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From the Editor

The American Association of Critical-Care Nurses defines critical care as a “specialty within nursing that deals specifically with human responses to life-threatening problems.” It’s that human response from nurses that often stands out in the minds of patients and their families. Whether it’s taking the time to explain a procedure in the ICU or listening to a family member’s concerns in the emergency department, a critical care nurse makes a difference.

This special issue of ADVANCE for Nurses focuses on several aspects of critical care nursing.

Gunshot wounds can be one of the most complicated traumas nurses encounter. “Gunshot Wounds to the Brain” examines immediate and long-term challenges critical care nurses can encounter with this patients. Your assessment of how the patient is doing day to day is crucial, as is your work with patients and families as patients begin to recover.

In “Nurse-Driven Infection Control Measures,” you’ll hear how nurses around the country are working with the CDC’s National Healthcare Safety Network to report incidences of central line-associated bloodstream infections. How have data mining techniques worked for you?

Some may tend to think of nurse leaders as outgoing, expressive people. But what if you’re opposite, someone who prefers to observe and work with small groups? “The Introverted Leader” offers tips for being a successful leader even if you’re not a gregarious person by nature.

Nurses tend to develop close relationships with patients and families, particularly families of pediatric patients. Those relationships can become extremely important for families struggling with transitions to end-of-life care for young patients. The nurses profiled in “End-of-Life and Kids” offer insight into how they work with families at this difficult time.

This special issue also features news about honors and achievements of nurses in the region. For more regional information, visit www.advanceweb.com/NurseMidAtlantic.

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Pamela Tarapchak

How to Contact Us: Merion Matters, ADVANCE for Nurses, Midwest, 3100 Horizon Drive, King of Prussia, PA 19406-0956 On the Web: www.advanceweb.com ▶ E-mail: advance@advanceweb.com ▶ Editorial: 800-355-5627 ▶ Pamela Tarapchak, Editor, ptarapchak@advanceweb.com, ext. 1360 ▶ Barbara Mercer, Managing Editor, bmercer@advanceweb.com, ext. 1282 ▶ Robin Hocevar, Senior Regional Editor, rhocevar@advanceweb.com ▶ Linda Jones, Editorial Director, ljones@advanceweb.com, ext. 1229 ▶ Article Reprints: 800-355-5627, ext. 1446 ▶ Subscriptions: 800-355-1088 ▶ To place an ad, call our Sales Department: 800-355-JOBS (5627)
Over the past decade, hospitals and health systems have implemented a number of nurse-driven initiatives to reduce their incidence of central line-associated bloodstream infections (CLABSI).

Recognizing the importance of gathering and comparing successful efforts, the Centers for Medicare & Medicaid Services (CMS) now requires all hospitals to collect and report their incidences of CLABSI using the CDC’s National Healthcare Safety Network (NHSN). The CLABSI rates for each healthcare facility will be posted on the Hospital Compare website www.hospitalcompare.hhs.gov/. Ultimately, the data will be used to establish prospective payments for these complications in fiscal year 2013.

Working With NHSN

According to Barbara Goss-Bottorff, BSN, RN, CIC, director of infection prevention at Hoag Memorial Hospital Presbyterian, Newport Beach, CA, practitioners in her state have an advantage because of their history with NHSN.

“Data reporting is challenging because, as infection preventionists, we’re receiving reporting requirements from a number of different directions and, unfortunately, they can vary a great deal,” she acknowledged.

“It can be difficult to gather and format data for various purposes. California has decided to use NHSN for their data reporting, which provides specific definitions for events such as central line-associated bloodstream infections. It’s taken time to train everyone to use the NHSN definitions, but now we’re ahead since CMS is using NHSN definitions as well.”

Still, NHSN has its drawbacks.

“It was designed as a voluntary hospital-based reporting system to monitor healthcare-acquired infection rates, and not for national data reporting,” explained Goss-Bottorff.

“It has undergone a number of changes over the years and there are some limitations with its definitions. However, it’s the most effective tool we have, as long as we train the clinicians gathering the data and the people reporting it.”

Infection preventionists at Hoag make good use of the infection prevention module within their electronic medical system.

“We can use it with our surveillance procedures, but we’re working with our IT staff to create an interface for us to upload data to NHSN,” said Goss-Bottorff. “Currently, there’s a great deal of data to enter into NHSN by hand, and NHSN can accept data uploads only in very limited ways.”

