice and up-to-date clinical trends. This group of nurses wanted representation for their practice, and they were prepared to become involved— to reach out to their peers and to the public at large—and to work toward promoting medical-surgical nursing as a specialty.

How Does Volunteerism Benefit AMSN?

Volunteerism benefits and grows AMSN in many important ways. Individuals who volunteer for the organization are creative, energetic, and dedicated to advancing the specialty of medical-surgical nursing. They likely have received encouragement and support from many mentors, bosses, employers, and colleagues, and they want to reciprocate by serving their peers through AMSN at the chapter or committee level or by putting themselves up for election to a board position. AMSN has grown (and continues to grow) because of these confident, passionate, and resourceful volunteers. It takes a village.

With over 11,500 members, AMSN has relied on volunteers to form committees, set up chapters in each state, and contribute their clinical knowledge and expertise for the benefit of the members and to advance the specialty of medical-surgical nursing. AMSN now has a Clinical Practice Committee that answers members’ questions online; a committee that offers grants, scholarships, and awards to members; certification in both medical-surgical nursing (CMSRN) and in care coordination and transition management (CCCTM); up-to-date information on the latest evidence-based practice; an Online Library with free contact hours; and the MedSurg Matters! newsletter and the MDSURG Nursing journal, which each member receives as part of their membership. None of this would be possible, or available to members, if it not for volunteers. Members volunteer for the organization, for themselves, and for each other.

Friendships Formed Through Volunteering

Having been a nurse for over 45 years, working in almost all areas of medical-surgical nursing, Mary Behr shared her thoughts on why she has volunteered for AMSN. She explained that during this time, she has learned and benefitted from the support and mentoring of other nurses. “While serving in the Air Force, I needed to become involved in a nursing organization to help with my promotions. I found AMSN, attended a convention, and was hooked.” Mary said she began volunteering for various committees, was involved in writing position statements and policies, and then became a member of the Certification Task Force. “This led to my involvement in helping to establish the Medical-Surgical Nursing Certification Board (MSNCB) and developing the first medical-surgical nursing certification exam,” she said. Mary has also volunteered for the recertification board and the Board of Directors (BOD) nomination task force, and she has served as a CCCTM exam item writer and an AMSN Ambassador. “Through these volunteer opportunities,” she said, “I have made some amazing friendships, have had the opportunity to travel, and been able to network with med-surg nurses and nurses from other specialties from all over the world.”

Proud to Serve

Deirdre Bauer, a current Ambassador for AMSN and MSNCB, described her experiences as a volunteer with the organization. “My first opportunity to volun-
teer came in 2001, when I flew to Atlanta, GA, to meet up with a group of AMSN members and begin the arduous but fascinating task of developing the very first certification exam specifically for medical-surgical nurses. As we developed the exam and worked toward a common goal, the creativity, energy, and dedication of this group was all encompassing, and my engagement with AMSN solidified. My volunteering meant taking time out and increasing my involvement with the organization, but I knew that I was making a difference and helping empower med-surg nurses nationwide as we worked tirelessly to emphasize medical-surgical nursing as a specialty in its own right. My involvement in volunteering with AMSN also allowed me to be a part of the Scholarships and Awards Committee, and it is impossible to define the pleasure we experienced as we gave out monies to help medical-surgical nurses achieve professional goals, work on professional growth, and engage in research.” Deirdre explained that AMSN gives and it receives in the form of volunteerism. “It is a two-way process,” she said. “My experiences over the years and the steadfast relationships that I have formed are all due to my volunteering with this professional organization. I have been given the opportunity to educate, mentor; and learn, and it has been an amazing and memorable relationship. I am truly proud to have been allowed to serve.”

Part of Something Bigger Than Myself

“Volunteering for AMSN has profoundly enhanced and changed the trajectory of my professional development,” said Kathleen Singleton. She added that her personal life had been “enriched beyond measure with the gift of life-long friendships and relationships that go beyond hospital systems, geography, and time zones.” Her first introduction to AMSN was as a volunteer at her local chapter, where she learned about the organization. She realized, “I was part of something bigger than myself.” Kathy then signed up for a national committee. “I was mentored, encouraged, and expected to seek other roles along the way.” She explained the excitement of being a charter member of the Awards and Scholarships group and how they brainstormed ways to give back to the members through research, education, and convention opportunities. “Bringing new information, thinking differently, having a national network of medical-surgical colleagues at my fingertips, and continuously learning, are just a few of the contributions that benefit my workplace daily as a direct result of volunteering with AMSN.”

Memories of Milestones

“Volunteerism only works for me if I am 100% committed to the cause,” explained Cindy Ludwig. “I believe that is what makes volunteering successful to me. It also really helps if the people volunteering with you have that same goal. AMSN had many challenges as a start-up organization, but the volunteers could see the vision and were committed to sharing their great experience with others.” Cindy’s volunteer efforts started early in life as she was growing up in a small town, and when she was old enough, she became a student teacher at her village grade school. She has since held many volunteer roles within AMSN, including the role of President, and she is currently an Ambassador for AMSN and MSNCB. “The lifelong friendships I have made during my years of volunteering are invaluable to me. I have memories of milestones we could not have accomplished alone; but together, we were unstoppable. And we worked hard, but we always had fun! Take that first step and apply for a volunteer position because you will discover that it can enrich your professional and personal life.”

Volunteering and the Personal Touch

Kathleen Reeves also shared her volunteering experiences, stating “It was the personal touch that was the impetus to seek national office with AMSN.” “Professional service is something I have valued since childhood and was one of the missions of my employer.” Kathy stated that she responded to the call for the national AMSN Treasurer position and served four years on the BOD before she sought the office of President-Elect. “I found my experience on the BOD to be very rewarding – meeting passionate med-surg colleagues from across the country, becoming more knowledgeable about my nursing specialty, giving back to the profession, and making life-long friends were but a few of the benefits of serving on the BOD.” Kathy explained that when seeking national office, it is important to have confidence in your own abilities, but it is equally important to have the support and encouragement of your employer and colleagues. “That personal touch can have such an impact,” she said. “When someone approaches you about seeking national experience on a committee, task force, or board, consider it seriously. Take the risk and apply for one or more of those positions. You will be glad you did!”

