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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.

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Pamela Tarapchak

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Due to a state budget crisis and the plummeting housing market, 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.

Though residents of northern part of California seems to be faring better than their counterpart in Los Angeles County, unemployment in San Francisco-Oakland-Fremont was reported at 8.5 percent by the Bureau of Labor Statistics in December 2011.

Although nurses haven’t been laid off in large numbers, many are finding themselves to be the family breadwinner because a spouse has lost a job. Others are still working part-time or per diem well into their 70s. Even in urgent care, recruiters meet many applicants with 32-hour work weeks who are looking to add hours.

“Because of the economy, we have full-time nurses who otherwise would’ve been part-time nurses and full-time moms,” said Ines Gourley, nurse recruiter at Dignity Health Mercy San Juan Medical Center, a member of Dignity Health. “When the husbands lost their jobs, these nurses bumped up their hours, which decreased opportunities for new grads.”

Experienced RN Shortage

Though most nurses are holding onto their positions, prospects are plentiful for those with solid work experience who are looking for a new position.

At Mercy San Juan Medical Center, a member of Dignity Health Mercy, the most immediate needs are for emergency and OR nurses who’ve been on staff in the specialty area at another acute care facility for more than 2 years.

“Working in the OR is very specialized,” said Gourley. “It’s an area without a lot of training opportunity so managers want experienced nurses.”

One recruiter at Sacramento’s Shriners Hospitals for Children commented that they’ve traditionally had challenges finding nurses who are trained in burn care. ICU nurses with an interest in treating burn victims are usually trained internally.

Management Anyone?

In recruiters’ eyes, the only candidates more desirable than experienced nurses are nurse managers.

At University of California at Davis’ Betty Irene Moore School of Nursing, many of the graduate students already hold management positions in hospitals and are promoted even higher upon graduation.

“All healthcare organizations need to pay a lot of attention to succession planning,” said Debbie Ward, PhD, RN, FAAN, associate dean and health sciences clinical associate professor. “We always need a new generation of leader, especially now when we’re preparing for a bolus of previously uninsured patients.”

New Grad Challenges

With the promise of abundant opportunities after less than 3 years and steady employment 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. Mercy San Juan still operates a new grad residency program but Gourley reports seeing a record number of applicants for the 15-18 slots. In addition, it’s not uncommon for her to get resumes from 2010 graduates as well as the most recent classes.

“No matter how much we may like to get new blood, we can’t saturate a unit with new grads because our experienced nurses will burn out,” explained Gourley. “For new grads to have a quality residency experience, they need the experienced nurses to share their knowledge and expertise.”

Beyond Acute Care

Though the traditional career path was to join an acute care staff upon graduation and then maybe switch hospitals or specialties after a few years, Gourley predicts ambulatory care jobs will dominate the nursing employment landscape shortly.

“I find it interesting that new grads always want to go into acute care, yet most of the focus will be on preventive maintenance if healthcare reform is enacted,” Gourley said. “Younger nurses are going to be very disappointed because it’s not where their interest lies. The healthcare system they wanted may not be available and we may have a lot of people educated in a field they’ll never work in.”

Although it’s contrary to the traditional mindset about the first job after college, Ward agrees that high growth potential exists outside of acute care settings in businesses or government agencies. While students have difficulty in wrapping their mind around working outside the hospital setting, Ward said the second-degree nursing students she meets are thrilled about the new prospects.

“Opportunities for new and experienced nurses are growing,” Ward said. “Ten years ago, nobody talked about nurse informatics. Now every health system links data and information to nursing care, which is the reason people go to the hospital in the first place.”

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 in their hometown with a hefty signing bonus. Even taking a job in long-term or sub-acute care is better than competing with the next year’s graduating class, said Gourley.

Gourley advises sticking close to the college campus because of connections between the nursing school and the community.

“You’re a known commodity in the area where you went to school,” she stated. “As a student, nurses have a chance to make a good impression. I get resumes from people who grew up here but maybe went to school in Hawaii. These nurses are unknown commodities to me but the students who went through clinical rotations at this hospital are familiar.”

If this doesn’t work, Gourley advises moving to a geographical area where prospects are better.

Her remaining advice is logical but commonly ignored. Explain gaps in employment, include exact months in employment dates and eliminate insider lingo from the resume.

“Experienced nurses always think you know what Unit 5E means,” she said. “People who take the time to go into greater detail and prepare an accurate resume get a closer look.”

Hiring Rebound

Despite the current challenges in finding a nursing job, California employment figures are steadily increasing and the average age of nurses is creeping into the mid-40s, so it’s a relatively safe bet that the healthcare employment picture will brighten.

While nobody can pinpoint an exact timeline of when nursing jobs will again appear in abundance, Ward guarantees it’s a career with a bright future.

“It’s reasonable to be optimistic,” she said. “As the Baby Boomers age, we’re going to need nurses in every retirement community as the link for people to age at home. Nurses with clinical skills will have a place in the business world. Take an aggressive stance about marketing yourself in places you never thought of and finding opportunities where they’re not spelled out.”

Robin Hocevar is senior regional editor at ADVANCE.

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At Mission Hospital, Asheville, NC, a 750-bed, acute care hospital, Mary Caldwell, MDiv, MA, ethics coordinator, posted the announcement: “Ethics Grand Rounds, Thursday, Jan. 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 between morals and ethics 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
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.
- Design a workshop.

Caldwell said when nurses learn about moral distress they talk about how they’ve been affected. When they can identify the cause of their feelings and behavior, they are more apt to speak up.

The Politics of Staffing
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**April 11, 1-2 pm ET**
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**Management**

**Moral Courage: Always the Solution?**

Developing moral courage to speak up and carry out some of the interventions discussed above takes time, resources and commitment from the clinical nurses, nurse leaders and administration 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 healthcare 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.

“Central to the nurse’s ability to act in a morally courageous manner is the nurse’s knowledge of the situation (wisdom), emotional control (temperance), management of the risk and ability to address assertively the moral problem (courage),” Lachman summarized.

**Redundant Terms?**

Some experts contend moral leadership is a redundant term; however, many disagree. In nursing, for example, 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 when necessary. Values clarification must be modeled by moral leaders if the next generation of leaders are going to embrace conflict as a means to resolve ethical dilemmas.

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 concrete examples of moral leadership for each of the prevalent leadership styles.

References for this article can be accessed at [www.advanceweb.com/nurses](http://www.advanceweb.com/nurses). Click on Resources, then References.

*Kay Bensing is staff nurse consultant at ADVANCE.*
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,” said Berkowitz. “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.
**Labor & Delivery**

“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 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.
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 CLABSIs.

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
Critical Care

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, 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 hospitalwide 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.
Emergency Care

Clarifying ED Congestion

Nine associations sign off on standard definitions to avoid ED overcrowding

By Beth Puliti

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, and 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.
Consequently, 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.

Standard Definitions Outline
Nine healthcare organizations have agreed to these standard definitions:

**Time Stamps**
- Emergency department
- Emergency department arrival time
- Emergency department offload time
- Emergency department transfer of care from pre-hospital provider’s time
- Emergency department triage time
- Emergency department treatment space time
- Emergency department physician/advanced practice registered nurse (APRN)/physician assistant (PA) contact
- Emergency department documentation of disposition to discharge
- Emergency department decision to admit
- Admission time
- Emergency department departure time

**Time intervals**
- Emergency department length of stay
- Admitted emergency department patient
- Emergency department offload interval
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