THANKS TO OUR ADVERTISING PARTNERS

SEE BELOW FOR OPPORTUNITIES FROM TOP FACILITIES AND EDUCATIONAL PROGRAMS IN THE ADVANCE FOR NURSES, GREATER LOS ANGELES AREA.
CHA Hollywood Presbyterian Medical Center (HPMC), the official hospital of the Clippers, is a 434-bed acute-care facility distinguishing itself as a leading healthcare provider. At CHA HPMC we have invested in new heart surgery capability, neuroradiology interventional services, new imaging technology and are on the path to becoming a STEMI receiving center. Our credentials continue to improve as evidenced by our stroke certification award in 2011.

We are currently recruiting the following key positions:

- **Clinical Nurse Director**: DOU/Telemetry
- **Clinical Nurse Director**: Emergency Department
- **Clinical Nurse Manager**: L&D and MBCU
- **Registered Nurses**: Critical Care, DOU, L&D, NICU, Med/Surg Korean bilingual

Apply online at www.hollywoodpresbyterian.com

For more information call Susan Steinberg, Recruiter at 323-644-5808

---

Glendale Adventist Medical Center

Now open, our new patient care tower including a Neuro Critical Care Unit, bringing the medical center’s bed count from 457 to 515!

Patients who come through our doors tell us our nurses are something special. We know that too. At Glendale Adventist Medical Center, a recognized healthcare leader located in Southern California, we provide life-changing experiences, excellent benefits that begin on the first day of hire and many other advantages that encourage our nurses to deliver perfect care.

To find out more on how you can join us to deliver perfect care, visit GlendaleAdventist.com or call (800) 576-3113. Contact Sally Munoz at MunozS3@ah.org.

---

PACIFIC HOSPITAL OF LONG BEACH

A 184-bed acute care teaching hospital has opportunities available for full-time and per diem RNs and Case Managers

Opportunities available for
- MedSurg
- L&D
- ER
- LCSW
- Psych
- SDS
- ICU
- Surgery

We offer outstanding opportunities for growth, as well as generous benefit & compensation plans.

Interested candidates should e-mail lgarcia@myfmm.org or apply online at www.phlb.org or fax to 562-424-8663.
Join the Community!

As a member of the ADVANCE community, you receive free access to lots of information. Don’t miss out. Visit www.advanceweb.com/Nurses to sign up for the e-newsletter.

The ADVANCE community provides:

➤ Daily web updates
➤ Weekly e-newsletters
➤ One-stop shopping for work, play and in between
➤ Access to regional and national job fairs
➤ CE opportunities online and in person
➤ Invitations to virtual open houses and conferences
➤ Blogs
➤ Facebook group
➤ Twitter updates
➤ LinkedIn
➤ Job searches
➤ Salary survey results
➤ Nurses Book Club
➤ And more!

From the Editor

Your connection to clinical stories, nursing news and CE articles doesn’t have to end when you’re done reading this publication. There are several ways you can find information and be involved in the nursing community from your computer, email or cell phone. ADVANCE has a multitude of resources you can pick and choose from in whatever format you’re most comfortable with.

To stay connected with nurses and programs throughout the country, visit the website devoted specifically to you — www.advanceweb.com/Nurses. Feature articles offer a look at nursing initiatives and clinical topics to strengthen your nursing knowledge. Regional news gives you the scoop on timely regional topics. In addition, the site also offers CE opportunities to help you meet your licensure needs — one of the newest ones: Cardiac Testing. You can find a complete list of CEs at www.advanceweb.com/NurseCE.

Are you a social networking butterfly? If so, ADVANCE is the place for you. Our social network communities are rich in content and provide a forum for career advice and networking opportunities. Facebook and Twitter bring you instant access to a community of nurses throughout the country. Connect with your colleagues, and add to compelling discussions, such as “Keeping Nurses Safe,” on LinkedIn. Nurse POV Blogs offer differing points of view on professional topics, and Nurse POV Forums allow you to ask questions and find answers from your peers.

We encourage you to connect with your colleagues online, but we want to hear from you as well. Help us expand our content by sharing your story topics, experiences and additional ideas for resources we can provide you. Let’s continue to strengthen the nursing community. Let’s stay connected.

Pamela Tarapchak

FREE Virtual Conference Events

➤ ADVANCE is committed to providing our readers with up-to-date information on industry trends and technologies without the expense of traveling to a trade show.

Visit www.advanceweb.com/Events to learn about conference topics and to register.

How to Contact Us: Merion Matters, ADVANCE for Nurses, Greater Los Angeles, 2900 Horizon Drive, King of Prussia, PA 19406-0956 On the Web: www.advanceweb.com/nurses 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: 800-355-1085 (5627)

Find some balance www.advanceweb.com/NurseLifestyleCenter

© 2012 by Merion Matters. All rights reserved. Reproduction in any form is forbidden without written permission of the publisher. Code NLA03

Cover photography Jeffrey Leeser/Christian Adams, John Ciuppa/Jeffrey Leeser design by Doni Mahr

You’ll notice we’ve included a few QR codes. These “quick response” codes work much like a bar scanner. To use them, download an app to your smartphone (like ScanLife or QuickMark). Open up the app, zoom in on the code, and you instantly have access to ADVANCE for Nurses content.
Once a land of opportunity for aspiring starlets, the greater Los Angeles area is still golden for experienced nurses looking for work.

However, that’s not to say that the Great Recession hasn’t impacted nurse recruiting. California has been one of the hardest hit states in the economic downturn. According to a report released by the California Employment Development Department, the state’s unemployment figures in January 2012 stood at 10.9 percent. This figure represents an improvement over the 11.2 percent unemployed in December 2011.