The electronic system allows infection prevention staff to know immediately when there’s a positive culture result from the lab.

“Instead of getting a stack of paper results to review every day, we can access results anytime,” said Goss-Bottorff. “Once we have the results, we review the medical record, including the nursing and physicians’ notes, against established criteria for a primary central line-associated infection. We can discuss our findings and share results with the clinicians involved in the care of the patient.”

Consistency Is Key

Sinead Forkan Kelly, BSEH, RN, CIC, infection control professional for the NICU, PICU and pediatric units at Advocate Lutheran General Hospital, Park Ridge, IL, described how her organization currently gathers and reports data about CLABSI through NHSN.

“There’s a very specific process about how to apply their definitions for primary and secondary infections, and in-depth training on the use of the system,” she said. “We use a
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APIC, the professional organization for infection preventionists, provides Forkan Kelly and her colleagues with focused education about consistent definitions and data reporting.

“At a recent conference in Springfield, a CDC representative did a presentation and ran through various scenarios around data reporting,” she said.

“NACHRI, the National Association of Children’s Hospitals and Related Institutions, also has done a study about applications of NHSN definitions and provided direct feedback to professionals.”

Data mining software provides more timely information about CLABSI and other hospital-acquired infections.

“We report that data to the immediate leadership on nursing units, as well as to directors, and pull together multidisciplinary teams of professionals who were involved in the care of the patient,” Forkan Kelly said.

“We assure everyone we want to do better, not point fingers in any way. We use a model known as Apparent Cause Analysis, or ACA, that guides us through possible contributing factors. If we identify an area for improvement, we implement an action plan.”

The ACA process works well at Advocate, Forkan Kelly added.

“Our 15-bed PICU has not had a central line-associated infection since January 2010,” she said. “Our leadership is dedicated to quality improvement and we have a lot of buy-in from our bedside caregivers. We learn lessons from every infection and apply them to improve the care of the next child.”

**Data Mining Surveillance System**

Dori Prasek, BSN, RN, CIC, manager of infection prevention at Overlook Medical Center, Summit, NJ, an Atlantic Health affiliate, agrees data mining surveillance systems make a big difference in infection prevention.

“This type of system does a good job of identifying triggers and providing alerts about patients with possible central line-associated bloodstream infections,” she explained. “When we receive an alert, we can then take a closer look at the patient to see what’s going on.”

Alerts from the system help infection prevention specialists target areas of concern whether process issues or outbreaks of particularly virulent organisms.

“We look for patterns in the intensified reports we receive on a monthly basis,” Prasek explained.

“If we see a *Clostridium difficile* infection in a patient, we’ll look at that particular patient to see what’s going on. If we get another positive *C. difficile* culture on the same unit, we’ll go up to the unit and do an outbreak analysis. We’ll spend time with staff reviewing isolation precautions, see if we can identify any causative factors, and collaborate with the nurses and physicians involved in the care of those patients,” she said.

It’s important to take proactive measures to stop an outbreak early on.

“We use bleach as a disinfectant whenever we have a *C. difficile* infection and a different-colored isolation sign so that housekeeping is aware and can change their products for that room,” said Prasek. “We’ll also change cubicle curtains and take other precautions to protect the next patient in that bed.”

The IV Access Team at Overlook Medical Center has made a big difference in infection prevention.

“We beefed the team up so they can do consults, place all PICC lines, do dressing changes and monitor all PICC lines,” said Prasek. “We use a special patch that’s impregnated with chlorhexidine and releases the chlorhexidine over 7 days, reducing the biofilm on the end of the catheter.”

Prasek and her colleagues are working closely with their data mining surveillance vendor to establish a data feed to NHSN. “Our trained infection prevention specialists gather data about infections using NHSN definitions, but there’s still a lot of information we need to enter and upload manually,” she said.

“NHSN is slowly releasing some information about automatic uploads; it’s been slow progress, but we are getting where we need to be. Within the next couple of years, most facilities with data mining software will be able to upload to NHSN, greatly reducing the administrative burden of data reporting.”

*Sandy Keefe is a frequent contributor to ADVANCE.*

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When a bullet travels through a person’s brain, the damage can result in a cascade of neurological symptoms and challenges both in the immediate aftermath and over the long term.

