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From the Editor

Each May, ADVANCE takes a moment to celebrate nurses. In this issue, we profile three extraordinary nurses who are on the front lines of executive management, oncology, and heart and lung transplant. Each exemplifies compassion, care and service all while creating a safe and positive environment for their patients and their families.

After receiving hundreds of entries from nursing teams across the country, a panel of judges identified 10 teams that excel in adaptability, expertise, outreach and initiative. You’ll learn more about Glendale Memorial Hospital — one of ADVANCE’s 2012 National Best Nursing Teams. Visit www.advanceweb.com/Nurses to read more about the other nine winners.

As with each issue, we offer diverse content. Learn more about preventing the risk of hospital-acquired infections in “Keeping It Clean,” and improve blood management and the need for transfusions during surgery in “Picking the Right Agent.” In addition, you’ll find more information on critical care topics and management issues affecting the workplace.

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Pamela Tarapchak

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As vice president and chief operating officer at St. Mary Medical Center in Long Beach, CA, Gail Daly’s main philosophy is that patients come first. Daly, RN, has built her dynamic career around this thought — from her early career as a bedside nurse to her current role as a hospital executive.

However, patient care has been an ongoing theme in Daly’s personal and professional life. As a 10-year-old, Daly cared for a wheelchair-bound neighbor who needed nursing care but lacked the finances to afford full-time care. Later in high school, Daly wanted to become a doctor, but she later decided to enter nursing school to avoid the burden of medical school loans.

“When I started to look at nurses versus physicians, I liked how nurses interacted with patients,” Daly explained. “It was more of a hand-to-heart approach. I felt that the impact I could have from a caring perspective was better served being a nurse.”

After graduating from nursing school, Daly worked for two organizations before embarking on a career as a traveling nurse. She landed a 3-month assignment at Olympia Medical Center in Los Angeles working as a night nurse in the HIV/AIDS unit. “At the time, no one wanted to care for those patients,” Daly said. “In my opinion, the nurses I worked with were a special group.” Daly stayed at the hospital for 14 years evolving into many different positions – from charge nurse to educator to an emergency room director to chief nursing officer (CNO).

In 2004, St. Mary Medical Center’s chief operating officer encouraged Daly to apply for the CNO position. In the midst of organizational transition, the hospital was in need of stability. Daly’s vast experience served her well in this new role, which eventually lead to her promotion as chief operating officer and vice president.

“I think the benefit of being a bedside nurse who evolves to a leadership position is that you see all aspects of care, including how systems work and how departments interface together,” Daly explained. “Once you’re at the CNO level, you understand what impacts the patient and the nurse, and what hinders the nurse from being able to perform nursing care.”

As a nurse executive, Daly has been an integral component to St. Mary Medical Center’s success. Crediting her early career, Daly said she has a better ability to see where systems and communications can be improved to streamline operations, so patient care comes first. A patient’s best interest is always at the core of every decision the hospital makes, she said.

In addition, she examines the hospital’s departmental relationships, so each supports the other, helping to prevent silos in the organization. Daly’s leadership agenda has helped earn St. Mary a reputation for helping all sectors of society while earning high marks and top metrics.

During her tenure, St. Mary instituted the Comprehensive AIDS Resource Education (C.A.R.E.) Program dedicated to taking care of patients with HIV/AIDS. Supported by a donation from the Sisters of Charity of the Incarnate Word, C.A.R.E. is one of the largest comprehensive care clinics in Southern California. “The program is instrumental to our mission,” said Daly, “and it also supports my philosophy of taking care of all patients — no matter what their background is.”

**Patient Support**

Oncology nurses witness patients through all stages of cancer — diagnosis, treatment and recovery. As Linda Nguyen-Flores, RN, said — it’s about “respecting humanity and helping others in need.”

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Transplanting Hearts

In 1994, Caron Burch, MSN, RN, FNP, CCTC, was hired as a heart and lung transplant coordinator at the University of California, Los Angeles (UCLA) Health System. It wasn't Burch's first foray into cardiac care; she previously held positions in Ohio, Texas and California caring for chronic heart patients.

