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Pamela Tarapchak

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With all the replacement hospitals, new towers and private patient rooms opening in Chicagoland, nursing job seekers might be inclined to think there’s a plethora of employment opportunities.

In the city, Children’s Memorial Hospital is moving to a new structure adjacent to Northwestern Memorial Hospital on June 9. Rush University Medical Center opened a new hospital building called the tower at the beginning of 2012. The new University of Chicago Medicine is slated to unveil its new hospital pavilion in January 2013. Massive facilities opened in the past few years or are under construction in suburban Elmhurst and Hinsdale. Expansions are under way at NorthShore University Health System’s Glenbrook and Skokie Hospitals. Recent Illinois Hospital Association data unveils a $6.6 billion price tag for new and upgraded facilities between April 2009 and April 2011.

During this same time period, the American economy plummeted into a recession. Unemployment in metro Chicago-Naperville-Joliet was 9.3 percent in December 2011. Earlier this year, Gov. Pat Quinn proposed $2.7 in Medicaid cuts, which would have a devastating effect on hospitals’ bottom lines, especially after years of delayed or inadequate Medicaid reimbursements.

Given the local fiscal and political environment, hospitals have been wary of hiring extra staff, but the tide may be turning, albeit very slowly, say nurse recruiters at leading Chicago hospitals.

“When our new 14-story tower opened in January, it increased our need for nursing staff,” said Suzanne Klinetop, RN, PHR, senior human resources consultant at Rush University Medical Center. “We recruited and hired both new grads and experienced nurses.”

At University of Illinois Hospital & Health Sciences System in Chicago (UIH), changes within the state university retirement system fast tracked some nurses’ decision to leave the workforce, so a number of positions are opened.

“We recruited and hired both new grads and experienced nurses.”

At University of Illinois Hospital & Health Sciences System in Chicago (UIH), changes within the state university retirement system fast tracked some nurses’ decision to leave the workforce, so a number of positions are opened.

“‘For us, things are looking up,’” confirmed Cheryl Pinotti, MS, RN, NE-BC, manager of recruitment and retention at UIH. “‘We have a number of open positions in all areas, including critical care, OB, med/surg, ambulatory services, really across the board.’”

Hot Specialties
While UIH’s hiring is widespread, neighboring facilities are only slowly starting to recruit again in very high demand areas.

At Loyola University Medical Center in west suburban Maywood, labor and delivery nurses with 1-2 years of experience represent the biggest challenge. “Generally, L&D nurses don’t move around very much,” said Paul Walden, RN, CHCH, nurse recruitment manager at Loyola. “We’re a Magnet facility so we have to keep in mind that 75 percent of our nurses need BSN preparation.”

As the new patient tower at Rush opened in early 2012, patient census increased, creating a demand for experienced med/surg and adult critical care nurses.

“There’s also an increase in the number of NP and CNS opportunities they’re asking us to recruit for,” said Debra Pilolla, RN, senior human resources consultant at Rush University Medical Center. “These positions continue to provide challenges as they require at least a year of experience. If candidates have significant experience as a staff nurse before coming into the APN role, we’ll give consideration to that.”

Improvement in New Grad Market
For the past few years, new grads have been in a bit of a conundrum. Nurses freshly hatched from campuses across the country were told there was plenty of opportunity after a year or two on the floor, but no new grad hiring.

Prospects for the class of 2012 seem slightly brighter, but the market is still highly competitive. At Loyola, Walden anticipates signing on about 100 newly graduated nurses in all specialties. “It’s
more than last year, but the market is still tight for them," Walden noted.

Loyola still operates a new grad residency program in med/surg, as has been their policy for many years. The program accepts 10 students a time and Walden commented on the high volume of applications he’s noticing.

Rush offers an established new grad residency program in the first year. As far as new grad hiring, Klinetop classified the job market as “more encouraging than last year as we’re approaching the spring/summer graduation season.”

“More new grad opportunities are starting to peek open,” confirmed Pilolla. “Units are continually assessing to ensure that excellent orientation for new grads is taking place.”

UIH announced commencement of its University HealthSystem Consortium/American Association of Colleges of Nursing Residency Program that will begin this July.

“Since we anticipate hiring more new grads, it’s an ideal time for the residency as the goal of the program is retaining your new grads,” said Pinotti. “Even before the recession, we’ve never had a problem with retention, however, with all our retirements, this seemed like a good year to introduce the program.”

