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From the Editor

Nurses hear the phrase “best practices” almost every day, but what does it really mean?

In general, “best practices” refers to nursing practices based on the best evidence from nursing research. What have nurses learned from research into how they can best care for patients? What interventions and guidelines have proven successful at other acute care facilities?

Perhaps it’s following the ANCC’s Magnet Recognition Program Model. The model provides a framework for nursing practice and research, according to the ANCC. It is guided by five model components: transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation and improvements; and empirical quality results.

This special issue of ADVANCE for Nurses focuses on best practices for acute care nurses and celebrates facilities in the region that achieved magnet recognition. For a complete list of Magnet facilities in the region, turn to page 11.

“Evidence-Based Practice Drives Wound Healing” presents an overview of staging and treating pressure ulcers. Carole Kulik MSN, RN, CRNP-PC, originally presented the information at an ADVANCE virtual conference on best practices in nursing.

The authors of “Create Your Own Evidence Base” detail their evidence-based practice project to assess the best method to correct mild hypoglycemia.

Technology can change how you deliver quality nursing care. “Mobile Technology and Nursing Education Practice” delves into how handheld mobile technology such as smart phones affects patient safety and care planning.

Finally, “Hand Hygiene Compliance” looks at how nurses can be leaders in improving infection control through hand hygiene.

We hope you find this special issue valuable. Remember you can find more great content and regional news at www.advanceweb.com/NurseWest.

While at our website, check our expanding community. If you’re not already connected with us through Facebook or Twitter, click on “Community” at the top of the page and get involved. You can also sign up for our free biweekly e-newsletter on our website, as well as earn CE credit through our Learning Scope online program.

Lisa A. Brzezicki
The successful use of topical dressings depends on wound pathophysiology, wound assessment and evidence-based practices. "Wound healing is driven by nurses' knowledge and use of evidence-based practices and products in the effective management of wound care," said Carole Kulik, MSN, RN, CRNP-BC, director of patient care services, Stanford Hospital and Clinics, Stanford, CA.

"There is not an exact cookbook recipe for wound care," she said. "Rather, it depends on nurses' assessment of the basic skin and understanding what the wound needs in order to heal so they can choose the proper dressing."

Pressure Ulcers

Acute care nurses will encounter many types of wounds among their patients. From surgical wounds (those caused intentionally for surgical incisions) to autoimmune wounds (associated with chronic inflammation caused by autoimmune processes), skin and tissue damage can be painful for patients and potentially life-threatening due to related infections.

During a recent presentation to an ADVANCE for Nurses audience, Kulik focused on pressure ulcers. "These are the most prevalent and can be the most difficult for which to develop a treatment care plan and assess accurately in hospital and healthcare facility settings, as well as in at-home-care situations," she said.

Not only are pressure wounds the most common wounds seen in practice, they also are among the most preventable.

Pressure wounds develop when capillary blood flow to the skin and tissue over a bony prominence is decreased for a sufficient amount of time. They can occur in as little as 20 minutes, Kulik said.

The main causes are pressure, friction and shearing. Direct pressure on tissue can lead to ischemia, with the extent of damage dependent on how intense the pressure is and how long the pressure goes without relief. Friction wears away the top layers of skin from continual rubbing against an external service such as poorly fitted shoes or bed linens. Friction can manifest as blisters, tissue edema or an open pressure wound.

Shearing occurs when skin is unable to move against the surface with which it is in contact, while underlying bone and tissue are forced to move. Shearing can lead to deep-tissue injuries. It can occur if a patient sits in bed or on a chair and gravity forces his body to slide down while the skin adheres to bed linens or the chair's surface.

Wound Stages

Stage I ulcers often present as intact skin with areas of redness over a bony prominence. “These occur very quickly, but can be reversed very quickly as well by moving the patient off the affected area,” Kulik said.

In stage II, patients experience a partial thickness loss of dermis.
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Wound Care

and may have shallow, open ulcers. Full thickness tissue loss categorize stage III wounds that may expose fatty tissue, although bone, tendon and muscle are not exposed. Undermining or tunneling from the wound bed may be present.