In addition, to her duties as coordinator, Burch was also a graduate student at the University of Southern California working toward an MSN/ family nurse practitioner certificate. Burch credits her fellow nurses for this successful venture. "I was fortunate to have a very supportive group of colleagues who helped me out," she explained. "I was able to get through my schooling because of them."

With the exception of a short stint as a cardiothoracic surgery nurse practitioner, Burch has remained in heart-lung transplant
at UCLA. Currently, she is the nurse manager of the UCLA Heart and Lung Transplant program, the pre-pediatric heart transplant coordinator and the manager of the ventricular assist device (VAD) program. In addition, she works intermittently for the Joint Commission as a VAD reviewer.

Burch's ambitious career has been in cardiac care with a focus on transplants. In her multiple roles, she works to maintain a balance that puts patients first while striving to maintain standards and rules, which include managed care processes, regulatory compliances, staffing issues and increased hospital costs.

As with her earlier schooling, she credits her team for her success. “I have a fantastic team, and I could not do what I do without the team that I have,” Burch said. Her current nursing team includes 10 heart and lung transplant coordinators, two VAD coordinators and eight administrative assistants. They manage approximately 30 heart and 60 lung transplant candidates on the waiting list and follow close to 200 adult heart, 120 pediatric heart and 300 adult lung post-transplant patients.

In fact, Burch is adding to her team. To allow her more time to manage, she is hiring someone to replace her as the pre-pediatric heart transplant coordinator. As a hiring manager, she looks for the same qualities that have been inherently part of the heart and lung transplant unit — enthusiasm, ambition and the love of learning. “There’s a lot of outpatient care,” she explained, “and a lot of responsibility when it comes to the [donor] call. You have to learn to step back and let people teach you.”

As a manager, Burch’s goal is to have an environment that is comfortable, effective and efficient. “These nurses work so hard. It’s a tough work environment. To me, it’s important to foster an environment that’s compassionate,” she explained.

Burch also is concerned about the patient environment. Although patients and their families are more educated and savvy about their health, it’s important they feel comfortable asking questions and voicing their concerns. They need to actively participate in decisions that affect their care, she explained. “We [at UCLA] are very sensitive to patient satisfaction,” Burch said. “Patients usually have a choice of where to go for their healthcare, and if they choose UCLA we strive to provide a positive experience each and every time.”

Alison DiPaolo is custom communications coordinator at ADVANCE.

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A special message to our dedicated nurses

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Blood is thicker than water. Four times thicker to be precise. Still, controlling blood flow can pose many problems. Conserving blood in the preoperative and perioperative setting is vital to positive patient outcomes. To help reach those positive outcomes, various hemostatic agents may be used to conserve patient blood levels.

“Effective blood management keeps patients from having to receive a blood transfusion. Not only does this keep the patient from potentially compromising his or her immune system, it avoids a costly and unnecessary [procedure],” said Vangie Dennis BSN, RN, CNOR, CMLSO, administrative director, Spivey Station Surgery Center, Jonesboro, GA.

Many different items fall under the umbrella of hemostatic agents. Ranging from gauze all the way to fibrin-based surgical sealants, many different hemostatic agents are available to nurses. The key is picking the right one for the right application.

“The biggest thing people need to know about hemostatic agents is that there are different types that are used for different purposes,” Dennis said.

Broadly speaking, there are three different types of hemostatic agents: absorbable hemostatic agents, surgical sealants and surgical adhesives. A fourth tool, hemostatic thermal tools such as ultrasonic scalpels and lasers, may be added to any hemostatic repertoire.

Testing & Evolution
The various hemostatic agents currently available have been rigorously tested in both laboratory and clinical settings. Yet, many of these hemostatic agents have received their most rigorous testing on the battlefield.

“Our research primarily deals with battlefield trauma. Getting the patient stabilized and into the perioperative setting is our end goal in studying these hemostatic agents,” said James Burgert, MSNA, CRNA, staff nurse anesthetist at Brooke Army Medical Center (BAMC) in San Antonio.

Burgert and other researchers at BAMC have been studying the safety and effectiveness of hemostatic agents. According to Burgert, a very clear evolution has occurred within the types of hemostatic agents available.