Receiving More Than You Give

Cecilia Quade is an Ambassador for AMSN and MSNCB. She told her story about volunteering, stating that she started as a member of a local AMSN chapter, participating in several walk/run activities for charities and also at food banks, parades, clinics, and more with her central Indiana chapter. This chapter was granted the coveted National Chapter Award for community involvement. “It gave us national recognition and brought pride to our chapter and community, all while helping others,” stated Cecilia. “I also volunteered to serve the local chapter as an officer on all levels. After receiving the Clinical Practice Award, I was asked to volunteer for the task force and charged to help write the first certification exam. Later, I became one of the first members of the certification board, and I served as lead for the End-of-Life Special Interest Group (SIG).” Cecilia emphasized that she has always believed in volunteerism and giving back to the community. “I always receive so much more than I give emotionally and spiritually. Most of my best friends have been made while volunteering.”

Commitment of AMSN Members

When Marlene Roman prepared for the role of President of the organization, she spent a great deal of time
Caring for Patients with Schizophrenia
On the Med-Surg Unit

Stephanie Kemery

Adult patients with schizophrenia are admitted to medical-surgical units for the same reasons as those without schizophrenia. However, patients with schizophrenia as a co-morbidity have a higher rate of complications and adverse events, and medical-surgical nurses have reported discomfort with caring for them. This article aims to educate and promote personalized, high-quality care.

Patients diagnosed with a serious mental illness (SMI) have an increased risk of also being diagnosed with a chronic illness such as diabetes or cardiovascular disease. Some may have lower levels of access to tertiary care. On average, these patients die 25 years earlier than those without a diagnosis of SMI, often due to medical diagnoses that are considered treatable (Hensel & Flint, 2015; Keltner & Steele, 2015; National Association of State Mental Health Program Directors [NASMHPD], 2006). These patients have an increased rate of complications and adverse events when hospitalized, including nurse-sensitive indicators such as infections and skin breakdown (Assi, 2015).

Many patients who may be classified as seriously mentally ill have an underlying diagnosis of schizophrenia; approximately 1% of adults in the United States are living with schizophrenia (Keltner & Steele, 2015; National Institute of Mental Health [NIMH], n.d.). It can be assumed that nearly every medical-surgical nurse will encounter a patient with schizophrenia in his or her practice. However, studies have shown that non-psychiatric nurses who are charged with caring for patients with a psychiatric co-morbidity tend to view these patients as difficult, unpredictable, complex, and dangerous, resulting in a negative effect on the care provided (Zolnierek & Clingerman, 2012). These attitudes reflect the widespread stigma of mental illness in general and schizophrenia in particular; however, research has shown that education on mental illness can have a modest effect on these negative stereotypes (Dalky, 2012). Therefore, it is the aim of this article to provide medical-surgical nurses with education regarding schizophrenia in order to reduce the associated stigma and improve patient care.

Schizophrenia Myths

Violence

A commonly perpetuated stereotype amongst the public is that people with mental illness in general, and schizophrenia perhaps in particular, are prone to unpredictable and violent outbursts. This is perpetuated by media reports that frequently highlight a diagnosis of mental illness when reporting stories about crime (McGinty, Webster, Jarlenski, & Barry, 2014). Although this myth persists, in fact, most people with schizophrenia are not violent and do not commit violent crimes (NIMH, n.d.). It should be noted, however, that the presence of substance abuse does increase the risk of violent behavior in patients with schizophrenia; these acts of violence are most commonly directed at members of the patient’s own family, not members of the community at large (NIMH, n.d.).

Prognosis

Many patients diagnosed with schizophrenia experience significant, ongoing improvement in symptoms, while many others will achieve somewhat less, but still marked, improvement with some residual disability (Townsend, 2015). Like many other chronic illnesses familiar to med-surg nurses, patients with schizophrenia may experience alternating periods of stability and exacerbation of symptoms (Keltner & Steele, 2015; Townsend, 2015). In order to maintain periods of remission of symptomology for as long as possible, many patients are pre-
scribed antipsychotic medications; it is critical for the nurse to ensure these prescriptions are included on the admission medication reconciliation and addressed by the attending provider.

Symptoms of Schizophrenia

Symptoms of schizophrenia are generally categorized as “positive” or “negative” symptoms. Current theory regarding the origin of these symptoms involves unbalanced levels of the neurotransmitter dopamine in the brain, creating areas in which too much dopamine is present (resulting in the positive symptoms) and areas in which too little dopamine is present (resulting in the negative symptoms) (Keltner & Steele, 2015).

Positive Symptoms

Generally, the easiest way to remember which symptoms of schizophrenia are categorized as ‘positive’ is to think of the symptoms as an ‘addition’ to typical cognition, behavior, and perception (Keltner & Steele, 2015; Townsend, 2015). Patients exhibiting the positive symptoms of schizophrenia may present in a way that a lay person may consider to be almost stereotypical of the disorder. These symptoms include, but are not limited to, hallucinations and delusions.