A stage IV wound is characterized by full thickness tissue loss and exposure of bone, tendon or muscle. Slough or eschar may be present on the wound bed, and these ulcers often extend into muscle or supporting structures. Stage IV wounds are highly susceptible to infection and must be kept clean and properly dressed to achieve healing, Kulik said.

Nurses may encounter unstaged wounds. These are typically stage III or stage IV wounds covered by slough or eschar of varying colors. Until enough slough and eschar are removed to expose the extent of the wound, an accurate stage cannot be determined. However, Kulik cautioned nurses against removing stable eschar from heels. Stable eschar — dry, intact, without erythema or fluctuance — may actually protect the wound as it heals from the inside out.

Wound Healing

A number of factors affect wound healing. Some are systematic, such as diabetes. Diabetes can have a negative effect on collagen synthesis due to low levels of growth factors or responsiveness to increased cellular sequence, Kulik said. Tight glucose control can reduce the risk for wound infections.

A patient’s nutritional status affects wound healing. Malnourished patients are unable to synthesize and crosslink collagen normally. Patients with muscle wasting and subcutaneous wasting face a greater risk for pressure and shearing damage.

Wound healing depends on oxygenation, and patients with poor perfusion may experience slower rates of healing. Oxygen is critical for collagen synthesis and leukocyte function. Nurses should be able to assess pulses in lower extremities and use pulse oximetry to monitor perfusion.

Among critical environmental factors is obesity. Body folds can trap moisture, leading to maceration. Friction and shearing are a risk, given the additional pressure an obese patient’s own body can exert on itself.

Wound Management

“Wound healing progresses rapidly in an environment that is clean, moist and insulated; relieves and prevents pressure; prevents trauma; and reduces the bacterial level,” Kulik said. “Assessing the patient is critical to understand changes in his wound along with understanding his co-morbidities, compliance and social support and financial support mechanisms. Patients may want to be compliant, but may not be able to afford the dressing or appliance we want them to use.”

Evidence-based solutions for wound treatment follow the advice of “assess-treat-reassess.” Assess your patient and the wound. Treat the underlying pathology and the wound. Reassess the wound to evaluate the treatment’s effect: Continue treatment as planned if the wound is healing as expected; if not, adjust treatment.

Topical therapy focuses on debriding necrotic tissue, absorbing excess exudates, filling dead space to prevent abscess and maintaining a moist environment to promote cell healing, Kulik said.

“Your treatment approach of filler vs. covering dressings and absorptive vs. hydrative dressings could change throughout treatment,” she added.

Pillows and padded dressings can relieve pressure to prevent further damage to a wound. Padding can also reduce friction.

Reducing infection is also key to wound healing. Nurses should strive to reduce the bioburden within wounds. Calcium alginate dressings, hydrocellular dressings and polymer dressings can absorb exudates and provide a bacterial barrier. Depending on the amount of exudate, dressings may need to be changed on a daily basis.

Wounds should be cleaned with every dressing change, Kulik said, and nurses should be careful not to scrub excessively. “Just remove debris in the wound and use saline to keep the wound moist,” she said.

Creams can create a barrier against unwanted moisture, such as wounds related to incontinence-associated dermatitis. Antifungal creams can reduce fungal infection in body folds, while cooling and comforting a patient’s skin.

Although it can be expensive, wound vacuum-assisted closure can greatly reduce wound healing time, Kulik said. Constant negative pressure pulls excess fluid from the wound, helping the wound heal from the inside out.

Finally, a variety of dressings are available to cover the wound and surrounding area. These dressings can contain alginates (seaweed-based products) or hydrocolloids, which become gel-like and absorb exudates. Some provide antimicrobial properties through the inclusion of silver to assist with infected wounds. Other wound management therapies include dressings that use honey, larval therapy, ultrasound or surgical debridement and tubular bandages.