“Early hemostatic agents used granular, porous, mineral-based substances to absorb plasma and concentrate platelets and clotting factors at the hemorrhage site,” he said. “However, this first generation of hemostatic agents generated an exothermic reaction in excess of 140°F. This reaction caused increased potential tissue damage to the patient and could potentially cause injury to the provider if the substance came in contact with their mucous membranes.”

Though plagued by unintended side effects, these early hemostatic agents showed promise. The next step was to find an absorbable hemostatic agent that did not induce an exothermic reaction.

Although the heat issue was eventually overcome, early hemostatic agents posed other significant problems when it came to application. “All of the early hemostatic agents used in a combat setting were a particulate poured into the wound,” Burgert said. “The problem was that high velocity hemorrhage would eject the particulate before it could work. Even worse was that there was the possibility some of the particulate could enter into the patient’s circulation, causing an embolic event,” he explained.

A new generation of absorbable agents aims to correct these problems. “Recently, a third generation of hemostatic agents has been developed that consists of gauze-like dressings impregnated with the hemostatic agent. With these you have the benefits of the hemostatic agent combined with the benefits of traditional wound management. The mass of the dressing fills the wound cavity, increasing direct pressure on the wound, while the hemostatic agent concentrates platelets and clotting factors,” Burgert said.

Many Agents Available
The rigors of combat call for unique hemostatic agents. Even though the operating room is dramatically different than the battlefield, a large degree of hemostatic agent crossover occurs.

Absorbable hemostatic agents are currently being used in the perioperative setting. Some may be composed of cellulose, collagen, plant-based polysaccharide or gelatin-based materials, while some use bovine thrombin to promote clotting.
Along with the absorbable hemostatic agents, sealants and adhesives are available. Surgical adhesives may be used as adjunctive therapy with sutures or staples. Also, surgical sealants may be used as adjunctive therapy when bleeding is uncontrolled by standard suture, ligature or electrosurgical methods.

“Surface agents can be used to create a seal at the bleeding site. These are essentially adhesives that hold two tissue surfaces together. However, it is important to note that there are some types of arterial bleeding that these will simply not work on,” Dennis said.

Another option for intraoperative blood management comes in the form of electrosurgical hemostatic agents, such as ultrasonic scalpels, lasers and vessel sealing technology, but can result in adverse side effects. “Many of these can lead to tissue death within 2 seconds of use,” Dennis warned. “Nurses must consider the complications related to the device.”

Of all the hemostatic agents available, the most effective method has to occur before the patient enters the operating room. “Before relying on hemostatic agents, nurses need to rely on a preoperative assessment,” Dennis said. “This is a clinical fundamental that provides early intervention for high-risk patients. Preoperative anemia can be addressed ahead of time by increasing red blood cell mass, for instance, while an assessment of current medications can go a long way in saving blood in the intraoperative setting.”

In some form or another, nurses are involved in hemostatic agents. That interaction may occur in the OR with the nurse applying sealant to a leakage of blood. “Preoperative and postoperative assessments are crucial to blood management,” Dennis said. “Attending to those will prevent excessive bleeding better than any hemostatic agent.”

A. Trevor Sutton is a frequent contributor to ADVANCE.
Even though evidence suggests faster healing at home and patients are eager to resume a more normal routine, it’s also very common for patients to receive the doctor’s OK and then start arranging a ride home.

Dignity Health’s Glendale Memorial Hospital in Glendale, CA, was no exception. At the corporate level, managers encouraged a quicker discharge so units weren’t unnecessarily staffed. Yet, in May 2011, the average med/surg or telemetry discharge time was stalled at 4 hours.

The 90-minute discharge goal seemed elusive when the initiative was handed down from corporate. According to Carol Cogswell, BS, RN, nurse manager, only 17 percent of patients were leaving within 90 minutes of getting the discharge order at this time last year.

Although the hospital was in the midst of staff reductions and low census, nurses committed to achieving the transformational care goal set by administration. Most units within the program plateaued when

50 percent to 60 percent of patients were heading home with the allotted discharge time. In the beginning, even this seemed lofty for the med/surg and telemetry units at Glendale Memorial.

Monica Hernandez, RN, headed up a 14-member team who refused to push the problem off to case management or say that the patients’ conditions were too complex for a speedy discharge.