Hallucinations. Hallucinations are sensory experiences not associated with actual sensory stimuli and are not limited to patients experiencing symptoms of schizophrenia. Most commonly, hallucinations are auditory (Keltner & Steele, 2015) and are often described as “hearing voices.” Auditory hallucinations may be rather benign or may be a frightening experience for the patient, and they can be associated at times with periods of increased anxiety (Townsend, 2015). Indications that a patient may be experiencing auditory hallucinations include tilting of the head to one side (as if listening to someone) and laughing or talking to oneself (Townsend, 2015). If a patient is suspected to be experiencing auditory hallucinations, the nurse should ask the patient directly (Keltner & Steele, 2015; Townsend, 2015). If the patient confirms the presence of auditory hallucinations, the nurse should attempt to discern the content of the hallucinations before providing reassurance to the patient that the hallucinations are not real, even though they seem very vivid to the patient (Keltner & Steele, 2015; Townsend, 2015). Under no circumstances should the nurses reinforce the hallucinations (Townsend, 2015). Once the nurse understands the content of the hallucinations and has assessed for safety concerns, reality-based activities should be utilized as a distraction (Keltner & Steele, 2015; Townsend, 2015). However, if the patient has not experienced hallucinations previously or is experiencing a new form of hallucinations (e.g., visual hallucinations when previously only auditory had been present), then it may be advisable to eliminate causes not related to schizophrenia.

Delusions. Delusions can be described as false, fixed beliefs held by the patient, which cannot be altered by use of logic or reasoning (Townsend, 2015). An example might be that a patient believes that he or she is being followed by the government and no evidence presented to the contrary will convince him otherwise. Frequent types of delusions encountered include delusions of persecution (the example above), grandeur (“I am the President”), or reference (“The news anchor is sending me a message”). The nurse should assess for safety concerns related to the delusions (e.g., the patient believes the staff is attempting to harm him or her) that may put the patient or staff members at risk for harm. Once the content of delusions is understood, the best course of action is to distract the patient with reality-based activities; arguing with the patient about delusions may only serve to strengthen the beliefs (Keltner & Steele, 2015; Townsend, 2015). In the case of patients with paranoid or persecutory delusions, it may be best to consider assigning primary caregivers when possible, to allow for a trusting relationship to develop (Townsend, 2015).

Negative Symptoms

Negative symptoms of schizophrenia may be thought of as diminished functioning; something that is present in a neurotypical person is absent (Townsend, 2015). Patients can experience both positive and negative symptoms simultaneously (Keltner & Steele, 2015; Townsend, 2015). Negative symptoms have historically been harder to treat than positive symptoms, but treatment has improved with newer medications (Keltner & Steele, 2015).

Antipsychotics

Antipsychotics are typically categorized as “typical” (first-generation/traditional) or “atypical” (second-generation). Each categorization has side effects common across medications in the group, though some side effects, such as sedation, anticholinergic effects, and orthostatic hypotension, can be seen with both typicals and atypicals (Keltner & Steele, 2015). For patients on antipsychotics of any type, it is therefore prudent to monitor the patient closely for fall risk and to implement fall precautions as necessary. Additionally, the timing of the medication may be important when dealing with the side effect of sedation, and nursing interventions can be utilized to compensate for anticholinergic side effects such as dry mouth, urinary retention, and constipation.

Typical Antipsychotics

Traditional antipsychotics include the commonly used haloperidol (Haldol®) and other drugs that frequently end in the suffix “-azine” (Keltner & Steele, 2015). In addition to the previously mentioned sedation and orthostasis, typical antipsychotics are much more likely to cause elevated prolactin levels and extrapyramidal side effects.

Elevated prolactin levels. Dopamine is a natural inhibitor of prolactin, but traditional antipsychotics block dopamine; the result is elevated levels of prolactin (Keltner & Steele, 2015). Elevated levels of prolactin can lead to amenorrhea, impotence, gynecomastia, and galactorrhea, all of which are potentially distressing to patients (Keltner & Steele, 2015).
**Extrapyramidal side effects.** Extrapyramidal side effects (EPSEs) are more commonly associated with the typical antipsychotics. EPSEs are caused by an imbalance between acetylcholine and dopamine in the brain and are usually treated by administering an anticholinergic agent, such as benztropine (Cogentin®) or diphenhydramine (Benadryl®); this may be administered intramuscularly in emergent situations or orally in patients who are known to be susceptible (Keltner & Steele, 2015). Some of the most serious EPSEs that may be seen on the medical-surgical unit are involuntary muscle spasms (dystonias) of the neck (also called torticollis), the eye muscles (oculogyric crisis, in which the eyes are locked in an upward position), and the airway (potentially life-threatening due to obstruction) (Keltner & Steele, 2015). A patient experiencing severe EPSEs in association with a high fever should be suspected of having neuroleptic malignant syndrome (NMS), a potentially fatal complication requiring immediate intervention (Keltner & Steele, 2015).

**Atypical Antipsychotics**

Atypical antipsychotics commonly end in the suffixes “-apine” or “-idone,” such as olanzapine (Zyprexa®), quetiapine (Seroquel®), risperidone (Risperdal®), and ziprasidone (Geodon®) (Keltner & Steele, 2015). While atypical antipsychotics have a lower risk of EPSEs, they do carry their own troublesome side effect: many frequently cause weight gain associated with insulin resistance and carbohydrate cravings (Keltner & Steele, 2015). Patients on atypical antipsychotics are also at risk for developing metabolic syndrome, characterized by increased abdominal girth, dyslipidemia, hypertension, and elevated fasting glucose (Keltner & Steele, 2015). Therefore, the medical-surgical nurse should counsel these patients on the importance of diet, exercise, and blood pressure monitoring. It would also be advised to request a lipid panel if one has not been completed recently and an A1C to check long-term glycemic control.

**Conclusion**

Caring for a patient with a mental health co-morbidity can be intimidating to the medical-surgical nurse without a background in psychiatric nursing. However, the majority of patients are not inclined toward violence, and with the proper treatment, many patients lead fulfilling lives. When medical-surgical nurses have a basic understanding of the needs of their patients with mental illness, they are better equipped to provide high quality care in order to assist their clients in returning to an optimal level of health.