“Gunshot wounds are one of the more complicated head traumas we see in this day and age,” said Megan Keiser, MS, RN, APRN-BC, CNRN, a neurosurgery nurse practitioner and secretary/treasurer of the American Association of Neuroscience Nurses (AANN). “There are so many factors that influence patient outcomes, including the ballistics of the bullet, where penetration occurred and what part of the brain is affected.”

Patti Lemke, RN, CNRN, CCRN, a staff nurse in the neuro ICU at Provena Saint Joseph Medical Center, Joliet, IL, shared two scenarios that illustrate the wide variation in clinical presentations following a gunshot wound to the brain.

“I cared for an older lady who had received a gunshot wound to the back of her head, and the thick occipital bone shattered, deflecting the force of the bullet,” she said. “The bone actually protected her brain, so she initially lost vision because of the damage to the occipital lobe, but was regaining vision when she left our unit.”

A young man who was shot in the left temporal lobe wasn’t as lucky. “The bullet exited the occipital lobe, passing through vital areas of the brain,” Lemke recalled.

“He developed significant swelling in the brain and pseudoaneurysms because of shearing forces on major blood vessels in his brain. He was responding to commands on one side of his body when he left for imaging, but the swelling abruptly increased and he had a brainstem herniation. After 10 days in the neuro ICU, he succumbed to his injuries.”

Complicating Factors
TBIs in general typically involve one lobe of the brain.

“With that focal component, we can anticipate some deficits based on brain mapping,” explained Tiffany LeCroy, MSN, RN, FNP-C, CRNN, a clinical nurse specialist at Shepherd Center, Atlanta. “If there’s frontal lobe involvement, we can expect changes in mood, personality and problem-solving, for example. If the parietal lobe is injured, patients typically have difficulty with eye/hand coordination and awareness. But gunshot wounds don’t leave that clear-cut picture.”

As the bullet passes through one or more lobes of the brain, it causes direct tissue damage. “Then there’s the wave effect of the bullet that impacts surrounding tissue, so a lot more of the brain is involved,” LeCroy explained. “On top of that, we need to be concerned about swelling that’s contained in a small skull that doesn’t yield. That swelling increases intracranial pressure and can create more deficits. That type of secondary damage can occur weeks after the injury, so we see it developing in some of our rehab patients.”

When bullets affect critical areas of the brain and/or cross the midline, patients often face significant disabilities from brain damage.

“If the bullet doesn’t damage major blood vessels in the brain and stays away from eloquent areas of the brain, patients can survive with better outcomes,” said Keiser. “Patients with this type of injury have symptoms similar to those of a stroke in the area of the brain affected by the penetrating trauma.”

The least complex gunshot wounds involve small caliber bullets that travel at slower speeds and penetrate minimally into the brain.

“In that situation, we often take the patient to surgery to debride bits of skull, scalp and hair that have been driven into the wound tract,” Keiser explained. “The patient then needs intensive nursing care as outlined in AANN’s Nursing Management of Adults with Severe Traumatic Brain Injury.”

Intensive Nursing Care
There’s no such thing as a simple gunshot wound to the brain, Keiser noted. “Even simple injuries tend to turn more complex within the first 3 days after the injury,” she emphasized. “The initial gunshot wound involves both a wound tract from the projectile and shock waves throughout the brain tissue.

“The patient may look pretty stable for the first couple of days until the effects from the shock wave caused by the bullet begin and the brain tissue starts to swell uncontrollably. Suddenly, the patient won’t look so good.”

According to AANN, nursing care centers on prevention of seizures, glycemic control, adequate nutrition, deep vein thrombosis prevention, maintaining or decreasing intracranial pressure, and maintaining optimal cerebral perfusion.

“In patients with run-of-the-mill blunt head trauma, the course of brain swelling and increasing intracranial pressure is somewhat more predictable, but that course is not at all predictable with gunshot wounds,” said Keiser. “The ballistics of the bullet and the location and depth of penetration can change the clinical picture.”
Shotgun blasts release multiple pellets that strike different areas of the skull. “A few will get through and cause skull fractures, but other pellets don’t penetrate,” Keiser said. “In all patients with penetrating head trauma, nurses need to watch carefully for infections — meningitis and cerebritis along the wound tract. These patients need frequent wound assessments, vital signs monitoring and fever management.”

Patients who arrive at Provena Saint Joseph with a gunshot wound to the head are sent for diagnostic imaging and often go directly to the operating room for a decompressive craniectomy to remove a portion of the skull and allow tissue to swell without damaging the brain.