Beginning in early 2011, unit clerks, case managers and monitor techs peeled away at the sources of delay. Notably, managers were excluded from the grassroots effort, as it was meant for bedside staff to resolve the issue with which they were all too familiar.

Prepping Patients
One major workflow change involved starting the discharge process much earlier: upon admission.

“We would talk about their home needs as soon as they arrived in the hospital,” said Cogswell. “In my medical unit, with surgical

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overflow, the average length of stay is 2-4 days. If you educate, inform and engage them about the therapies and recovery they can expect, and they know when their goal time is to go home, they’re ready.”

The concept sounds simple enough but required a seismic shift in the practitioners’ minds. Instead of planning only for tasks during an individual nurse’s shift, staff was asked to consider the entire length of stay. Furthermore, it wasn’t only a nursing endeavor but required the contribution of everyone from physicians to transporters.

“This is an example of remarkable adaptability to achieve a goal,” said Claire H. Hanks, MBA, RN, vice president patient care services/chief nurse executive at Glendale Memorial Hospital. “It took the cooperation of hundreds of staff across multiple disciplines to achieve this fivefold improvement in discharge times.”

Thinking Colorfully

Propelling the movement was the idea to color coordinate discharge planning. Colored magnets indicating a countdown until discharge was placed next to a patient’s room number and initials on a new discharge-planning white board hung prominently on the wall of the unit. “Red” magnets signified 3 or more days until discharge and corresponded to a set of tasks the nurse could begin upon admission. The other colors were “Yellow” (2 days), “Green” (1 day) and “Blue” (discharge day). A color-coded task list outlined simple tasks corresponding to each color. The nurse manager ensured staff kept up with their “color” checklists to avoid a scramble on the day of discharge.

Key to the success of this model was consistency, said Cogswell. It was perfectly acceptable not to discharge a yellow patient if the condition changed, but each patient had to be assigned a color.

Condition changes were discussed at the daily huddle. Surprisingly, Cogswell said this concept was difficult for staff to accept.

“At first no one would show up,” she recalled. “The team investigated and learned the term ‘huddle’ connoted a too-long, irrelevant meeting, pulling staff away unnecessarily from the bedside. In a stroke of genius, a team member changed the name to ‘metric minute.’”

The metric minute was more successful and involved social services, nurses and case managers meeting out of patients’ earshot to avoid a HIPAA violation. Staff isn’t required to stay for the case management part of the meeting, but the daily 60-second meeting to review discharges from the day before has been critical to staying on target.

After 4 months, the program was rolled out to four more units in the hospital. More importantly, patients and families leave the hospital on a happier note, as reflected by patient satisfaction scores on the unit.

“It’s scary to come to the hospital and lose independence,” Cogswell said. “When patients know what’s happening, they feel more comfortable. It’s the next customer service step beyond friendliness. We’re giving them the information to feel human again.”

Robin Hocevar is senior regional editor at ADVANCE.
Determining proper placement of a nasogastric (NG) or orogastric (OG) feeding tube is a common process for many nurses and a vital safety practice for all patients. Despite newer devices to aid with placement, feeding tubes are generally inserted during a blind attempt at the patient’s bedside. Feeding tubes can also be placed with the aid of devices that guide the process such as through ultrasound, fluoroscopy or endoscopy.1 Proper placement of any feeding tube should be obtained with the tip of the tube within the stomach or advanced past the pylorus and into the duodenum of the small intestine.

When using either a large-bore tube such as a standard Salem sump NG tube (14-16 French) or a small-bore one with a stylet and narrower (8-10 French) more flexible tubing, complications can occur. One large research investigation showed that, when examining insertion of 2,000 NG tubes, 1.3 percent to 3.2 percent were not correctly positioned, potentially leading to adverse events.2 Further investigation showed 28 percent of the incorrectly positioned tubes led to the development of a pneumothorax or pneumonia from aspiration.3 Improperly positioned feeding tubes can cause serious injury and can even lead to fatal patient events.

Complications such as respiratory distress, dyspnea, pneumothorax, aspiration pneumonia, sinusitis and epistaxis may occur.1 Rarer but more serious injuries include improper positioning into the brain or pleural space, which can lead to fatal outcomes.3

Verification Methods
Ultimately, proper verification of a feeding tube is vital to avoid dangerous outcomes for patients. The following six methods to predict proper tube placement will be reviewed: radiographic confirmation (chest or abdominal X-ray), auscultatory method, capnography, measurement of potential hydrogen (pH) in aspirate, respiratory distress observation and observation of visual gastric aspirate.