Insider Tips
Although opportunities are starting to open up, competition is fierce and recruiters say it takes more diligent marketing than ever to land a position in the Windy City. Walden said attention to detail is a must for all nurses. Don’t assume an uploaded résumé fills in all the blanks in the application, he said.

“Show your professionalism in little ways by capitalizing the letters in your name,” he advised, adding that passion plays a big part in the interview. Rush’s recruiters agreed passion comes into play. “Most units want to seek nurses who have a demonstrated interest in the unit’s clinical specialty,” said Klinetop.

Should the dream job not materialize this year, recruiters advised taking another job in nursing. “Consider various clinical areas to work in while you’re striving for a position in your preferred specialty or facility,” said Pilolla. “You may discover you enjoy a nursing specialty you never considered.”

Most in the industry are familiar with the projected 1 million nurse shortage by 2020, but nobody claims to know when mass hiring of nurses will occur. The Chicago economic climate is volatile, but recruiters are certain nursing is a career with a future.

“We’re in the midst of a lot of funding changes in our state government and the Affordable Care Act is coming soon,” said Pinotti. “Nobody has the exact answer. Hospitals have to live in their budget but also have to staff the unit to provide the care patients deserve. It’s a balance between being fiscally responsible and patient-centered.”

Robin Hocevar is senior regional editor at ADVANCE.
A microscope is being aimed at healthcare-associated infections (HAIs), 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 HAIs. Starting in January 2011, hospitals have been mandated to share data on central line-associated bloodstream infections (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 (VAPs) — can be prevented if the correct policies and protocols are followed.

Simple Measures
It's about simple measures in most cases. The University of Pennsylvania Health System, Philadelphia, 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. The change was started when the chief nursing officer at Penn met with shared governance leadership to set 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 worked closely with an external consultant to identify the steps they were taking in the care and maintenance of central lines. Any variations 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. From 2007 to 2010, CLABSIs fell by more than 90 percent.

Leading the Way
Massachusetts General Hospital, Boston, 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 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 standardized kits and supply carts, and incorporated a monitor 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.

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. “VAP prevention is all about keeping secretions out of the lungs,” Wright said.

As with CLABSIs, 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,
The power of One

As of November 1st, 2 exceptional health care systems came together as 1. Provena Health and Resurrection Health Care have now formed the largest Catholic healthcare system in Illinois, encompassing 12 hospitals, 29 long term care and senior residential facilities, numerous outpatient services and clinics, home health services, hospice, private duty, comprehensive Behavioral Health services and more.

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nurse manager of the critical care unit at Penn, again, it all comes down to the nurses. “The nurses on the floor take ownership on improving VAP, and they bring information back to the unit,” Ranjo said.

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. Some hospitals have automated reminders. “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
The simple measure of hand hygiene helps prevent the spread of antibiotic-resistant bacteria in the ICU. Yet compliance is still at or below 50 percent. Part of the issue may be the time involved. It’s estimated nurses could spend up to 30 minutes per hour washing their hands. But an easy solution is alcohol-based rubs.

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.” In 2007, a modest hospitalwide bonus was awarded if targets were achieved. 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.

Culture Change
With reimbursements now 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. ICUs with the lowest HAI rates report sister ICUs in the same hospital system now share data and information. “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. … 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. Consequently, they become angry. “Facing an angry
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

These definitions are agreed to by 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 the National Association of EMS Physicians.

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.

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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
researchers. These included: “stories that haunt us.”

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.

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. 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.”

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. 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.

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. Click on Resources, then References.

Kay Bensing is staff nurse consultant at ADVANCE.

The Politics of Staffing
Demand for nurse staffing legislation at the state level continues to rise. But will there ever be a national safe staffing law? Visit www.advanceweb.com/Nurses and search “Politics Staffing.”
A jumbo jet crash makes for horrific headline news. On the other hand, a rogue sponge left inside a patient following surgery is rarely newsworthy. Nevertheless, human errors in medical care are in fact more deadly than a headline-worthy plane crash.

“The Institute of Medicine published a study, ‘To Err is Human: Building A Safer Health System,’ which showed the yearly number of deaths caused by healthcare errors is the equivalent of a jumbo jet crashing every day. That statistic made everyone take a step back and begin looking for ways to decrease human errors in healthcare,” said Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN, the CEO and executive director of the Association of PeriOperative Registered Nurses (AORN).

A Human Factors Toolkit made available by AORN [www.aorn.org] seeks to increase patient safety and decrease human errors by assisting operating room teams in effectively working together.