Los Angeles County seems to be lagging behind its counterparts in the rest of the state. The latest data from the U.S. Department of Labor Statistics’ November 2011 report stands at 11.6 percent unemployment. While this too is an improvement from the 13.4 percent in July 2010, the recovery is gradual.

“Vacancy rates in southern California are going down but it doesn’t tell the story,” confirmed Jamie Bituin, nurse recruiter at Good Samaritan Hospital in Los Angeles. “Because of the economy, people are taking multiple jobs or delaying retirement.”

Experienced RN Shortage

Though most nurses are staying put in their positions, prospects are plentiful for those with solid work experience who are looking for a new position. At Good Samaritan Hospital, the most immediate needs are for labor and delivery and perinatal nurses.

“These are our busiest areas,” said Bituin. “In L&D, if your résumé shows specialty experience, we’re inclined to interview. The perfect candidate will have that specialty experience, or, at a minimum, an externship within the specialty.”

Management Anyone?

In ambulatory care, résumés complete with subheads illustrating nursing experience are the best bet as well. The need for managers is particularly strong.

George Eckhardt, Director of Talent Acquisition, at HealthCare Partners Medical Group in Los Angeles, has been hiring nurses and physicians for more than 25 years. Over his career, he has seen many challenges in the recruitment of nurses, including the current challenge in finding qualified nurse managers. “Fewer and fewer nurses are willing to take on management responsibilities,” he said. “Nurses now have a wide variety of choices.” Eckhardt expects the management shortfall to get worse in the coming years. “Our retention rate at HealthCare Partners is fantastic, yet we still have to replace nursing leaders who are retiring.”

No New Grads Need Apply

With the promise of abundant opportunities after less than 3 years and eventual retention bonuses in this tough economic climate, it’s logical to think the nursing Class of 2012 is the happiest on campus. Yet, according to a 2010 survey by the California Institute for Nursing & Healthcare, a full 40 percent of new graduate nurses aren’t finding a job as quickly as anticipated.

Because of the economy, Good Samaritan Hospital slowed down its New Graduate Residency Program for all areas but in the NICU. Last year, five nurses in the program were offered full-time bedside positions upon completion, but that number is down from the numbers of new grads who were signed on in the earlier part of the decade.

“The schools knew the shortage was coming and bolstered their nursing programs, but it’s hard for hospitals right now,” said Bituin. “The cost of taking on new grads is high from a patient safety perspective as is the actual expense of preceptoring and training. Going through an internship is not the same as having nursing experience and we don’t want to leave new grads alone on the floor without the training they deserve in transitioning from learning nursing care to practicing it.”

CE Article: Healthy Work Environments

Recruitment and retention efforts are more effective in healthy workplaces. This CE offering provides you with strategies to improve your workplace and create an environment that promotes effective decision making and respect. Visit www.advanceweb.com/NurseCE and scroll down to Nursing Trends/Management and look for CE #918.
A New Prospect
The most traditional career path for new grads was to take an acute care position upon graduation and then maybe switch hospitals or specialties after a few years. Eckhardt urges new grads to consider ambulatory care.

“Typically, HealthCare Partners Medical Group considers nurses with 3+ years’ experience, yet we anticipate tapping into the new grad market very soon. New grads as a group offer organizations enthusiasm and the latest best practices. For a new nurse, ambulatory care presents some interesting career paths. As we strive to be the role model for integrated and coordinated care, we will continually seek to find the finest nursing professionals to support our mission at HealthCare Partners,” Eckhardt said.

Getting the Offer Letter
Whether they’re from the Class of 2012 or 1992, recruiters urge nurses seeking employment to set aside strict criteria for finding their dream job with a hefty signing bonus.

“Nursing positions in many environments offer excellent opportunities for new grads,” stated Lonnie Friedman, RN, Nurse Recruiter, at HealthCare Medical Group. “I encourage new grads to consider all opportunities. The experience they will gain is invaluable, and can serve as the stepping stone to the next step in their nursing career.”

Friedman has been a nurse recruiter since 1988, so she is very aware of the changes in the field of nursing. She advises all nurses to present themselves on their résumé so that their education, abilities, and experience work for them. Typos are always a no-no. Fluency in a foreign language is an asset which should be mentioned. She also encourages all nurses to clearly state what their technical skills are on their résumés. Often, nurses are required to fill out online applications, to use electronic medical records and other programs on a daily basis. Good technical skills are an essential requirement for all healthcare professionals today.

Bituin’s advice also seems simple but makes the difference between an offer letter and a CV idling in the folder with the others.

“I’ve noticed that nurses always are diligent about their employment history but rarely include their specialty,” she said. “If you’re specialty certified in med/surg, ICU or perinatal, note that on your résumé, even if the job you’re applying for is in cardiac care. It’s the one thing that helps the recruiters review your résumé.”

$1 Million Question
Despite the tough challenges in finding a nursing job, Los Angeles employment figures are steadily increasing and the average age of nurses is creeping into the mid-40s, it’s a relatively safe bet that the healthcare employment picture will brighten.

The trouble is, nobody’s exactly sure when the million nurse shortage will dominate the hiring landscape again. “The number of available jobs has gone down,” conceded Eckhardt. “However, organizations are more and more looking for ways to extend nurses’ practice. Ten years ago, the nursing shortage was headed in the wrong direction. It’s still a field with a lot of opportunity.”

Robin Hocevar is senior regional editor at ADVANCE.
At Mission Hospital, Asheville, NC, a 750-bed, acute care hospital, Mary Caldwell, MDiv, MA, ethics coordinator, posted the announcement:

“Ethics Grand Rounds, Thursday, January 19, 2012, noon to 1 p.m.”