“It’s an up and down roller coaster ride with any kind of traumatic brain injury,” Lemke noted. “A patient can be doing well one day but comatose the next because of swelling or bleeding in the brain.

“Nursing assessment is critical with these patients. We monitor vital signs, intracranial pressure, fluid balance, electrolyte levels, arterial blood gases and coagulation panels to identify DIC [disseminated intravascular coagulation] that’s often seen with TBIs.”

Rehabilitation
Beth Ann Daugherty, MPH, BSN, RN, CRRN, chief nursing officer of Adventist Rehabilitation Hospital of Maryland in Rockville, described the admissions process for patients who have sustained gunshot wounds to the head.

“They arrive in our acute rehabilitation setting once they’ve been stabilized in the acute care hospital,” she said. “Some come directly from ICUs, and there’s a wide range when you’re looking at damage to the brain. If patients show the potential to return to home and community, and can tolerate the 3 hours of daily therapy required in acute rehab, they may come to us.”

Rehabilitation nurses have a broad, all-encompassing scope of practice. “When we’re caring for patients with brain swelling, monitoring neurological status and providing wound care, we’re delivering medical/surgical care to patients,” Daugherty said. “We’re monitoring all body systems and, on top of that, we’re adding the rehabilitation component to the nursing care of the individual. Our patients aren’t always oriented after brain injuries, but they must be able to follow commands and directions.

“Rehabilitation nurses can supplement understanding of verbal directions with cueing on a regular basis, allowing the patient to participate in the rehab process. We also work with families and with resources in the community where the patient will be discharged. In the 2 years I’ve been here, most of our gunshot wound victims have gone home.”

Daugherty shared a final thought for nurses: “As people with gunshot wounds to the head recover, they start looking normal in appearance, but they still have trauma inside the head,” she explained. “We need to be aware, and teach families to be aware, that they may not act the same even though they look the same.”

Sandy Keefe is a frequent contributor to ADVANCE.
Falls Church, VA – Inova Fairfax Hospital’s Prematurity Program Awarded Joint Commission Certification

Inova Fairfax Hospital earned the Joint Commission’s first ever Gold Seal of Approval for Prematurity (NICU) by demonstrating compliance with the Joint Commission’s national standards for healthcare quality and safety in premature birth care. The certification recognizes the hospital’s dedication to continuous compliance with the Joint Commission’s state-of-the-art standards.

“To be the first in the United States to achieve this certification is a tribute to the multidisciplinary team of enthusiastic and knowledgeable professionals who are truly dedicated to improving the health of the diverse community we are privileged to serve through excellence in patient care,” said Reuven Pasternak, CEO of Inova Fairfax Hospital and senior vice president, Inova Health System.

The Joint Commission’s Disease-Specific Care Certification Program, launched in 2002, is designed to evaluate clinical programs across the continuum of care. Certification requirements address three core areas: compliance with consensus-based national standards; effective use of evidence-based clinical practice guidelines to manage and optimize care; and an organized approach to performance measurement and improvement activities.

“In achieving this Joint Commission certification, Inova Fairfax Hospital has demonstrated its commitment to the highest level of care for its premature birth patients,” said Jean Range, MS, RN, CPHQ, executive director, Disease-Specific Care Certification, the Joint Commission. “Certification is a voluntary process, and I commend Inova Fairfax Hospital for successfully undertaking this challenge to elevate its standard of care and instill confidence in the community it serves.”

National – ANCC Names New Director of ‘Pathway’ Nursing Recognition Programs

The American Nurses Credentialing Center (ANCC) named Christine G. Pabico, MSN, RN, NE-BC, director of its Pathway to Excellence and Pathway to Excellence in Long Term Care programs. She succeeds Ellen Swartwout, MSN, RN, NEA-BC, who became director of ANCC’s Certification Program earlier this year.

Pabico brings more than 16 years of progressively increasing clinical and supervisory experience to her new role. Most recently, she was patient care director of the medical telemetry unit, hemodialysis unit and short stay unit at Inova Fairfax Hospital in Falls Church, VA.

“In achieving this Joint Commission certification, Inova Fairfax Hospital has demonstrated its commitment to the highest level of care for its premature birth patients,” said ANCC Executive Director Karen Drenkard, PhD, RN, NEA-BC, FAAN. “At Fairfax Hospital, she improved nurse job satisfaction and retention, patient outcomes, quality and safety. Christine was consistently recognized for best practices and creating a workplace and positive practice environment where her staff could excel.”