**References**


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25 Years of Volunteering for AMSN

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reflecting on what makes medical-surgical nursing special. A large part of her answer was the uniqueness of the nurses within the specialty and their willingness to participate in growing the organization. Marlene shared that her first exposure to AMSN was from Annette Levitt, one of the members of the steering committee. Annette informed her staff about this new organization that was to represent the thousands of medical-surgical nurses across the country. Marlene remembers, “We started a local chapter and attended the first annual convention in Chicago. The participants at this convention were not only having fun but were caught up in the excitement of learning. They had a pride in their specialty that shined in their eyes and on their faces.” Marlene related that one of the unique qualities she has seen at AMSN’s national conventions is the level of enthusiasm, and members are eager to share their experiences, clinical problems, and successes. “Something else that I saw as I attended conventions and became more involved with the organization,” Marlene said, “was the commitment of AMSN members to become involved.”

Why Volunteer?

Different people volunteer for different reasons. Those who volunteer for AMSN appreciate the opportunity to serve others and truly want to give back. The networking and friendships that are created allow them to share their clinical knowledge and their enthusiasm with members who may not have previously considered volunteering. AMSN volunteers aim to empower members and help them recognize their potential, encouraging them to start at whatever level makes them feel comfortable. Each volunteer brings diverse assets that enrich AMSN and make it a successful professional organization. Volunteerism gives one the opportunity to celebrate successes and to realize that the contributions of one can benefit many.

AMSN gives back to its members through research, education, and convention opportunities, and allows its volunteer members to gain experience and increase their confidence in areas such as public speaking, leadership, and team-building. To volunteer for AMSN is to gain a sense of achievement and satisfaction in giving back to your peers, to serve with fellow dedicated colleagues, and to make lifelong connections and friendships.

Volunteering for AMSN gives one the opportunity to educate, build relationships, form friendships, and make connections. There are many task forces, committees, and chapters to get involved with, each offering a different area of interest and a chance to help improve the quality of medical-surgical nursing. You also have the knowledge that you are part of a community with a national voice and that your expertise is valued; there is the ‘feel good’ factor in the knowledge that you are making a difference. You know that your involvement as a volunteer is going to encourage and assist medical-surgical nurses to reach their full potential and will result in improved patient care with positive patient outcomes. You can incorporate your career and nursing experience into a volunteer role, as they work together hand in hand, and you can allow yourself to be totally taken in by the experience.

How to Get Involved

Getting involved is easy! 1) Join AMSN. 2) Attend a convention if possible; there are grants available through the organization to help offset the costs. 3) Go to the website (www.amsn.org) and look through the various volunteer units. When you see a “call for volunteers” for one of these or a new task force that interests you, submit an application. If you are not chosen, respond to another call. 4) Find out if there is a local chapter in your area, and become involved with that chapter.

Each AMSN member is important to the success of the organization, and everyone brings their own qualities and talents to AMSN. Many of the volunteers mentioned in this article have been active members and volunteers for 20 years or more, and they continue to volunteer because they have seen how AMSN has grown and continues to grow, and they take pride in the knowledge that they have contributed to that growth.

Reference


Ambassadors for AMSN and MSNCB

Deidre Bauer, BSN, RN, CMSRN
Retired Nursing Supervisor

Mary Behr, MSN, RN, CMSRN, CCM, CCCTM
Retired
Volunteer for Mission of Mercy and Circle the City

Ann DiAgostino, MSN, RN, CMSRN, NEA-BC
Nurse Administrator – Med-Surg
Orange Regional Medical Center
Middletown, NY

Cindy Ludwig, BSN, RN, MS, CMSRN
Retired Med-Surg Nurse Manager
Director of Roy and Patricia Disney Family Cancer Center

Cecilia Quade, MSN, RN, CMSRN, CHPCA, NE-BC
Retired Director of Nursing
Franciscan St. Francis Health

Kathleen Reeves, MSN, RN, CMSRN, CNE
Retired Faculty
University of Texas Health Science Center at San Antonio

Marlene Roman, MSN, RN, ARNP, CMSRN
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Kathleen Singleton, MSN, RN, CNS, CMSRN
Clinical Nurse Specialist Medical-Surgical Nursing
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High residual volume and the practice recommendations of ASPEN were not addressed in the hospital policy or practice. To bridge this practice gap, an algorithm (see Figure 1) was created by the research team using the ASPEN guidelines (Bankhead et al., 2009) for an intensive care unit (ICU). The research team developed a study to evaluate nurses’ knowledge of managing enteral feedings before and after implementation of this algorithm. The Institutional Review Board approved this study.

**Methods**

The researchers constructed a handwritten survey to ascertain the base knowledge of nurses who worked in the ICU regarding the management of enteral feedings before an educational intervention. The survey questions included:

**Figure 1.**

ICU Gastric Feeding Guideline for Adults

**GOAL:** To safely deliver $>80\%$ of required calories daily.

*Follow if no specific orders from the physician*

- Measure residuals q4hr after initial feeding started then q4hr and PRN while feedings continue.
- **Gastric Residual < 250 mls**
  - Replace residual.
  - Flush with 30 mls of water or Normal Saline (as ordered by physician).
  - Maintain rate if feeding goal has been attained.
  - OR
  - Continue to increase feeding rate every 4 hrs or as ordered to reach goal rate.
- **Gastric Residual > 250 mls x 1**
  - Replace residual.
  - Flush with 30 mls of water or Normal Saline (as ordered by physician).
  - Continue current rate.
  - Recheck residual in 4 hours.
  - Replace 500 mls of the residual. Discard the rest and document as output.
  - Flush with 30 mls of water or Normal Saline (as ordered by physician).
  - Stop feeding for 2 hours and if $> 500$ mls, notify MD.
  - Assess for abdominal distention or pain.
  - Evaluate hyperglycemic control.
  - Evaluate effects of pain medication.
  - Consider minimizing sedation.
  - Consider promotility agent such as metoclopramide.
- **Gastric Residual > 500 mls**
  - Replace 500 mls of the residual. Discard the rest and document as output.
  - Flush with 30 mls of water or Normal Saline (as ordered by physician).
  - Stop feeding for 2 hours and if $> 500$ mls, notify MD.