Caldwell noted the topic: “Terry Schiavo, 7 years later: What have we learned?” A photo of a smiling, young Schiavo accompanied the flyer.

Landmark Case
For those not familiar with this case, it became a rallying point for end-of-life issues for ethicists, healthcare professionals, lawyers, politicians and concerned individuals internationally.

Caldwell’s announcement continued: “The Terri Schiavo case involved a young woman who lived in a persistent vegetative state for 15 years. There were protracted family disagreements, legal battles and ethical disagreements during those years. Schiavo died March 31, 2005.”

The stage was set for the 1-hour discussion, including the topics: withdrawing nutrition and hydration, appropriate decision-maker ethical responses to varying stages of consciousness; and provider responsibilities to futile care.

Packed House
Caldwell was delighted with the response, especially since, due to budget cuts, lunch would not be provided.

“I wasn’t sure how many people would attend,” she admitted. “The room was packed, including two attorneys and three physicians, among nurses and other healthcare professionals.”

An ethicist at Mission Hospital for 5 years, Caldwell said ethical issues and education have been a priority for 20 years. Nurses have served on the hospital’s ethics committee, she reported.

Morals & Ethics Defined
It is premature to define moral leadership without a solid understanding of moral distress and moral courage in ethical decision-making. Ethicists, philosophers, healthcare practitioners and others have long debated whether the terms are the same. Many argue the common ground makes the terms interchangeable.

Many scholars accept that morals define personal character while ethics relate to a social system in which morals are applied. In other words, ethics relate to the standards or codes a group of individuals agrees upon. Morals of individuals go mostly unchanged, but group ethics are dependent on others and do change over time.

Ethical Viewpoints
The study of ethics is a branch of philosophy. The word “ethics” comes from the Greek ethos which means customs, habitual usage, conduct and character. For nurses, the study of ethics includes understanding concepts in the American Nurses Association Code of Ethics for Nursing published in 2001 and versions dating back to 1950. These concepts include patient rights, autonomy, beneficence, nonmaleficence, justice and fidelity. Patient rights have been federally mandated since the 1970s. Hospitals are required by law to inform patients of these rights upon admission.

Autonomy gives individuals the right to informed consent. Religious or cultural beliefs must be respected even when dangerous or controversial. The only reason an individual can lose his autonomy regarding healthcare decisions is mental impairment.

Beneficence means to do good, and not harm. Nonmaleficence means to prevent intentional harm. Both concepts are in the ANA Code of Ethics. Nurses must report any unsafe, illegal or unethical practices. Nonmaleficence includes extending life with technology.

Justice refers to the obligation to be fair to all. With advanced technology and increasing costs, rationing of care to the frail, elderly and disabled is already the source of ethical challenges, and is expected to increase in the future.

Fidelity in ethics refers to accountability. What is the nurse’s responsibility to patients, employers, society, government — and
When you’re ready to make a greater impact
When you’re ready to advance your career
You are ready for American Public University

American Public University is ready to help you move your career forward. We offer a respected RN to BSN program, undergraduate and graduate degrees in Public Health, and more — completely online. And people are taking notice. We’ve been nationally recognized by the Sloan Consortium for effective practices in online education, and 99% of employers surveyed would hire one of our graduates again.*

When you’re ready, visit StudyatAPU.com/advance

*APU Alumni Employer Survey, March 2006—September 2010
We want you to make a fully informed decision about the university that’s right for you. For more about our graduation rates, the median debt of students who completed each program, and other important information, visit www.apus.edu/disclosures.

SERIOUS ABOUT NURSING?
There’s a smarter way to earn your degree.

West Coast University offers focused programs to help you earn the degree you need. New classes are forming now at all West Coast University campuses — featuring cutting-edge simulation centers to help put you ahead of the curve.

Bachelor of Science in Nursing (BSN) Program Options
- BSN
- Licensed Vocational Nurse (LVN) to BSN
- Registered Nurse (RN) to BSN*

Graduate Studies Program Options
- Master of Science in Nursing (MSN)
- Nurse Educator Certificate**
- Master of Science in Health Care Management (MSHCM)

GET AHEAD OF THE CURVE
877-398-6139
chooseWCUnursing.com

Programs and facilities vary by campus. For graduation rates, median debt of graduates completing these programs and other important information, visit westcoastuniversity.edu/disclosures.
*Applicants must have graduated with an Associate Degree in Nursing and hold a current license as an RN in the US.
**Applicants must have a master’s degree or be enrolled in an MSN program.
Management

herself? Privacy and confidentiality issues can be challenged under this ethics concept.

Emergence of Moral Distress
In 1984, Andrew Jameton, philosopher, defined moral distress as a phenomenon in which one knows the right action to take in an ethical dilemma but is constrained from taking it largely due to organizational policies. While moral distress has been demonstrated in other healthcare professionals, most of the studies published have focused on nurses.²

Jameton's book, Nursing Practice: Ethical Issues, (Prentice Hall, 1984) was published at a time when end-of-life issues were being debated aggressively. Jameton argued moral issues were not defined by the scientific means of caring for patients but rather the ought to's of how and to whom care should be provided. He concluded nursing was the moral center of patient care and the inspiration for ethical care and compassion.

Jameton published his moral distress theory during the end-of-life case of Karen Quinlan, more than 20 years before the Schiavo case.³ Quinlan's case became a precedent in right-to-die law and triggered wide discussion of morals and ethics. It was during this time when many hospital ethics committees were formed.