Radiographic studies such as a chest X-ray or abdominal X-ray, confirmed by a radiologist, are the gold standard for ensuring proper placement of a gastric feeding tube.4 After an NG or OG tube is inserted blindly at the patient’s bedside, confirmation with an X-ray is the most concise method to verify placement within both the stomach and small intestine. It is important to note the X-ray should visualize the entire feeding tube within the gastrointestinal (GI) tract in order to help identify the proper positioning.

Listening for a “whoosh” of air through the feeding tube over the epigastric area, located below the rib cage on the upper left quadrant of the abdomen, can confirm placement. This auscultatory method is most frequently taught and easily performed. Use a piston or luer lock (30-60 cc) syringe, insert 20-30 cc of air into the tube and listen with a stethoscope over the epigastric area.5

Although recommended for preliminary confirmation, this is not a dependable method because it can be difficult to distinguish between respiratory and gastric placement.

Air sounds can emanate from the tube...
and be transmitted throughout the lower airway or upper abdomen to give false position verification. The auscultatory method also does not confirm exactly where the feeding tube is positioned, i.e., upper or lower stomach or small intestine.

The capnography method is performed by using a carbon dioxide (CO2) detector to assess if any CO2 is identified in the NG tube, indicating placement in the pulmonary system. The downfall of using a CO2 detector to verify placement is that this method is not specific or sensitive enough to detect CO2 gas.5

And, like the auscultatory method, the capnography method cannot determine the exact placement and location of the tip of the feeding tube.

Observing the appearance of the gastric aspirate and monitoring the pH of gastric aspirate can inform a practitioner if the tube is within the GI tract. Potential hydrogen levels in respiratory secretions generally are greater than six, while the gastric pH is usually less than five, even for those patients receiving gastric acid inhibitors.6

Utilizing litmus paper to test the gastric pH is another possible confirmatory method. Applying a drop of aspirate from the NG tube on the litmus paper will establish the pH level.4 But, this method is also unreliable due to the changes in pH within body secretions.

For example, secretions from the small intestine typically can have pH levels greater than six, which may lead one to believe the tube is positioned in the respiratory tract and not the GI region.

Also, secretions can be more alkaline from saliva or acidic from gastric reflux juices, which will alter the pH of the secretions and, therefore, give an inaccurate result.5 Inaccurate results can lead to improper verification of the tube’s position. The appearance of the aspirate from an NG/OG tube may look like gastric content, but it is too difficult to determine with the naked eye.

**Monitoring for Adverse Placement**

Observing for signs of respiratory distress, coughing or dyspnea may also be seen if the feeding tube is positioned in the respiratory tract. This is because the tube is irritating to the trachea and can cause the patient to cough, gag and have difficulty breathing. Monitoring pulse oximetry may be helpful to determine this adverse result.

All of these methods will assist in verifying the proper placement of a temporary gastric tube, but the best type of confirmation is an X-ray after the tube is placed and then done daily.

Prior to infusing tube feedings or medication through an NG/OG tube, you should always verify placement to avoid aspiration complications.

Check for proper placement at regular intervals as recommended by your facility, such as every 4 hours. This is important because the tube can migrate out and also become knotted, kinked or displaced upward into the respiratory tract. Always mark the placement of the NG/OG tube and document the exact position, usually noted in centimeters on the smaller feeding tubes, to help with detecting tube dislocation.

While proper placement and verification of an NG/OG feeding tube is a skill learned by nurses and other healthcare providers, it is the first step in ensuring safe delivery of care for patients.

Additionally, close monitoring, care and assessment of the temporary gastric tube will help decrease complications leading to injuries or adverse outcomes for your patient.❖

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

Mary Ellen Dimatteo is a critical care nurse, charge RN and preceptor at the trauma center CCU at Advocate Good Samaritan Hospital, Downers Grove, IL.
Infection Control

Keeping It Clean

Keeping patients safe means more than just handwashing for nurses and other healthcare providers

By Candy Goulette

Everyone working in healthcare, from the hands-on practitioner to an environmental services worker, knows the drill: wash your hands before entering and when leaving a patient room to decrease the spread of infectious pathogens. But can what happens while practitioners are in the room also raise the risk of hospital-acquired infections (HAIs) spreading?