**Note:** Algorithm developed using guidelines from Bankhead et al. (2009).
• Do you flush after residual checks?
• If so, how much do you flush with?
• How often do you check residuals of enteral feedings?
• When do you hold enteral tube feedings?
• Do you ever discard enteral feeding residuals?

The research team displayed a poster in the ICU and gave a podium presentation at the ICU unit-based council meeting and unit meeting to educate all nursing staff to the new algorithm. The new algorithm was then implemented. Three months after the implementation of the algorithm, nurses voluntarily completed a post-intervention survey over a period of two weeks. The post-intervention survey included an additional question, “Have you noticed any deleterious changes in your patient since the implementation of the new algorithm?” for the protection of the participants.

**Results**

Standardization of nursing practice in the management of enteral feeding improved. There was an increase in the number of nurses who changed their practice to coincide with the new algorithm based on the management of enteral feedings (see Figure 2). The educational interventions affected nursing knowledge, which transferred to nursing practice as evidenced by the survey results.

**Conclusions**

Recommendations for this study include the repeating of this study in a similar setting with a focus on patient outcomes related to this innovative algorithm. Implementation of enteral feeding management algorithm and education intervention improved the nurse’s knowledge with standardization at the bedside. Evidence-based practice is the best resource to guide the management of enteral feedings. An algorithm enables nurses to understand the guidelines in a visual format. The greatest challenge becomes changing the nurse’s established behaviors to include this evidence-based practice. The algorithm, and consequently the evidence-based practice, is now a part of the organization’s culture, policy, and practice.

**References**


**Barbara Damratowski, BSN, RN, CCRN,** is a Charge Nurse, CHI Health Good Samaritan Hospital, Kearney, NE.

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What’s Involved in Becoming A Nurse Legislator?

As a nurse, are you aware of all your professional voice can offer? Nursing is a profession rich and broad in opportunities, but do you really know what it means to be a professional nurse? It means we are strong, mighty, and powerful in numbers. Medical-surgical nurses comprise 80% of the nursing workforce, and membership within the Academy of Medical-Surgical Nurses (AMSN) is currently over 11,000 members strong! That’s a lot of representation, which supports the point that nurses have identity and agendas. Our unified professional voice means we can make a difference in the workforce by advocating on the political front. Yes, nurses can legislate for a cause.

Nurses represent the largest portion of the health care workforce and are continually viewed as the most trusted profession, but unfortunately, nursing has traditionally remained silent and nearly removed from the political process (Lanier, 2014); however, that can be altered. Each year, the city of Washington, DC, welcomes a convergence of representatives from many organizations, and a great number of them represent the health care industry. These individuals arrive prepared to lobby and advocate on behalf of their group’s interest. This same concept can be adopted in representing nursing concerns such as staffing safely for clinical nurse-to-patient ratios and the importance of bills such as the “Right to Practice” for our Nurse Practitioners within the Veterans Health Administration. Even though nursing organizations have membership numbers that speak volumes, professional nurses still lack in recognizing their advocacy and lobbying abilities.

Advocacy and Nursing Involvement in the Legislative Process

Advocacy is defined as giving “active support, especially of a cause” (Antill, 2015, p. 94). As a professional nurse, you can begin to become involved in influencing policies on a local, state, and national level. Are you a member of your workplace shared governance committee? If not, then you should consider joining and commit to becoming involved. That’s a great place to start! As nurses, we practice advocacy in daily patient care. We advocate for our patient care needs, improvements on our nursing units, and often within the health care organization. Nursing has traditionally advocated for its patients, which is central to nursing ethics and can at times create conflict within the multi-disciplinary team (Antill, 2015). Such conflict can occur as the nurse takes action to protect a patient from a real or perceived threat, but historically nurses have identified and taken action to meet the needs of their patients (Maryland & Gonzalez, 2012). This is a clear example of how much influence the nursing profession holds and how it is equipped in power. A nursing pioneer by the name of Florence Nightingale famously advocated for improvements in hospital sanitation. As a result of her advocacy efforts, survival rates greatly increased among soldiers during the Crimean War. Lillian Wald, another pioneer in nursing advocacy, succeeded in using the political system to change policies concerning public health such as sanitation and child labor laws (Chen, 2013).

Nurses may choose to believe their interests lie outside of the policy process, but the reality is that the nursing profession needs to be present throughout the legislative process. Nurses unified by shared advocacy efforts can create a powerful force to promote legislation in support of the nursing profession (Lanier, 2014). There are many opportunities available to assist nurses in bringing their passion for advocating for others to a broader stance, specifically in the legislative arena.

This recently became evident when a group of us from the AMSN Legislative Team traveled to Washington, DC, for the Nurse in Washington Internship (NIWI) conference to attend a three-day advocacy training. The goal was for nurses to network with other nurses with similar clinical and political interests and to discuss nursing concerns. The training
included panel sessions led by professional nurse advocates and congressional representatives.

Nurses attending the NIWI event learn skills to influence the legislative process. Through utilization of these skills, nurses can provide valuable information to their State Representatives and Senators. These congressional leaders are in a position to facilitate navigating bills through the legislative process. The first step in the legislative process is for an individual to want to address a concern or pressing issue. According to Maryland and Gonzalez (2012), nurses should be prepared to discuss issues factually to support their position with credible research and to present information in a succinct manner using common terminology. Once their issue is communicated to legislators, a bill can be drafted, introduced, and if enough support is present on an issue, the bill will be recognized. Nurses should be aware that this process is an achievable goal for the profession.