Reducing Moral Distress
In 2002, M. Corley expanded Jameton's work on moral distress to include conflict nurses experience when their commitment to the organization or physician is misaligned with their duty to patients. Corley described how the conflict leads to chronic stress, burnout, hardening and disengagement from nursing. Rashotte further described the inability of nurses to resolve moral distress as “stories that haunt us.”²

In 2010, Elizabeth Epstein, PhD, RN, and Sarah Delgado, MSN, RN, ACNP-BC, published a compilation of strategies for nurses to reduce moral distress developed by several authors and researchers.³ These included: speak up; be deliberate; be accountable; build support networks; focus on changes in the work environment; participate in interdisciplinary moral distress education; find root causes; develop policies; and design a workshop.

Caldwell said when nurses learn about moral distress they begin to talk about how they've been affected.

Moral Courage: Always the Solution?
Developing moral courage to speak up and carry out some of the interventions discussed above doesn't happen overnight. It takes time, resources and commitment before positive outcomes become the norm. “Nurses who speak out against unethical, unlawful or outdated practices demonstrate moral courage,” offered Vicki D. Lachman, PhD, MBE, APRN, FAAN, professor, Drexel University, Philadelphia.

In 2002 Lachman received a master's in bioethics from the University of Pennsylvania and currently serves on the ANA Center for Ethics and Human Rights Advisory Board. Her third book, Ethical Challenges in Healthcare: Developing Your Moral Compass, was published in June 2009.

CODE: Primer on Moral Courage
In the Sept. 30, 2010, issue of OJIN: Online Journal of Nursing, Lachman wrote “Strategies Necessary for Moral Courage.” To help nurses better understand moral courage, she developed CODE, which stands for “courage, obligation, danger management, expression and action.”

“I created CODE for two reasons. First, the word ‘code’ in health-care signifies an urgent need to respond (act) in situations that may involve danger. Secondly, the word ‘code’ reminds nurses of their moral obligations outlined in the ANA Code of Ethics for Nurses,” Lachman wrote. Each component of CODE includes examples and resources for nurses to better operationalize moral courage.⁴

Redundant Terms?
Some experts contend moral leadership is a redundant term; however, many disagree. In nursing, we expect leaders to be of strong moral character and teach subordinates how to make the right decision at the right time when ethical issues are compromised.

Of course, a moral leader knows it is imperative to reassess her character and values. Values clarification must be modeled by moral leaders if the next generation is going to embrace conflict as a means to resolve ethical dilemmas, according to experts.

In a March 2011 article in the Journal of Radiology of Nursing, Bjarnason and La Sala discussed how moral leadership can be easily applied in four styles: transformational, authentic, servant or stewardship, and evidence-based. The authors provided examples of moral leadership, for each of the prevalent leadership styles.⁵

More From the Leaders
Nurse leaders are expected to role model and speak up in ethical dilemmas. Cole Edmonson, DNP, RN, FACHE, NEA-BC, vice president of patient care services/chief nursing executive at Texas Health Presbyterian Hospital, Dallas, said while there is no scarcity in the nursing literature about direct-care nurses and their experiences with moral distress/courage, among nurse leaders there is little documentation.¹ “Morally fit nurse leaders with the moral muscle must do what is right in the face of obstacles,” he concluded. ☀

References for this article can be accessed at www.advanceweb.com/nurses. Click on Resources, then References.

Kay Bensing is staff nurse consultant at ADVANCE.

Want to hear more about the nursing profession?
Visit ADVANCE Perspective: Nurses to read more information on clinical, management, professional and career development issues for nurses practicing in all areas of the profession. ADVANCE staff leads the conversation with help from guest bloggers on www.advanceweb.com/NurseBlogs.com.
Take the leap.

Pursue those three big letters that come after your name.

BSN and MSN

As a RN, you can advance your education online and work toward advancing your career. Online options include: RN to BSN Option, RN-BSN to MSN Option and Master of Science in Nursing (MSN) Degree Program.

Chamberlain College of Nursing offers a proven model with advanced degree program options to take you to the next step. Keep moving forward.

Now enrolling for spring, summer and fall semesters

For more information, please visit chamberlain.edu or call 888.556.8CCN (8226)

Comprehensive consumer information is available at: chamberlain.edu/studentconsumerinfo

National Management Offices | 3005 Highland Parkway | Downers Grove, IL 60515 | 888.556.8CCN (8226)

©2012 Chamberlain College of Nursing, LLC. All rights reserved.
Following a 15-year decline, home births are on the rise. A recent report released by the National Center for Health Statistics shows the number of home births in the U.S. rose 29 percent from 2004 to 2009. The report also found home births are more common among older married women who had several previous children (Home Births in the United States, 1990–2009, www.cdc.gov).

Though still only making up less than 1 percent of all births, approximately 1 in 90 births to non-Hispanic white women in 2009 were home births. Why the dramatic upsurge after a steady decline during the 1990s?

ADVANCE spoke with a few people in the field who feel today’s women are more mindful of the fact that they have a say as to where to have their baby, as well as what types of interventions are involved during delivery.

Personal Choice
Ronnie Falcao, MS, LM, CPM, became a home birth midwife when she saw how allowing the rhythms of natural labor to dictate every aspect of the event was “much easier for the woman and much nicer for both the mom and baby.” While home births may share some routine interventions with hospitals, “birth is not a voluntary function, and women cannot stop their contractions when the nurse has time to take their blood pressure,” she said. “More women prefer home births because of the control it gives them over their birthing environment and the tests/shots given to the newborn. We have entered an era where many people feel that important threats to health are autoimmune diseases and reactions to immunizations and other drugs,” said Nick Angelis, MSN, CRNA, from Sacred Heart Health System in Pensacola, FL.