Nurses are on the front line of wound management and should be familiar with a variety of topical therapies using evidence-based care to best assist their patients, Kulik said. ❖

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We are a group of nurses who work in an inner city hospital in which 60 percent of the patients are from minority cultures and have diverse healthcare needs. Our nursing community instituted a Nursing Research Council (NRC) to promote quality care through evidence-based practice (EBP).

A diverse group of staff nurses, nurse educators and multidisciplinary team members from nutrition and physical therapy compose the NRC. The members of the NRC decided to keep our council as diverse as our population, not only in membership constituency, but also in areas of interest and the types of research projects we manage. This commitment to diversity in knowledge development has enabled us to add to our evidence-based clinical practice by promoting projects both large and small.

This commitment to all types of projects has been successful in establishing and growing a research program that has steadily and effectively promoted best practice.1,2

For example, at one NRC meeting we discussed the current policy and procedure for treating a patient with mild hypoglycemia, a common problem within our population of hospitalized patients. A discussion ensued about different oral remedies that were being used. We used the PICOT (Population-Intervention-Comparator-Outcome-Time) format to devise our EBP question:3 “What is the best short-term method to correct mild hypoglycemia in patients that were able to consume a glucose source by mouth?”

Gathering Data

Many different opinions existed among nursing, endocrine and dietary about what oral intake was the safest way for a quick fix for mild hypoglycemia. The nursing policy and procedure stated to use 4 ounces of orange juice, a frequently used solution to the problem.

Nurses were randomly surveyed and asked, “What is the best method to raise a patient’s glucose if they are mildly hypoglycemic?” Many nurses thought that by adding one or two packets of sugar the treatment would be more effective. Others thought milk would not only increase the short-term glucose level but it would maintain the glucose level for a longer period of time, thereby off-setting a “glucose crash.” Others thought graham crackers helped well.

We informally and anonymously surveyed approximately 10 registered nurses to find out the reasons why different remedies were being used. Several reasons surfaced, such as: It was the culture of that particular nursing unit and everyone there used that remedy; there was better accessibility to certain food items; and this was the way they were taught in nursing school.

We checked the literature and found that the American Diabetes Association4 recommends 15-20 grams of carbohydrate or sugar and that can be given to a hypoglycemic patient as 4 ounces of juice or regular soda; 2 tablespoons of raisins; 4 or 5 saltine crackers; 4 teaspoons of sugar; or 1 tablespoon of honey or corn syrup.

Other sources also indicate appropriate choice of liquids to combat mild hypoglycemia is important because over-stimulation with large amounts of carbohydrates produce counter-regulatory hormone responses which lead to hyperglycemia.5 Other authors substantiate that the goal is to treat mild hypoglycemia with 15 grams of fast-acting carbohydrate.6

Methodology & Results

The members of the NRC volunteered themselves (all normoglycemic) as the participants in a study. For six consecutive Tuesdays, the members met in the a.m. after remaining NPO for at least 12 hours.

Kimberly, the principal investigator, used a different food product to test an increase in blood glucose each week.

All blood glucose levels were tested at 30 minutes and on two of the weeks we were able to test the effects of the food substance on blood glucose levels at 30 minutes 2 hours. Blood glucose levels were taken with the same glucose monitor for consistency. The monitor had quality controls completed each session.

We found that using 4 ounces of orange juice with 15 carbohydrates raised blood glucose an average of 19 mg/dL in 30 minutes, while using 4 ounces of orange juice with two packets of sugar only raised it 9 mg/dL higher on average.

Evidence-Based Medicine

Create Your Own Evidence Base

Nurses assess the best remedy for mild hypoglycemia.

By Ruth A. Wittmann-Price, PhD, RN, CNS, CNE; Linda M. Celia, MSN, RN, BC; Stephanie Conners, MBA, BSN, RN; Rosemary Dunn, MSN, MBA, RN; and Judith Chabot, BSN, RN, NE-BC

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Eight full ounces of skim milk alone only raised 50 percent of the glucose levels of participants, with the glucose of three people actually decreasing slightly in 30 minutes. A second testing of eight ounces of skim milk raised blood glucose levels an average of 12 mg/dL in 30 minutes but failed to sustain the increase at 2 hours at which point four out of five people's blood glucose levels decreased an average of 10 mg/dL.