As Pathway director, Pabico will build on the significant growth that both programs have experienced in recent years. Her focus will include helping organizations around the globe achieve positive practice environments through the Pathway to Excellence designation.

Philadelphia – Nazareth Hospital Nurse Appointed to Heart/Stroke Board of Directors

Nazareth Hospital’s Theresa “Terry” Conejo, RN, has been appointed to the board of directors of the American Heart Association (AHA) & American Stroke Association Great Rivers Affiliate. The Great Rivers Affiliate includes five states: Delaware, Pennsylvania, West Virginia, Ohio and Kentucky.

Conejo has been an AHA advocate in the Pennsylvania 8th Congressional District for more than 4 years, received the Great Rivers Affiliate Distinguished Achievement Award in 2009 and
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All research grant applications open Sept. 1 and must be submitted online by Nov. 1. Principal investigators must be current AACN members. For more information, including award criteria and systems for optimal contribution of high acuity and critical care outcomes; healing and humane environments; processes and outcomes.

National – Researchers & Clinicians Invited to Apply for Grants From AACN

The American Association of Critical-Care Nurses (AACN) invites clinicians and researchers to apply for its grants, with awards ranging from $1,500 to $50,000.

This year, two Impact Research Grants of $50,000 each are available to support inquiry that drives change in high acuity and critical care nursing practice. Available to experienced clinicians and researchers, the grants fund priority projects to address gaps in clinical research at the organization or system level and support translation of these findings to bedside nurses. These projects include technology to achieve optimal patient assessment, management and/or outcomes; healing and humane environments; processes and systems for optimal contribution of high acuity and critical care nurses; symptom and outcome management; and prevention of complications.

AACN developed the Impact Research Grant program to ensure a pipeline for evidence-based resources that include protocols and practice alerts in support of AACN priorities.

AACN will award three $50,000 Impact Research Grants in 2012, the final year of the initial 3-year program. Applicants may request up to $50,000 in total costs over a 3-year period. Research must be completed in 2-4 years.

AACN continues to offer annually the AACN-Sigma Theta Tau Critical Care Grant and AACN-Philips Medical Systems Outcomes Grant, up to $10,000 each; AACN-Edwards Lifesciences Nurse-Driven Clinical Practice Outcomes Grant, up to $10,000; and AACN Physio Control Clinical Practice Grant, up to $1,500.

All research grant applications open Sept. 1 and must be submitted online by Nov. 1. Principal investigators must be current AACN members. For more information, including award criteria and supporting documents, visit www.aacn.org/grants, or contact Linda Bell, AACN clinical practice specialist, at 800-394-5995, ext. 318.

Langhorne, PA – Concussion & Brain Injury Symposium to Highlight Best Practices

St. Mary Medical Center will sponsor a Concussion and Brain Injury Symposium Sept. 20, from 5 p.m. to 9 p.m. at the Sheraton Bucks County Hotel, 400 Oxford Valley Road, Langhorne, PA.

The event will provide important information on best practices to diagnose and treat concussions. All athletes, coaches, athletic directors, parents, primary care providers, nurses and EMTs are invited.

The event is co-sponsored by Bucks County Sports Commission; Newtown, Middletown and Northampton Parks and Recreation; Princeton Brain and Spine Care; ProPT; and NovaCare.

From 5 p.m. to 7 p.m., there will be a concussion expo with refreshments.

A roundtable discussion will follow the expo from 7 p.m. to 9 p.m. Moderated by Kim Everett, St. Mary trauma prevention coordinator, the discussion will feature several local school district athletic directors.

The program also includes guest speaker Margot Putukian, MD, Princeton University director of athletic services, who will discuss NFL Concussion Guidelines. PNA and Trauma hours are available for nursing and EMS providers.

To register, call 215-741-3141 or e-mail n.edwards@PrincetonBrainandSpine.com.

Selllersville, PA – Grand View Hospital Recognized for Stroke & Heart Failure Treatment

Grand View Hospital received the American Heart Association/American Stroke Association Get With The Guidelines - Stroke Gold Plus Quality Achievement Award, its highest honor, for the second consecutive year.

The achievement award recognizes Grand View as being among the top hospitals in the nation for offering aggressive stroke care using evidence-based protocols to provide the best patient outcomes.