The fact that the nation’s statistics in many important birth categories lag significantly behind those of other developed nations weakens his own argument that home births are a poor idea, especially when meticulously planned with emergency backup readily available, noted Angelis.

D.L. Carter, MSN, RN, NNP-BC, SCM--retired (state certified Midwife U.K.), works in a New York birthing center and has encountered a number of women who have come to the hospital after a failed home birth. Many had decided to deliver at home to prevent over-involvement of technology in the birthing process. “For most, it was the rejection of technology and avoiding interference in the birth process,” she said. “They wanted to avoid obligatory staying in bed so that machines can monitor their fetus’ heart rate. They wanted to avoid medications and a cesarean section if the birthing process goes on too long — in their doctor’s opinion.”

A hospital is a scary place for most people, remarked Bayla Berkowitz, CNM, MSN, nurse midwife at Mercy Medical Center, Baltimore. “Putting a woman in a hospital gown, attaching monitors to her belly, and sticking needles and an IV in her gives her the impression that she has few choices and options in this setting,” she said. “There should be no ‘routine’ interventions. Interventions should be done as appropriate in the right situation.”

Eschewing technological meddling in favor of a lower-intervention experience might not be the only reason home births are trending upward. As healthcare costs continue to rise, people could very well be settling for the less-expensive option.
The analogy is similar to gas prices: no one changes their habits until a certain price is reached," explained Angelis. “That benchmark is different for everyone, but with the wealth of knowledge available on the Internet, more people are feeling comfortable with turning back to traditional or alternative methods of healthcare, even for child birth.”

In the long run, home births are much more cost-effective for society as they cost much less, and use fewer procedures and interventions, noted Berkowitz.

The Safety of Home Births
When asked why there is such an intense debate over the safety of home births, Carter offered two explanations.

“Because I see the infants being brought into the hospital moribund. Because if you go back a hundred years our infant mortality rate was higher for good reason," she said. “We are afraid of infants missing important assessments and physical examinations, and missing vaccinations and medical testing that is lifesaving.”

Part of Carter’s job includes assessing infants for discharge. She mentioned that she has found cardiac defects that require early assessment by a cardiologist. In a separate instance, an infant had two of the major plates of the skull fused, which necessitated cranial surgery in the first month of life. “Even something as simple as congenital dislocation of hips needs early identification, assessment and treatment if the infant is going to walk properly,” she said.

Angelis, who administers epidurals and spinals in the obstetrics department as part of his job, noted patient condition changes faster in obstetrics than in any other specialty.

“I can’t tell you how many times a happy labor suddenly turns into a hemorrhaging emergency, or the fetus took a rapid turn for the worse in a progressing mother with an epidural and she needed a spinal or general anesthetic for a stat C-section," he acknowledged.

He lists several safety issues surrounding home births, including not recognizing the subtle signs of internal bleeding, dehydration and fetal changes that basic monitoring allows. Using a doula increases safety, but childbirth in traditional cultures was historically more dangerous than it is now. This, of course, is in contrast to the very low rates of chronic disease (diabetes, heart disease, etc.) experienced by traditional cultures that placed a much higher emphasis on preconception health and healthy eating than most Americans do today, he remarked.

Such intense debate over the safety of home births exists, in part, because the medical community is very powerful, noted Berkowitz. “Physicians have lobbyists and financial backing. Moving birth back to the home may be seen as a threat to the field of obstetrics. There is also the concern of the training of non-nurse midwives. CPMs (certified professional midwives) do have a thorough training system and testing mechanisms in place. But because they don’t have a university degree they are seen as incompetent and untrained. Nurse midwives legally need a collaborating obstetrician to agree to their
Labor & Delivery

practices. Few obstetricians are willing to back up a home birth midwife because of the fear of litigation,” she said.

Angelis believes organizations, such as the World Health Organization, the American College of Nurse-Midwives and the American Public Health Association support home and out-of-hospital births for low-risk women because they realize there are two groups in America’s healthcare system: chronic patients and occasional visitors.

“If my patient wakes up from surgery complaining of a mild headache, I give them the IV narcotic Fentanyl. If I have a headache at home, I try to discern the root cause and avoid medicine. If done safely, encouraging home births for those healthy visitors will concentrate hospital resources on those who need them the most,” he explained.

Savvy Healthcare Consumers

Carter has an ongoing concern that people get incorrect information from erroneous websites and believe it to be true. Then, because they choose to avoid medical care, they do not get any other information.

“Research over the past 30 years has demonstrated an increase in the number of instrumental births and C-sections with the increased use of fetal heart monitors without a decrease in maternal and fetal morbidity and mortality,” she stated, noting there are birthing centers around the U.S. that limit the routine, and obstetric education conferences that emphasize thinking rather than routine.

The trend of more savvy healthcare consumers will reap more positive benefits and less wasted bureaucracy than Medicare’s attempts to control quality by taking money from each hospital, only giving part of it back if nebulous criteria are met, stated Angelis.

In truth, most homebirth midwives are very thoroughly trained and competent. They don’t have the benefit of an operating room around the corner or a neonatal resuscitation team down the hall. They need to be fully prepared and trained to act in all situations and be ready to transfer to a hospital way in advance of a tragedy occurring. They must see the signs early and act accordingly,” said Berkowitz.

Home births are safer than they were 100 years ago for the same reasons that hospital births are safer than they were 100 years ago: cleaner water, better overall hygiene and better nutrition, noted Falcao.

“Home birth safety primarily comes from supporting labor as a natural physiological process and not using routine interventions, such as pitocin and epidurals, which introduce risk,” she concluded.

Beth Puliti is a frequent contributor to ADVANCE.