Eating 3 graham crackers increased blood glucose on an average of 21 mg/dL in 30 minutes and whole milk raised blood glucose levels an average of 14 mg/dL in 30 minutes but again failed to sustain the increase at 2 hours.

The limitations of this study included different age groups of subjects whose activity was not regulated for the 30 minutes, or between the 30 minute and 2 hour wait time between tests. Tests with graham crackers and orange juice were done at the 30 minute time and 1 hour or 2 hour may have added evidence. There was also a small sample size and results of normoglycemic subjects may not be accurately interposed on insulin-deficit subjects.

The small sample size in this study prohibits the use of these results as a single source of evidence. This study does support the American Diabetes Association standard treatment for hypoglycemia.

Validating Evidence
We concluded from our evidence-based practice project that for mild hypoglycemia in patients who are still oriented and alert, four ounces of plain orange juice with no sugar added may still be the best remedy to increase blood glucose levels approximately 20 mg/dL within 30 minutes. This provides most nurses enough time to obtain more sustaining nutrition for their patients to ingest.

Therefore, we validated that our current nursing policy is appropriate and the results of this project were advertised to our nurses and educational sessions completed. Evaluation of the project has shown nurses are using 4 ounces of orange juice to treat mild hypoglycemia.

References

Ruth A. Wittmann-Price is professor and chair, department of nursing, Francis Marion University, Florence, SC; Linda M. Celia is senior nurse educator, Stephanie Conners is chief nursing officer, Rosemary Dunn is senior director of nursing, and Judith Chabot is director, professional development and Magnet, all at Hahnemann University Hospital, Philadelphia.
Motivating Staff

Magnet’s Pull on Nurses

Nurses enjoy talking about Magnet journey with patients, families.

By Stacey Miller

Ask any Magnet program directors whether Magnet status improves staff satisfaction, and you’re bound to hear an astounding “yes.” Mary Morrow, PhD, APRN, ACNS-BC, director of nursing and Magnet program director at Loyola University Medical Center, Maywood, IL, compared the nurses’ motivation pre- and post-Magnet recognition.

“I definitely found Magnet status motivated nurses. The nurses were energized and applied the Magnet criteria of enculturation to their practice. I was blown away seeing everything nurses were doing to provide quality care.”

A Point of Pride

Nurses at Georgetown University Hospital cherish their Magnet pins, Eileen Ferrell, MS, BSN, RN, director of nurse recruitment and retention, said and take pride in educating patients and families on the significance of the designation.

“Our patients want to know about our badges and our nurses relish the opportunity to talk about our Magnet journey,” Ferrell said. “We emphasize it’s a very difficult status to achieve and that it’s an ongoing process based on continued excellence and evidence-based progress toward very specific goals. Word-of-mouth is a big part of our marketing. Every day we think and breathe Magnet.”

“Nurses not only touch but also save lives every day, and Magnet status brings this to the attention of everyone,” a nurse from NorthEast Medical Center (NEMC), Concord, NC, said. “Magnet helps highlight nursing as what it is — a true profession of caring. Everyone wants to feel valued and that what we as individuals do really matters. Magnet does this for the RN. It tells the people of our region that excellent nursing care is right here at home instead of miles away. It has communicated a sense of pride and feeling of comfort to our whole community.”

More Engaged Staff

“Our nursing satisfaction scores were really good before Magnet, but they’ve improved since,” Cindy Day, MS, RN, NEA-BC, vice president for patient care/chief nursing officer of Stanford Hospital & Clinics in Palo Alto, said. “All the outcomes other Magnet facilities have reported have come true here as well. It’s really about changing the culture. We have a much more engaged nursing staff than when we first started, and it’s really reflective of the organization’s commitment to and value of nursing.”

The way Joan Trofino, EdD, RN, NEA-BC, FAAN, a Magnet appraiser based in Las Vegas, sees it: a happy nurse is usually a Magnet nurse. Nurses who work at Magnet facilities “want to be there. It’s a humanistic endeavor. Nurses project how they feel and patients picks that up. So do the doctors and other team members. Magnet creates a joyful environment. It’s a pleasure to see that joy and harmony, between all groups in the hospital, and especially, between nurses.”