“With a stroke, time lost is brain lost,” said Denise Kistler, RN, CNRN, stroke program and vascular care coordinator. “Receiving quick and efficient treatment is essential. Following Get With The Guidelines protocols helps us provide exceptional stroke care here at Grand View.”

Some of the measures implemented include aggressive use of medications, such as tissue plasminogen activator, antithrombotics, anticoagulation therapy, deep vein thrombosis prophylaxis, cholesterol-reducing drugs and smoking cessation, all aimed at reducing death and disability and improving the lives of stroke patients.

To receive the Stroke Gold Plus Quality Achievement Award, Grand View achieved 85 percent or higher adherence to all Get With The Guidelines-Stroke Quality Achievement indicators for two or more consecutive 12-month intervals and achieved 75 percent or higher compliance with six of 10 Get With The Guidelines-Stroke Quality Measures, which are reporting initiatives to measure quality of care.

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When parents face end-of-life choices for their children, talking about it is much different than officially documenting it. That insight, shared by Erin Mullaney, MSN, RN, PNP-BC, is one of many expressed by nurses involved with advance directives for pediatric patients.

Relationships, timing and understanding are key considerations for nurses in this area.

While advance directives are encouraged for adults and legal once finalized, they are not required for pediatric patients, because parents or guardians are the decision-makers.

Nonetheless, discussions about end-of-life decisions are most effective when a chronic illness is recognized, giving parents time to consider their options more thoughtfully.

Mullaney said that, in her palliative care role at Children’s Memorial Hospital, Chicago, she strives to give parents empowerment.

“I try to frame it to parents that it’s not that they will be doing nothing, but more that they are protecting their child from invasive treatments they do not want to happen,” she said. “For example, a lot of people decide if their child is going to die at home, then they don’t want the invasion of EMTs coming in; they don’t want a breathing tube.”

The close relationships nurses develop with patients often are the foundation for these discussions, said Sean O’Mahony, MD, director of palliative care at Rush University Medical Center, Chicago.

“They are quite familiar with aspects of family dynamic that might not come to other members of the healthcare team,” he said.

He recommended using open-ended questions to ask about families’ emotional reactions to what is going on and to allow family time to respond.

Ties with other members of the healthcare team should also be considered, said Jo Ellen Rust, MSN, RN, CNS, clinical nurse specialist for children with complex care needs at Riley Hospital for Children, Indianapolis. “When we switch to palliative care, families may feel primary caregivers are pulling away, and that can be hurtful for them,” she said.

Timing Different for Each Family

If transitioning to a new level of care is gradual, then, ideally, end-of-life conversations should also be gradual, O’Mahony said.

“The trajectory of life-threatening illnesses in children is often more unpredictable as compared to adults,” he said. “It’s not unusual for children to have rapid periods of decline, but then they return to their previous condition.”

With that in mind, he said, it is beneficial for clinicians to approach families about these decisions in advance. “It can be very hard for families to make those decisions in a crisis situation.”

Gail Kellberg, MSN, CPNP, in pediatric oncology hematology at Loyola University Medical Center, Maywood, IL, said appropriate timing varies for each family. “We are constantly exploring when the appropriate time is. When we do our best, we have brought it up well in advance of it actually needing to be addressed.”

Patient Involvement Varies

In addition to timing, patient involvement is also different with each case.

Depending on their age and maturity, pediatric patients sometimes take part in discussions, Kellberg said, though for some families that’s too difficult.

Maureen Hancock, MSN, RN, clinical director of the pediatric critical care center at Riley Hospital, said, “[Often] children will talk to a nurse, doctor or caregiver and ask questions or state what they want, which gives caregivers an opportunity to talk to the guardian or parents about it.”

Kellberg said some parents struggle with that inclusion. “Some will never address end-of-life issues as the child is dying. They want to shield the child from the process,” she said, adding that a
common sentiment among many parents is that, even when their child is dying, they still want all treatment options to be applied.

To help sort out the dialogue, Rust said an ethics tool, “The Four-Box Method,” is useful. It centers on the patient’s condition, family values, concerns for quality of life and expectations. It first focuses on the clinical diagnosis, morbidities and complications, and asks what is the goal of intervention, according to Rust. “Then there is the quality-of-life section, in which we ask what that means to the child and family,” she said. “What are their priorities?” And finally, the contextual factors, economic and legal, are factored into how the child’s care is proceeding.