Elective Delivery

Hospitals nationwide enact policies that aim to eliminate elective deliveries at less than 39 weeks. Visit www.advanceweb.com/Nurses and search “Elective Delivery.”
Discover a Smarter Way to learn...

Online.

Take care of your patients AND your career with a CCNE-accredited nursing degree from WGU!

- **Relevant and Accredited**—CCNE-accredited degree programs designed to produce highly qualified, caring nurses, educators, and administrators.
- **Flexible**—Log in and learn anytime, anywhere you can find the time before, during, and after rigorous nursing shifts.
- **Affordable & Non-Profit**—One of the best values in higher education, WGU tuition is among the most affordable in the entire country.
- **Competency-based**—Challenging programs that measure your learning rather than your time spent in class.

Programs begin the first of every month.
Your future can start right now!
*RN Prelicensure programs available in select areas!

www.WGU.edu/WGUAdvantage  1.800.579.0169

---

**White Memorial Medical Center**

**Adventist Health**

Remember why you chose NURSING?

**A MESSAGE to experienced RNs.**

We invite you to regain your passion and reenergize your career as a member of our nursing team. At WMMC, you’ll leave at the end of your shift knowing you’ve made a difference in the lives of others.

*All positions require a current CA license and 1-3 years acute care experience.*

- ER
- ICU
- NICU
- Float Pool
- L&D
- Maternity
- M/S Telemetry
- PICC RN
- NICU Clinical Supervisor

We offer job satisfaction, great benefits and a culture that promotes personal achievement and growth. Apply today.

www.whitememorial.com P: 323-268-5000 x5790, Email: Kwakj1@ah.org, 1720 Cesar E. Chavez, Los Angeles, CA 90033
A microscope is being aimed at healthcare-associated infections, and hospitals are responding.

In 2008, the Centers for Medicare and Medicaid Services began denying payments to hospitals for certain conditions that occur during a hospital stay and were not present at admission, including certain healthcare-associated infections (HAIs). And starting in January 2011, hospitals have been mandated to share data on central line-associated bloodstream infections, or CLABSIs, on the publicly available Hospital Compare website.

It’s part of a growing trend toward transparency to help ensure hospitals take every possible measure to reduce the incidence of HAIs, which kill nearly 100,000 U.S. patients, sicken 1.7 million and cost U.S. hospitals up to $34 billion every year. Studies, such as one published by the Center for Evidence-Based Practice at the University of Pennsylvania, show the most common ICU HAIs are actually preventable. Up to 70 percent of CLABSIs and catheter-associated UTIs — and up to 55 percent of ventilator-associated pneumonias (VAP) — can be prevented if the correct policies and protocols are followed.

**Simple Measures**

It’s all about simple measures in most cases. The University of Pennsylvania Health System took a lesson from the automotive manufacturing industry in attacking CLABSIs. It incorporated the Toyota Production System, which helps reduce variation in practice and streamline and improve care, along with checklists to guide line insertion and maintenance, electronic infection surveillance and leadership initiatives. The change was jump-started at the bedside, when the chief nursing officer at Penn met with shared governance leadership to set reasonable goals for reducing infections.

“When the person at the bedside providing care has a stake in the percent reduction of HAIs, and when the leader of the institution comes to the bedside nurse, that shared governance person, and wants that insight, that’s very empowering for staff and creates buy-in from all the critical care nurses,” said Robin Strauss, MSN, ACNS, BC, CVN, WCC, a clinical nurse specialist in the cardiovascular ICU at Penn.

Nurses also worked closely with an external consultant to identify the number of steps they were taking in the care and maintenance of central lines. Any variations among units or nurses were noted, which became launching points for discussion and streamlining, all set in evidence-based practice.

“With everyone doing the same thing all the time, the results were better and there was improvement,” Strauss said. The results were impressive, with CLABSIs falling by more than 90 percent from 2007 to 2010.

**Leading the Way**

Massachusetts General Hospital has already taken the initiative to publish data on HAIs on its own quality and safety website and, since 2008, the hospital has bested national rates set by the National Healthcare Safety Network for CLABSIs. Like Penn, Mass General instituted a checklist to help streamline the process and
ensure all nurses were following the same procedure in caring for CLABSI.

Using the prevention bundle established by the CDC, which calls for hand hygiene, using full barrier precautions during the insertion of the central line, cleaning of the skin with chlorhexidine, avoiding placing lines in legs if possible, and early line removal, the hospital also worked to standardize kits and supply carts, and incorporated a monitor, or observer, to ensure sterile techniques were being followed.

“We also acknowledged that there are times in emergent situations, for example in the ER during cardiac arrest, when a line must be placed emergently, without the ability to create a sterile field,” said Paula Wright, RN, CIC, director of the infection control unit at Mass General. “We developed a system to identify those lines, and as soon as the patient is stable, to replace it.”

The hospital is now shifting its focus to ensuring lines are assessed every day to see if they can come out and to ensure consistent care.

“Also, within the critical care group, we inform the ICU as soon as we identify a CLABSI and they try to look back as best they can to see if anything contributed to it, to learn and share information,” Wright said.

“It’s a team huddle in real time, to think about how it might have been prevented.”

**Bundling VAP Care**

The “bundle” has become the last word in preventing HAIs, and in preventing VAP, there’s no exception. Both Penn and Mass General follow a VAP bundle that combines several tactics, including elevation of the head of the bed and regular oral care. “VAP prevention is all about keeping secretions out of the lungs,” Wright said.

As with CLABSI, bundling care helps ensure consistency. “It’s about making the VAP bundle sacrosanct,” Strauss said, “then auditing it to make sure it’s working.” Data is collected electronically at Penn so there is “tremendous transparency” on any current infections and recommended strategies and treatments, according to Strauss.