Spending a Day on Capitol Hill

Spending a day on Capitol Hill was the most rewarding experience. It involved nurses from many disciplines coming together as a nursing community for common goals, to discuss what matters most to our profession, and to disseminate the information to our individual Senators and Representatives. Nurses do a very good job in talking with many different people from all walks of life; discussing topics of health and the health care needs of our patients comes easy. However, we are not often given the opportunity to talk about our individual experiences, to express our concerns about the needs of the nursing workforce, or offer ideas to policymakers. Going to Capitol Hill gave us that chance.

Our journey to Capitol Hill began before leaving home. Each nurse was responsible for scheduling appointments to meet with his or her individual House of Representatives member. This process was fairly effortless and is open for any constituent to do. Essentially, one can start an online search by looking up a state’s congressional representative. Once information has been obtained, the individual can make contact by either email or phone. When arranging your appointments, you should clearly describe the nature of your visit so that the appropriate staffer is assigned to meet with you. Many times, a staffer is assigned to meet you in lieu of your state representative. This is due to prior scheduled congressional obligations. The staffer is perfectly equipped and knowledgeable to answer questions and record information of your visit to communicate to your state representative.

While going to the Capitol is a serious endeavor, the message each of us delivered individually and as a group to our Representatives and Senators meant we were powerful in numbers. Over the three-day meeting, the Nursing Organizations Alliance (2016) prepared us with information packets to deliver and leave with staff members as reference materials for our Representative and Senator. Depending on the legislator’s political party and/or assigned role in the House or Senate, our message had mixed reactions from the legislative assistants during our visits. During the meeting, we made our “asks” clear and requested support from our representative. After our meeting with the staffers, many of us quickly realized a much harder push in getting our information to our congressional persons was warranted. This was an eye-opening experience of what legislating is truly about.

The experience on Capitol Hill prepared and equipped us with messages of hope to introduce to our legislators in an effort to support nursing causes such as its workforce to ensure best patient outcomes. More importantly, the experience taught us how to present ourselves as advocate leaders and nursing legislative experts. It also aided in our being able to clearly communicate our message of support to our legislators. Was our goal met? Sure it was because as nurse constituents, we are the experts on the topics of nursing con-
licensed and board-certified APRNs would be able to provide care for these patients without restrictions. This is particularly important in rural and underserved areas where which decreases patient backlog. The 3,600 nationally – men and women – to have increased access to providers, the veterans without restrictions within practice agreements. More importantly, the Act will allow veteran patients the collaborative agreements that the APRNs are required to have to practice.

In summary, nurses should know there are abounding opportunities for nursing advocacy in the political arena, and perhaps the most important is to provide support for the nursing profession and its workforce. The NIWI program provides nurses an introduction to the important area of advocacy (Nursing Organizations Alliance, 2016). The advocacy training designs a program to allow for discussion on how best to work effectively with legislative staff to advance nursing policy agenda and also introduce steps to effect change in the legislative process. Part of the training aids in identifying legislative, political, and economic forces driving health care policy to deliver change. Learning to schedule a meeting for a Capitol Hill visit and role-playing in preparation for our big day on Capitol Hill were both a part of a rewarding experience to remember. We encourage fellow nursing colleagues to consider the role of the nurse legislator.

References

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Mr. L., 70-year-old male, presented to the emergency department (ED) via ambulance, accompanied by his brother. Mr. L.’s brother stated that they were eating breakfast together when Mr. L. began to speak incoherently and slur his speech. Mr. L.’s brother explained that the sudden change in his brother prompted him to call 911 immediately. He also noted the time of the incident coincided with the beginning of the television program they were watching.

Mr. L. was verbal, but unable to answer accurately any questions. His speech was slurred, and responses to questions were inappropriate. Mr. L. was unable to verbalize medical history; however, his brother stated that Mr. L. takes “pressure pills” and also a “water pill.” Mr. L. was not wearing any medical alert devices.

Mr. L.’s vital signs were: temperature 99 degrees Fahrenheit (F), pulse 118 beats per minute (BPM), respirations were rapid and shallow at 26 per minute, blood pressure measured 188/116 millimeters of mercury (mmHg), pulse oximeter reading was 88% on room air. An accurate weight of 74.5 kilograms was obtained using the bed scale. Mr. L. had pronounced left-sided facial drooping as well as ptosis of the left eye and significant weakness in his left arm and leg.

Before arrival in the ED, paramedics inserted an 18-gauge intravenous (IV) catheter. They also performed a capillary blood glucose in route, which resulted as 100 milligrams per deciliter (mg/dL). Upon arriving in the emergency department, the triage nurse placed Mr. L. on 2 liters per minute (LPM) of oxygen via nasal cannula (N/C) and utilized The National Institutes of Health Stroke Scale (NIHSS) to assess Mr. L. The NIHSS is a standard tool to determine the severity of the stroke and identify a variety of treatment options based on neurological presentation of deficits (National Institutes of Health, 2003). The original NIHSS tool served a 15-item scale; however, four items on the scale were removed to create an 11-item scale. The 11-item scale (see Table 1) serves as an effective and efficient assessment measure for utilization by a broad range of practitioners. In addition, increased reliability and validity scores resulted from the use of the 11-item scale as compared to the 15-item scale (Hinkle, 2014). Each category of the 11-item scale was assessed. The resulting NIHSS score was 17.

Using the NIHSS score as a guide, it was determined that the patient had a stroke with moderate to severe impact. Cardiac enzymes were drawn. Within eight minutes of Mr. L.’s arrival, the nurse completed an electrocardiogram (ECG) and placed a cardiac monitor. The ECG showed sinus tachycardia. The attending provider then ordered a computed tomography (CT) of the head. Mr. L. was transported to CT scan by the nursing supervisor and transporter. After the CT scan, Mr. L. was then transported back to exam room five in the ED, where the nurse continued her assessment.