Painful Time Has No Protocol
But even with a plan to facilitate productive conversations, every family — and relationship — is unique, Hancock emphasized.

“The plan of care, decision-making, patient comfort and emotional needs are broader nursing issues to address; but a unique approach is necessary with each patient, each family.”

Mullaney said even after conversations and decisions have been made, families still need support. “That moment of having to sign the papers is most difficult. The most painful time is to put pen to paper and write their child’s name and date of birth — that’s the most difficult.”

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Romi Herron is a frequent contributor to ADVANCE.

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The Introverted Leader

Introversion can be a benefit for nurses in leadership positions

By Lin Grensing-Pophal

Chita Taylor, RN-BC, is manager of the NICU and term nursery at The George Washington University Hospital (GW Hospital), Washington, DC. She considers herself an introvert and notes there can be drawbacks to this. “One drawback is that people associate introversion with being antisocial,” she said. “There is a big push toward customer service in the healthcare industry, but people presume you’re not customer-friendly if you’re not outgoing.”

Another drawback is visibility, she noted. “The earnest, hardworking introvert is not the person who regaled everyone with humorous tales at the last staff meeting. Neither is she the one engaging in small talk with each member of upper management. In some cases, the introvert is passed over for special projects or opportunities because they do not stand out from the crowd the way extroverts do.”

While extroverted leaders tend to capture the limelight and serve as gregarious role models for leadership wannabes in any profession, not all believe extroversion is a prerequisite to effective leadership.

Reserved, But Effective

Jennifer Kahnweiler, PhD, author of the popular The Introverted Leader: Building on Your Quiet Strength (Berrett-Koehler, 2009), said her research has led her to believe introverted leaders, particularly in the healthcare profession, can be successful.

Taylor agreed introversion can be a benefit for nursing leaders. “Leadership positions often involve planning, goal creation and decision-making,” she noted. “These tasks are perfect for someone who enjoys reviewing all the information and making thoughtful decisions.”

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In addition, she points out it’s often said that “it’s lonely at the top.” Introverted leaders “don’t have a problem with the solitary nature of the job.”

Donna Ciufo, MSN, RN, is another example of a successful introverted leader. She is corporate director of nursing education for Meridian Health and interim chief nurse executive at Ocean Medical Center, Brick, NJ. Ciufo has been successful not only in achieving and succeeding in leadership positions, but also in overcoming her naturally quiet tendencies. “I don’t think that everyone would say that I’m an introvert,” she said. However, “one of my criticisms is that I’m very quiet and don’t always speak up.”

Ciufo also found communicating first in small group settings can be helpful. Building relationships one-on-one not only increases her comfort level, but helps build trust and credibility among those she interacts with. She also benefits from the fact that she’s a “good listener.”

But, perhaps most beneficial to her has been her longevity with her organization and the ability to establish a reputation as somebody who is stable, reliable and supportive. “People may think, ‘She may be quiet,’ and ‘She needs to speak up in groups a little bit more,’ but they also think, ‘She gets the job done,’” Ciufo said.

“When you’re a little quieter, you need to be in a position a little bit longer before you really get the respect of others,” admitted Ciufo. “Somebody who’s a little bit more outgoing and a little more verbal can make it sound like they’re doing something when they’re not really doing anything!”

Points to Practice
For introverted nurse leaders, especially individuals first stepping into a leadership role, Kahnweiler offers “4Ps” for helping ensure effectiveness: preparation, presence, push and practice. It’s a cyclical process that begins with preparation.

Preparation. This literally involves preparing for interpersonal interactions: clarifying your purpose, thinking of specific things to say, taking notes and even rehearsing with a trusted peer.

Presence. Being “in the moment” is important, Kahnweiler said. “By focusing on the current moment and the person you are with, you also build rapport and personal power.”

Push. Kahnweiler urges introverts to push past their fears, admitting this is easier said than done. But, she adds, “Many of the introverted leaders I spoke with did take deliberate steps to push themselves out of their comfort zones and into uncomfortable interpersonal interactions.”

Practice. Particularly since many of the behaviors leaders are expected to exhibit do not come naturally for introverts, practice is important, Kahnweiler noted. The behaviors — like speaking up in a meeting or addressing conflict — may seem awkward at first, but after a while competency will grow.

Lin Grensing-Pophal is a frequent contributor to ADVANCE.
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