Previously documented just on the flow charts, Mass General is also collecting data on compliance to the VAP bundle in its electronic nursing documentation system. “We get the data back to critical care, so we can see if compliance is as good as we think it is,” Wright said.

According to Chris Ranjo, BSN, RN, NEBC, nurse manager of the critical care unit at Penn, again, it all comes down to the nurses. “They are the champions of this,” she said. “The nurses on the floor take ownership on improving VAP, and they bring information back to the unit. That’s the most important thing, it coming from each other and wanting to improve.”

Hospital recognition of their achievements adds to the ownership. When Ranjo’s unit achieved a zero percent VAP rate over 750 days and earned a celebration and a silver medal from hospital administration, nurses began immediately planning for 1,000 days VAP free and a gold medal. “There was a lot of talk and energy on the floor,” Ranjo said. “They want that achievement.”

**Removing Risk for UTIs**

Simply put, UTIs won’t happen in the ICU if a patient doesn’t have a catheter. Standardized processes help get the catheter out as soon as possible, by ensuring nurses perform daily checks to see if a patient still requires a catheter. Some hospitals have automated reminders established for both nurses and physicians. It’s a huge change from the past.

“For years, we left the Foley in all the time,” said Ranjo. “It’s a big practice change to say we don’t need the Foley in ICUs.”

Basic education on standardized practices also ensures everyone is on the same page.

“We did something called the ‘unit of horrors,’” Strauss said. “We identified suboptimal scenarios and walked through what was wrong, and did a return demo of catheter insertion and removal. If you’re not a new nurse, a lot of times, you don’t get to ever practice that after nursing school … having that hands-on return demo was really helpful.”

These practices helped Penn reduce its UTI rates by 65 percent in the medical ICU.
Critical Care

by 35 percent in the trauma ICU and by 18 percent in the heart and vascular ICU in the past fiscal year.

Hand Hygiene

Another relatively simple measure — hand hygiene — helps prevent the spread of antibiotic-resistant bacteria in the ICU. Yet compliance with hand hygiene standards is still at or below 50 percent, according to recent studies.

Why so low? Part of the issue may be the time involved. It’s estimated nurses could spend up to 30 minutes per hour washing their hands with soap and water according to guidelines. But an easy solution is alcohol-based rubs, which take only seconds and are better for the skin.

Mass General has had “a very strong hand hygiene program over the past 10 years, ” Wright said. “That’s our primary effort to ensure we don’t bring bugs to the patient. ”

The program provides education, ensures availability of alcohol hand rubs, conducts surveys and provides feedback, enlists local champions, promotes awareness through posters and publicity, sets goals, and encourages patient and visitor involvement — all with a goal of achieving 100 percent compliance.

In 2007, a modest hospital-wide bonus was awarded if the hospital achieved its targets. And since 2009, Mass General has had a hand hygiene compliance rate of greater than 90 percent both before and after contact with the patient.

In addition, infection control also works with local pharmacies to manage antibiotic stewardship to ensure antibiotics are being used appropriately.

Culture Change

With reimbursements now directly tied to how well hospitals prevent the rise of HAIs, hospitals and hospital ICUs have become increasingly transparent in the mechanisms they use to reduce this incidence. A widespread culture change has been the result. ICUs with the lowest HAI rates report that instead of working in silos, sister ICUs in the same hospital system now share data and information so they can benefit from each others’ knowledge and experiences. Even further, bedside nurses are empowered to play an active role in reducing HAIs.

“Years ago, the data was just given to you, if it was given to you at all,” Ranjo said. “Now, all of the nurses can speak to the data on the floor, it’s posted for all to see. … In the nursing professional practice model, it’s a pyramid, and at the top of the pyramid is well-crafted patient care, and that’s what we’re striving for in all these initiatives that we do, that we’re providing the best care we can for these patients.”

Danielle Wong Moores is a frequent contributor to ADVANCE.
According to Pulse Reports for the Emergency Department, a 2011 report by Press Ganey Associates, patients waited on average 6 hours in emergency departments in 2009.

But what exactly does that mean? “The issue is that people are speaking apples and oranges and bananas, if you will,” said Diane Gurney, MS, RN, CEN, 2010 Emergency Nurses Association president.

In other words, how does one define arrival time when addressing how long it takes to see the physician? One must first define their time stamp for when the patient enters: Is it when the patient comes up to triage? Is it when the patient goes to registration? What about ambulance patients? Is it when the ambulance comes in the door? Or if they’re fifth in line, is it when the nurse actually sees them?

“Everybody is defining it differently, and if you want to be able to measure metrics and talk intelligently about solutions, everyone has to be talking about the same metric. We in healthcare, especially in emergency care, were struggling with that for a long time,” Gurney explained.

This is why this past summer nine associations agreed on standard definitions for metrics to develop strategies to avoid ED overcrowding. Spearheaded by the Emergency Nurses Association, these agreed-upon standard definitions will help not only healthcare providers, but patients and hospitals, as well.

Impact on Hospitals & Patients

Gurney believes one of the biggest side effects of ED overcrowding is reduction in quality. “You can find any number of articles that show increased length of stay has been linked to delays in the patient getting to their bed. That’s overcrowding. Hospitals have reduced their beds, hospitals have closed and, when there’s crowding, we can’t get people out the back end, so to speak,” she said.

Vicki Good, MSN, RN, CCNS, CENP, administrative director of patient safety at Cox Health in Springfield, MO, and past national board member of the American Association of Critical-Care Nurses, concurred. “Crowding creates a longer queue of patients waiting for a limited number of inpatient beds. In critical care, it often means emergency departments need to provide ICU care while they attend to other patients whose needs range from ambulatory care to resuscitation,” she said.