And, in the midst of an economic recession, Rich Hader, PhD, RN, FAAN, senior vice president/chief nursing officer at Meridian Health, suggests nurses at Meridian Health are flourishing. “Nursing staff is not being laid off; we’re not closing the doors as other hospitals have. We pay for nurses to get national certification, and they get a $2 an hour increase when they pass. These are things we would never have been able to accomplish without the commitment to excellence.”

Stacey Miller is senior associate editor at ADVANCE.
### ADVANCE for Nurses, West

Congratulations to the following facilities for their achievement of Magnet recognition:

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#### Arizona
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- **Facility:** Scottsdale Healthcare - Thompson Peak, Scottsdale
  - **Year First Recognized:** 2011
- **Facility:** University Medical Center, Tucson
  - **Year First Recognized:** 2003

#### California
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- **Facility:** John Muir Medical Center Concord Campus, Concord
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- **Facility:** John Muir Medical Center, Walnut Creek, Walnut Creek
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  - **Year First Recognized:** 2005
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- **Facility:** Sharp Memorial Hospital, San Diego
  - **Year First Recognized:** 2008
- **Facility:** St. Joseph Hospital, Orange
  - **Year First Recognized:** 2007
- **Facility:** Stanford Hospital & Clinics, Stanford
  - **Year First Recognized:** 2007
- **Facility:** University of California, Irvine Medical Center, Orange
  - **Year First Recognized:** 2003

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- **Facility:** Craig Hospital, Englewood
  - **Year First Recognized:** 2005
- **Facility:** Medical Center of the Rockies, Loveland
  - **Year First Recognized:** 2010
- **Facility:** North Colorado Medical Center,* Greeley
  - **Year First Recognized:** 2007
- **Facility:** Porter Adventist Hospital, Denver
  - **Year First Recognized:** 2009
- **Facility:** Poudre Valley Hospital, Fort Collins
  - **Year First Recognized:** 2000
- **Facility:** The Medical Center of Aurora and Centennial Medical Plaza, Aurora
  - **Year First Recognized:** 2008
- **Facility:** University of Colorado Hospital, Aurora
  - **Year First Recognized:** 2002

#### Hawaii
- **Facility:** The Queen's Medical Center, Honolulu
  - **Year First Recognized:** 2009

#### Idaho
- **Facility:** Kootenai Medical Center, Coeur d'Alene
  - **Year First Recognized:** 2006
- **Facility:** St. Luke's Regional Medical Center, Ltd., Boise
  - **Year First Recognized:** 2001

#### Montana
- **Facility:** Billings Clinic,* Billings
  - **Year First Recognized:** 2006

#### Oregon
- **Facility:** Portland VA Medical Center, Portland
  - **Year First Recognized:** 2006
- **Facility:** Providence Portland Medical Center, Portland
  - **Year First Recognized:** 2005
- **Facility:** Providence St. Vincent Medical Center, Portland
  - **Year First Recognized:** 2000
- **Facility:** Salem Hospital, Salem
  - **Year First Recognized:** 2010

#### Washington
- **Facility:** Providence St. Peter Hospital, Olympia
  - **Year First Recognized:** 2010
- **Facility:** Seattle Children's, Seattle
  - **Year First Recognized:** 2008
- **Facility:** University of Washington Medical Center,* Seattle
  - **Year First Recognized:** 1994

*Re-designation pending

Information from ANCC, as of Aug. 31, 2011

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Mobile technology for nurses has changed the face of nursing education and clinical practice. During the past decade, colleges of nursing have responded to the call of the Institute of Medicine (IOM), Quality and Safety Education for Nurses (QSEN) and American Association of Colleges of Nursing (AACN) to increase patient safety through nursing informatics and technology. By utilizing mobile resources for nursing education in the classroom, lab and clinical venues, students develop enhanced skills in critical thinking and clinical decision making. Integrating handheld mobile technology into nursing curricula allows nursing students and faculty to provide safer patient care based on current best practices. Reference software applications are now available for download onto smart phones of all types including BlackBerry, iPhone and Android as well personal digital assistant devices such as the iTouch.