According to the electronic medical record, the patient had a past medical history of Stage II hypertension (HTN), gastroesophageal reflux disease, and lung cancer with metastasis to the spine. He recently finished chemotherapy and radiation treatments. Past surgical history included an appendectomy forty years ago and intraspinal surgery one week ago for removal of lesions. Current medications included

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### Table 1.
**Condensed National Institutes of Health Stroke Scale (NIHSS)**

<table>
<thead>
<tr>
<th>NIHSS Item</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Level of Consciousness (LOC)</td>
<td>0 – 3</td>
</tr>
<tr>
<td>1b. LOC Questions</td>
<td>0 – 2</td>
</tr>
<tr>
<td>1c. LOC Commands</td>
<td>0 – 2</td>
</tr>
<tr>
<td>2. Best Gaze</td>
<td>0 – 2</td>
</tr>
<tr>
<td>3. Visual</td>
<td>0 – 3</td>
</tr>
<tr>
<td>4. Facial Palsy</td>
<td>0 – 3</td>
</tr>
<tr>
<td>5. Motor Arm and Leg a. Right Arm b. Left Arm</td>
<td>0 – 4</td>
</tr>
<tr>
<td>6. Motor Arm and Leg a. Left Leg b. Right Leg</td>
<td>0 – 4</td>
</tr>
<tr>
<td>7. Limb Ataxia</td>
<td>0 – 2</td>
</tr>
<tr>
<td>8. Sensory</td>
<td>0 – 2</td>
</tr>
<tr>
<td>9. Best Language</td>
<td>0 – 3</td>
</tr>
<tr>
<td>10. Dysarthria</td>
<td>0 – 2</td>
</tr>
<tr>
<td>11. Extinction and Inattention (formerly Neglect)</td>
<td>0 – 2</td>
</tr>
</tbody>
</table>

*Source:* Adapted from NIH, 2003.
esomeprazole 40 mg daily, lisinopril 40 mg daily, hydrochlorothiazide 50 mg daily, and acetaminophen-oxycodeone 5 mg/325 mg every 6 hours as needed for pain.

The ED physician reported that the results of the CT showed an infarct of the middle cerebral artery (MCA). Active hemorrhage was excluded. Mr. L. was then evaluated for the administration of alteplase (tPA). Due to his recent intraspinal surgery, tPA was contraindicated. Cardiac enzymes were negative. The nurse continued to measure the blood pressure, which did not necessitate intervention at the time. Blood pressure measurements necessitating intervention in this case are systolic > 220 mmHg or mean arterial pressure (MAP) of ≥ 130 mmHg (Lewis, Dirksen, Heitkemper, & Bucher, 2013). The nurse inserted a Foley catheter to prevent urinary retention per the orders. Mr. L. was then admitted to the medical-surgical unit with remote telemetry monitoring.

Clinical Decisions

Based on the clinical presentation and CT of the head, acute ischemic stroke versus hemorrhagic stroke was suspected. Mr. L. had no recent history of head trauma, and his coagulation studies were within normal limits. Ruling out hemorrhagic stroke is an integral step in the clinical decision pathway for the care of ischemic stroke. Hemorrhagic stroke occurs when there is a bleed in the brain that compresses the surrounding brain tissue (American Heart Association/American Stroke Association, 2016). Ischemic stroke occurs when there is a disruption in blood flow to the brain due to thrombi or emboli. First line treatment in ischemic stroke is the administration of tPA, a fibrinolytic used to potentially dissolve the clot, thereby restoring blood flow to the affected brain tissue. Once a hemorrhagic stroke is ruled out, medical staff must assess the appropriateness of fibrinolytic therapy through the use of a fibrinolytic checklist. In this case, Mr. L. was unable to undergo tPA administration due to his recent spinal surgery; therefore, he received 300 mg of aspirin (ASA) rectally. ASA is the drug of choice for patients with ischemic stroke who are not candidates for fibrinolytic therapy (ACLS Training Center, 2016; Vallerand & Sanoski, 2014). Remote telemetry is indicated for a minimum of the first 24 hours after recognition of stroke to identify a cardiac arrhythmia that may contribute to the risk of ischemic stroke of a cardiogenic nature.

Upon admission to the medical-surgical unit, Mr. L. received oxygen at 2-4 LPM via N/C with instructions to titrate to keep oxygen saturation greater than or equal to 92%. Ischemic stroke patients often present with hypoxia. Hypoxia has been associated with poor outcomes following acute ischemic stroke (Jauch et al., 2013). Labs were drawn including a comprehensive metabolic panel (CMP), complete blood count (CBC) with differential, prothrombin time/partial thromboplastin time (PT/PTT), international normalized ratio (INR), and lipid profile.

The attending ordered a neurology consult in addition to consults for physical therapy (PT) and occupational therapy (OT). Mr. L. remained NPO pending the results of a swallowing study and speech pathology consult to assess for dysphagia. Mr. L. underwent a carotid ultrasound (U/S) to evaluate the patency of the common carotid arteries. Plaques forming in the lumen of the carotid arteries may rupture, leading to emboli that travel to the smaller vessels of the brain, leading to a cerebral vascular event (McCance & Huether, 2014). The patient also underwent Doppler U/S of the bilateral lower extremities to assess for superficial and deep vein thrombosis (DVT) (Lewis et al., 2013). While hospitalized, Mr. L. received 40 mg of subcutaneous enoxaparin sodium daily to prevent DVT and pulmonary embolism (PE). Both DVT and PE are potential complications of immobility associated with stroke (American Association of Neuroscience Nurses [AANN], 2008). The attending provider ordered fluid replacement with IV normal saline solution (NSS) at a rate of 125 mL/hour. Fluid balance should be positive for at least the first 24 hours following acute stroke as dehydration is associated with a less favorable outcome after a cerebral vascular thrombotic event (AANN, 2008).