ED overcrowding stretches all aspects of a hospital’s ability to provide safe quality care because every resource is in higher demand, including availability of clinical personnel, patient care space, equipment, supplies and all-over services. “Emergency department crowding jeopardizes patients and families no matter what level of care they need,” Good said. “Everyone becomes overburdened and overwhelmed — patients, families, healthcare providers and hospitals.”

William T. Durkin Jr., MD, MBA, FAAEM, vice president of the American Academy of Emergency Medicine, said ED overcrowding can also lead to patients experiencing a delay in treatment they require, being re-routed to another facility or having to wait a long time before receiving needed treatment. “[Overcrowding] delays the care that they need, it’s a less-than-ideal experience and it gives the impression that the staff doesn’t have time for them,” he said.

Impact on Healthcare Providers

ED crowding distracts, stresses and frustrates healthcare providers, Good explained. It also delays the time to assess and treat complex life-threatening situations accurately. “When clinicians can’t provide the care a patient and family require, they understandably become stressed and frustrated,” she explained.

Durkin said added stress stems from caring for more patients than the department was designed to care for. “This creates burnout and can be a set-up for medical errors. Patients who have waited a long time to be seen can be irate and create a less-than-pleasant experience for everyone,” he said.

Gurney elaborated that when healthcare providers are hurried and stressed, they might forget to smile, which leads to patients feeling as if they’re not getting the level of customer service they need.
Emergency Care

Consequentially, they become angry. “Facing an angry waiting room can be a very stressful and almost a dangerous place to be,” she noted. “Everyone suffers because of the delays in care. It’s a vicious cycle.”

Not only can’t nurses perform their jobs as they’d like to, but managers and directors are finding out they are having difficulty recruiting and retaining staff, she added. “We’ll never be able to develop effective solutions until everyone measures the problem in the same way,” Good said.

Agreed-Upon Standards
On Feb. 23, 2009, the ENA convened a stakeholders’ meeting in Washington, DC, to develop and support standardized metrics. After a few changes, a final consensus statement was published in summer 2011 in nine healthcare association journals. Organizations that signed the final statement are: the American Academy of Emergency Medicine; American Academy of Pediatrics; American Association of Critical-Care Nurses; American College of Emergency Physicians; American Nurses Association; Association of periOperative Registered Nurses; Emergency Department Practice Management Association; Emergency Nurses Association; and National Association of EMS Physicians.

“If you can’t measure it, you can’t manage it. Now there’s a baseline from which everyone can have a starting point,” Gurney, said, noting the goal was not to get hospitals to accept the standards, but rather come to a consensus regarding the language to conduct research. “I think we were very successful in getting so many organizations to come to a consensus,” she said.

Durkin added, “by having agreed-upon definitions of metrics, we now all agree upon what metrics are important to monitor.”

Take a look at the standard definitions and you’ll see other factors besides the actual number of patients that cause ED crowding, Good commented. Additional factors include method of transport to the ED, handoffs between pre-hospital and hospital personnel, triage time, first contact with a healthcare provider and time to document a decision on where a patient will go next.

As far as disseminating this information and getting hospitals to accept it as the standard, the ENA brought the nine organizations together.

“AACN will collaborate with ENA and our fellow organizations in developing and disseminating informational resources so these definitions move into the mainstream of data collection and policy development for emergency care,” Good concluded.

Beth Puliti is a frequent contributor to ADVANCE.
University of Phoenix®
College of Nursing

committed to working around your shift — at home and at work.

RN to BSN and MSN
Experience our commitment to nurses at phoenix.edu/nursing

You can find more details on all these programs, such as on-time completion rates, the median debt of students who completed the program and other important information at phoenix.edu/programs/gainful-employment.html

The Bachelor of Science in Nursing and Master of Science in Nursing programs are accredited by the Commission on Collegiate Nursing Education (CCNE), One Dupont Circle, NW, Suite 340, Washington, DC 20036-1120, 202.865.0731, www.acsenhs.org. The University’s central administration is located at 4451 E. Cline Rd., Phoenix, AZ 85044. © 2012 University of Phoenix, Inc. All rights reserved.
**ADVANCE** is your one-stop shop to dress yourself for success!

Unisex 3-Pocket V-Neck Top*  
XS-5XL. Personalizable.  
#10428  
Starting at $16.99

Women’s 37” iPad® Lab Coat*  
2-20 and 40-42. Personalizable.  
#19155  
Starting at $34.99

Ultimate Medical Bag*  
13” x 9” x 14”. Personalizable.  
#02444  
$34.99

Fingertip Pulse Oximeter  
#17723  
$69.99

Unisex 3 Pocket V-Neck Top*  
XS-5XL. Personalizable.  
13 colors available

Women’s Professional “Flannel” Vegan Clog  
#18126  
$134.99

Women’s “Dayna” Mary Jane  
#18358  
$119.99

Women’s PRO® Renova™ “Professional” Slip-On Clog  
#19773  
$109.99

**SAVE 15% on your order**

Use promo code LOCALRN319 now through 05/06/12.

Limit one promo code per order. Cannot be combined with other codes.

Not valid on Littmann stethoscopes, Ultrascope (#11840), Oximeter (#13221), Cherokee WorkWear, affiliate-specific merchandise or items ending in $.97 and $.98.

From the publishers of advance for **NURSES**

Catalog Code: RN-1212  
Prices and offers valid through 04/08/12

**Shop Advance**

[Advance HealthCare Shop](http://www.advancehealthcareshop.com)  
1-877-405-9978

Connect with us on Facebook, Twitter, and Google+.