A significant number of nursing references are available at a nursing student’s fingertips in the classroom, lab and point-of-care. They provide students with instant access to best practice information that can be applied in both simulated and clinical practice settings. Many mobile resources are based on evidence-based practice findings, include illustrations for the multi-modal learner and are updated more frequently than their printed counterparts. Due to the depth and breadth of information readily available on mobile devices, students can be more actively engaged in learning in the classroom and clinical laboratory setting through case study work, concept and conceptual care map development and clinical pathway or care plan work that in the past was limited by lack of textbook availability.

Patient Safety
Patient safety is by far the most essential reason for the integration of mobile technology into nursing curricula and practice. Early IOM reports called for all healthcare direct care providers to have immediate access to electronic references. The most recent IOM report, The Future of Nursing: Leading Change, Advancing Health, emphasizes that nurses use technology resources that “require skills in analysis and synthesis to improve the quality and effectiveness of care.” This underscores the need for mobile technology to be fully integrated at all levels of nursing education from associate degree to doctoral practice.

The most obvious use of mobile technology in nursing education and practice is in preventing medication errors. Nurses are often the final step in the administration process to prevent a medication error. Mobile technology provides nursing students and nurses with instant access to safe dose, compatibility, and pharmacokinetic information essential for safe medication administration. Instead of hunting for a medication reference book or calling the pharmacist to verify dosage or correct medication, nursing students and their faculty, and professional nurses now have resources to make safe decisions with up-to-date mobile references at their fingertips.

Care Planning
Mobile software resources help nursing students to be more prepared for clinical assignments and to provide comprehensive nursing care. As students are progressing through their coursework, it is impossible for them to have all of the knowledge of an experienced nurse. Yet even beginning students are expected to
provide care similar to that of experienced professional nurses from their first day on a clinical unit.

Using mobile references in the classroom and lab enhances the ability of students to analyze and synthesize critical information and apply it to simulated patient care scenarios. This is done through high fidelity simulation scenarios and case studies that require students to use assessment, nursing diagnosis, laboratory and diagnostic testing and drug references to answer questions and care for simulated and standardized patients. It is also accomplished through student development of care plans and concept maps.

At Kent State University College of Nursing, undergraduates use seven mobile references to develop conceptual care maps on clinical patients. The conceptual care map integrates the pedagogies of concept maps and care plans for enhanced student learning. Concept maps and conceptual care maps are similar to diagnostic algorithms. Each is a diagram that identifies relationships among ideas, assisting students to synthesize patient data. Students “map out” their patient assessment data, history, medications, lab values and treatments prior to documenting the reasons for each medication and lab value deviation and developing a patient-centered plan of care.

In the clinical setting, acute or community based, mobile technology allows students to look up medical diagnoses quickly, become familiar with underlying pathophysiology, identify potential patient needs and assessment requirements, develop patient-centered goals, implement appropriate interventions and evaluate patient outcomes.

Due to rapid patient discharge and the use of a variety of outpatient facilities for clinical education, the days when nursing faculty would give students their patient assignments the night before clinical are gone. Mobile technology allows student nurses to prepare rapidly for patient care at the beginning of each shift within the clinical setting. Nursing faculty report a significant increase in student knowledge and preparation prior to care when they utilize point-of-care resources.

Requiring students to turn off Internet access while in the clinical setting prevents them from receiving phone calls, accessing email or texting during clinical experiences. These types of restrictions enhance compliance with hospital regulations that prohibit the use of personal cell phones on nursing units. Mentoring students in the proper use of mobile references in the clinical setting minimizes abuse and demonstrates its value as an educational and practice resource.