“The toolkit is made to move an OR staff from problem to solution. The problems addressed are human factors, not medical failures per se. The solution is, of course, to develop a highly reliable OR team that can successfully solve problems,” said Groah.

Captain & Co-Pilot
Quantifying healthcare errors in terms of jumbo jet crashes is not the only similarity that exists between airlines and healthcare; both industries are fervently committed to keeping people safe.

“Years ago, when the airline industry saw an increase in incidents, they developed a program that looked at what was needed to enhance flight operations. Their studies showed that most complications were caused by human error, not mechanical failures,” Groah said.

Once the airline industry determined that human error was the source of their problems, a plan was implemented to limit mistakes in the cockpit. “What resulted from the airline industry’s study was a renewed focus on team attitudes toward safety called Crew Resource Management; prior to [CRM], their safety programs focused almost exclusively on individual efforts,” Groah said.

The creators of the AORN toolkit adapted the airline industry’s CRM to fit the unique demands of the OR setting. The toolkit topics include teamwork, communication, decision-making, situational awareness and other human factors. In addressing these five areas, the training encourages team members to
openly question decisions while being sensitive to each individual team member. “The correlations between pilot and surgeon are remarkable,” Groah noted. The airline industry found that lower-ranking pilots were hesitant to confront a higher-ranking pilot about the fuel gauge running low. Similarly, OR staff can be equally hesitant to confront the surgeon when he is about to make a wrong-site incision.

Pilot Locations
Five sites served as pilot locations for the AORN toolkit. Starting in 2005 and concluding in 2007, five facilities implemented the toolkit, including: Jackson Memorial Health System, Miami; Mayo Clinic, Phoenix; Memorial Health System, Colorado Springs, CO; Memorial Sloan-Kettering Cancer Center, New York; and St. Joseph Health System, Tawas City, MI. Of all the pilot sites, 1,700-bed Jackson Memorial was the largest. “At the time of the training, we had at least 39 ORs performing surgeries. We decided to start off small with the training, focusing on just the cardiac and trauma staff,” said Madelyne Hendricks, BSN, RN, CNOR, clinical nurse educator. Scheduling posed the greatest barrier to implementing the toolkit, Hendricks said. “Trying to connect the schedules of the nurses, surgeons and anesthesiologists proved very challenging. The biggest challenge that the training posed was scheduling it all,” she said. “Due to the OR team’s schedules, we were not able to train everyone at the same time. The training sessions were roughly 3 hours each so we had to get relief people in to cover shifts.” Nevertheless, the hassle of scheduling training was well worth the positive outcome of the Human Factors training. “We are much more patient safety oriented after going through this toolkit project,” Hendricks said. “We had always been committed to patient safety, but this training has allowed us to show it in a more tangible way.”

Communication Key to Teamwork
Few settings demand effective communication the way the OR does. Recognizing that precise dialogue is a must for an OR team, the AORN toolkit places a strong emphasis on
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Perioperative
communication.
“The toolkit addresses the fact that doctors and nurses have no training in communication with each other; both disciplines have a different communication style and educational background. Standardized communication is something that OR teams learn to utilize through this training,” Groah said.

Along with standardized communication, the training program seeks to give all members of the OR team a voice. “In the operation room, one of the issues that comes up is viewing the surgeon as the captain of the ship,” Groah explained. “If you have a young staff nurse and she sees that something is being done wrong, it will take a great deal of confidence to address that surgeon.”

Human Factors training can go a long way in remedying this hierarchical silence by placing all OR team members on the same level. “We strive to have teams work on a first name basis in order to flatten any positional hierarchy that may exist,” Hendricks said.

“One of the surgeons particularly likes this part of the surgical team briefing because he felt that he should know the surgical personnel by name, even if he was not working with the same team every week.”

Culture of Safety
Patient safety is the goal of Human Factors training; by minimizing human errors, an OR team can maximize patient safety.

“There has been a culture change toward patient safety not only here at Jackson, but throughout all healthcare centers across the country. Many more hospitals are making patient safety a focal point. This program was certainly a factor in our hospital’s change in culture,” Hendricks said.

Improving communication and reducing human errors in the OR is certainly not an overnight process. It requires formal training sessions, diligent practice and institutional support.

“Patient safety has to come before efficiency. A hospital’s leadership, from the CEO all the way down, has to believe that patient safety is most important,” Groah said. “It is a thread woven throughout an entire organization.”

A. Trevor Sutton is a frequent contributor to ADVANCE.

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