Immediate Interventions

Upon receiving the patient, the medical-surgical nurse completed an assessment, monitored vital signs and neuro-
logical checks every four hours, and completed the NIHSS daily. Vital signs were: temperature 99 degrees F, pulse 130 BPM, respirations 20 per minute, and blood pressure 158/86 mmHg; Glasgow Coma Scale (GCS) was 15, and the NIHSS score was 17. The health care provider allows the patient with an acute ischemic stroke to be slightly hypertensive, systolic blood pressure from 140 to 160 mmHg, to promote cerebral tissue perfusion. Mr. L. maintained bed rest with the head of the bed (HOB) elevated between 25 and 30 degrees to prevent a decreased blood flow to the brain (Ignatavicius & Workman, 2015).

Mr. L’s nurse received the results of the previously ordered lab tests. The CBC showed a slight normocytic, normochromic anemia with a hemoglobin of 10.1 g/dL. These results likely reflected an anemia of chronic disease and could be attributed to Mr. L’s metastatic cancer. The attending ordered a repeat CBC in 8 hours to trend results and rule out occult blood loss. The CMP was remarkable for a serum potassium of 5.3 mmol/L, alkaline phosphatase of 591 IU/L, and estimated glomerular filtration rate of 72 mL/min. Glucose was within normal limits (WNL) at 98 mg/dL. NSS remained as the maintenance IV fluid as there was no need for potassium or glucose replacement. Elevated alkaline phosphatase is a common finding in metastatic cancer patients due to bone destruction. Mr. L’s glomerular filtration rate classified him as having stage two chronic kidney disease (Leeuwen, Poelhuis-Leth, & Bladh, 2013). The PT/PTT and INR were WNL for the patient. Finally, Mr. L’s lipid profile showed a total cholesterol of 241 mg/dL with an HDL of 35 mg/dL, triglycerides of 120 mg/dL, and calculated LDL of 182 mg/dL. According to the American College of Cardiology and the American Heart Association (Stone et al., 2013), these results made Mr. L a candidate for moderate to high-intensity statin therapy. Once Mr. L resumes oral medications, atorvastatin 40 mg daily will be added.

**Ongoing Interventions**

Mr. L’s vital signs were stable 24 hours post admission to the medical-surgical unit: temperature 98.8 degrees F, pulse 88 BPM, respirations 20 per minute, and blood pressure 150/78 mmHg. Remote telemetry monitoring indicated that Mr. L remained in normal sinus rhythm with no cardiac arrhythmias. Mr. L’s remote telemetry monitor was discontinued. Neurological checks continued every four hours, revealing Mr. L was alert and oriented to person, place, time, and event with a GCS score of 15. Mr. L recognized that he was hospitalized due to stroke. He responded to commands as well as yes and no questions. His speech remained slurred, but appropriate. Significant weakness remained on the left side. The NIHSS score was 11. Results of the carotid U/S showed 60% narrowing of the left carotid artery and 40% narrowing of the right carotid artery. These findings were consistent with the patient’s presentation of an ischemic stroke. Upon discharge, the patient will need to meet with a vascular surgeon for possible treatment. The Doppler U/S was negative for any SVTs or DVTs. Repeat lab work showed Mr. L now had a potassium level of 4.5 mmol/L and a hemoglobin of 10.0 g/dL. The previously elevated potassium level was likely related to dehydration, and the stable hemoglobin ruled out any bleeding concerns (Leeuwen et al., 2013).

Following the results of the swallowing study, Mr. L was advanced to crushed medications with apple sauce. Mr. L’s daily home medications were resumed as well as metoprolol tartrate 25 mg daily, atorvastatin 40 mg daily, and chewable ASA 325 mg daily. Mr. L was scheduled for a swallowing evaluation of a mechanical soft diet and honey-thickened liquids. Mr. L’s diet orders were determined pending this observation. Nursing staff assisted Mr. L with meals and carefully monitored his intake and output. The Foley catheter and IV fluids were discontinued. Nursing staff assisted Mr. L with the bedside urinal while calculating urine output every shift.

Oxygen therapy was titrated downward to maintain at least 92% oxygen saturation. Mr. L remained on 2 LPM of oxygen via N/C with regular pulse oximetry spot checks, showing his oxygen saturation to be between 92-94%. The nurse assisted Mr. L with incentive spirometry every hour during his bed rest to enhance pulmonary function.

PT’s initial assessment recommended range of motion exercises. Mr. L completed physical therapy exercises daily with a trained physical therapist. Mr. L participated in active range of motion on his right side to maintain strength and ability. Passive range of motion was completed on his left side at the bedside with assistance every shift. An assessment by OT was completed, and the therapist began working with Mr. L to resume autonomy in activities of daily living.

A social service consult was completed to help transition Mr. L to a rehabilitation facility and eventual home planning. The attending physician also made a courtesy consult for Mr. L’s oncologist.

**Summary**

Four days post admission, Mr. L was discharged to a local rehabilitation facility on his previous home medications with the addition of enoxaparin sodium and warfarin sodium. The patient remained on enoxaparin sodium until his INR was within the therapeutic range of 2.0 to 3.0 (Leeuwen et al., 2013). Before transfer to the rehabilitation facility, Mr. L’s neurologist, oncologist, and social worker met with Mr. L and his brother to discuss Mr. L’s prognosis. Because only the left side of Mr. L’s body was impacted by the stroke, there was a good chance that Mr. L would gain some function back in his left arm and leg, and his speech and swallowing abilities would likely continue to improve (American Heart Association/American Stroke Association, 2016; Lewis et al., 2013). PT, OT, speech therapy, and palliative care services continued to help Mr. L regain the highest level of function possible. In this case, aggressive treatment was not pursued due to Mr. L’s terminal cancer diagnosis. Due to quick recognition of stroke symptoms by his brother, Mr. L had a good prognosis to continue his life with the highest quality of function.

**References**

Ischemic Stroke
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Leeuwien, A., Poelhuis-Leth, D., & Bladh, M.L. (2016). Gina Harrison, ASN, RN,

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