Patient Education
Patient education is perhaps one of the most challenging aspects of practice for students new to the nursing role. Resources available via mobile technology enhance the ability of students to provide current evidence-based practice information to their patients in the clinical setting. Some handheld references include specific suggestions for patient education based on medical diagnoses. Mobile resources provide step-by-step instructions and photos on hundreds of procedures for students to use prior to or during patient education.

Mobile Advantages
While the advantage of instant, current information available via mobile devices is fairly obvious, unique features make them an even greater educational tool. Features such as the ability to simultaneously search all software and link from one software reference to another enhance the ability of students to connect, analyze and synthesize disease and patient information. The search function provides research capability across references, while linkages connect one source to another. Simultaneous searching allows nursing students to type in a term on their mobile device and obtain a list of locations in which that term appears.

Linking features connect related information among references. For instance, when a student is reading about heart failure and sees that digoxin is a drug of choice, the student can hit the link to look up information on digoxin in a drug reference and then hit another link to obtain safe digoxin blood levels from a diagnostic test reference. These features support a more rapid and deeper understanding by students of the multi-faceted nature of patient care.

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Hospital acquired infections are increasing dramatically. Adherence to hand hygiene is the most important way to reduce infections in healthcare facilities, yet hand hygiene compliance among healthcare workers remains low. Committed nursing leadership using multidisciplinary and proactive approach is essential in promoting and sustaining hand hygiene compliance to decrease the incidence of hospital acquired infections. Nursing leaders must support and positively reinforce hand hygiene practice among healthcare workers.

Hand hygiene is the single most effective and cost efficient method for preventing and reducing the transmission of hospital acquired infections. However, the rates and outbreaks of hospital acquired infections continue to increase due to healthcare workers’ poor hand hygiene compliance.

A nurse management study found that poor leadership, low staffing levels and heavy workload are risk factors that affect infection control. Many studies found that healthcare workers neglect to wash their hands before and after patient contact. Barriers to compliance with hand hygiene are insufficient time for hand hygiene due to heavy workloads, inaccessible hand hygiene supplies, skin irritation caused by hand -hygiene products, forgetfulness and lack of knowledge of the guidelines.

Leadership Role
A multidisciplinary approach, including the use of feedback, education, the introduction of alcohol-based hand wash, and visual reminders, may increase adherence to hand-hygiene recommendations. In a multidisciplinary approach, committed nursing leadership and communication with team members is essential. The use of feedback may be key to increasing adherence.

Audit and feedback are widely used as strategy to improve many professional practices. Medical practitioners are more likely to change behavior if they receive feedback from a leader about their actual practices and process of care rather than about only clinical outcomes. Continuity in leadership and good teamwork has a direct impact on infection levels.

Another consideration is work based on evidence. Although hand hygiene practices are poor among healthcare workers, increased hand hygiene compliance with an alcohol-based rub has been attributed to product placement in the environment, convenience of use and the minimal time required for use. Supported by the evidence-based research, nursing leaders can implement alcohol-based rub into a multidisciplinary approach. Nursing leaders need to value research evidence and support healthcare worker’s hand hygiene practice through products that are more readily available, less expensive and result in better skin integrity of the nurse.

Motivating Healthcare Workers
A nurse leader can use a health belief model as a theoretical framework to motivate and influence infection prevention behaviors of healthcare workers. The health belief model is a psychological model that helps predict health behaviors by focusing on the attitudes and beliefs of individuals. The model has some key components of perceived susceptibility, perceived severity, perceived benefits and perceived barriers.

According to this theory, healthcare workers would adhere to hand hygiene if they believed that they were susceptible to infection if they did not wash their hands. Education on infection control may influence staff’s perceived risk of contracting and spreading infection. Staff may perceive severity by understanding the serious consequences of infection caused by poor hand hygiene compliance, such as prolonged hospital stay, expensive medical cost, and increased morbidity. Staff may perceive benefits regarding the effectiveness of hand hygiene practice when it comes to decreasing infection among patients and thereby decreasing healthcare workers’ heavy workload.

To sustain hand hygiene compliance, education and role modeling at both the individual and organizational levels might be beneficial.

References

Min Jeong Seo is a team leader, Boston Dialysis Center, Boston.
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