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A t 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 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.

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
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Management

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; 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 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.

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.

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. “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.
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 (VAPs) — 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, 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, 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.

“When 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.

MRSA UP CLOSE: This scanning electron micrograph depicts numerous clumps of methicillin-resistant Staphylococcus aureus bacteria. courtesy CDC/Jeff Hageman

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 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
Critical Care

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 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, 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 the future.

“It’s a huge change from the past,” Strauss 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 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.

Keeping Pace in Critical Care
As advancements in technology continue, nurses must ensure patients’ safety while maintaining ethical integrity. Visit www.advanceweb.com/Nurses and search “Keeping Pace.”
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 Madelynne 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 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.
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

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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
Feb. 23, 2009, the ENA convened a stakeholders’ meeting to develop standardized metrics. After a few changes, a final consensus statement was published in summer 2011 in nine healthcare association journals. Organizations that signed the 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.
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 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.

“The 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. 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.”

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 a debate over the safety of home births, Carter offered two
have a university degree they are seen as mechanisms in place. But because they don’t have a thorough training system and testing (certified professional midwives) do have the training of non-nurse midwives. CPMs of obstetrics. There is also the concern of home may be seen as a threat to the field financial backing. Moving birth back to the Berkowitz. “Physicians have lobbyists and medical community is very powerful, noted home births exists, in part, because the preconception health and healthy eating cultures that placed a much higher emphasis rates of chronic disease (diabetes, heart historically more dangerous than it is now. This, of course, is in contrast to the very low 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.

“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 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 thoroughly trained and competent. “They must see the signs early and act accordingly,” said Berkowitz.

Home births and hospital births are safer than they were 100 years ago: cleaner water, better hygiene and better nutrition, noted Falcon. Home birth safety comes from supporting labor as a natural physiological process and not using routine interventions, she concluded.

Beth Puliti is a frequent contributor to ADVANCE.
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