Sue Barnes, BSN, RN, CIC, director of Northern California Regional Infection Control for Kaiser Permanente in Oakland, and a past board member of the Association for Professionals in Infection Control and Epidemiology Inc. (APIC), said that’s the question of the hour for infection preventionists. The simple answer is yes.

Protection & Prevention

While stressing proper hand hygiene is the most important weapon in the fight against HAIs, Barnes said contamination in the near-patient environment — the hard surfaces — also is a very real issue.

“When we’re talking about infection transmission risk, the greater risk is with hands and hard surface contamination, so it’s important to focus both on the hands and the contaminated environment,” she told ADVANCE.

“If you think of how hard surfaces are touched, it’s obvious that it’s much easier to contaminate solid, flat, hard surfaces, and for those bugs to remain on those surfaces,” she explained. “That means a more vigilant cleaning in the patient environment by housekeeping is crucial. Along with hand hygiene, that’s where the bang for the buck is.”

Due Diligence

Barnes said the focus on hand hygiene has been strong for the past 10 years for both infection preventionists and practitioners.

“There have been many creative ways put forth to optimize hand hygiene and we continue to explore new methods to support optimal hand hygiene with advanced technology,” she said. “Similarly, there have been large initiatives with a lot of focus placed in the past years on optimizing cleaning and disinfection of the patient environment.”

To that end, APIC is partnering with other organizations as part of a group of initiatives, called Building Bridges, designed to establish relationships between APIC’s infection preventionists and members of other stakeholders. One initiative, Clean Spaces, Healthy Patients, is a collaboration with the Association for the Healthcare Environment of the American Hospital Association.

Under a Microscope

Barnes shared information about a recent study at the University of Maryland Medical Center (UMMC), Baltimore, in which researchers tested 10 environmental surfaces in each of 50 rooms used by patients with a positive culture for Acinetobacter baumannii. In the UMMC study, nearly half of the rooms and about 10 percent of the surfaces in the near-patient environment were contaminated, including supply cart handles, room floors, infusion pumps, ventilator touch pads and bed rails. It also suggested patients with either a recent or remote history of positive cultures were equally likely to contaminate their environment.

Barnes said she was not surprised. “A. baumannii can stay moist for a long time, making it accessible in the patient environment,” Barnes explained. “This study correlates with others on different nosocomial pathogens, including MRSA and Clostridium difficile, and just underscores how important it is to optimize cleaning throughout the patient environment, for both nursing staff and environmental services, to eliminate or decrease the risk for infection for inpatients. “No matter where they are, if [patients are] in a vulnerable position, these things need to be maintained to ensure they aren’t exposed to any opportunistic bug,” she continued. “The bad bugs are not exclusively in the hospital setting — many patients bring them in with them from the community. Healthcare workers need to be especially vigilant in these situations, using correct hand hygiene and ensuring the environment is adequately and appropriately cleaned.”

And that’s the heart of the issue, said Bill O’Neill, vice president of infection control applications for PurThread Technologies Inc. For O’Neill, ensuring the soft surfaces are contamination-free is equally important.

“Microbial contamination is endemic in the hospital setting, in spite of the Herculean efforts made by both clinicians and environmental services staff over the past several years,” O’Neil shared. “Consider the challenge: whether colonized or infected, many patients bring pathogens with them when they enter the hospital. The environment can be further compromised by visitors, delivery people, service technicians and even clinicians who may carry unwelcome microbial guests with them as they move through the hospital.”

Candy Goulette is a frequent contributor to ADVANCE.
The nurses on our unit became the family she didn’t have.

The patient had made poor choices in her life that contributed to her being in our unit for four months. She was difficult at first, yet we became fond of her and were very sad when she died. It’s easy to feel instant affection for some patients. Others are more of a challenge. As nurses, we know that everyone deserves not only to be cared for, but also to be cared about.

Most people go to work. Nurses go to care.

A Community of Exceptional Nurses
Irrefutable evidence supports the efficacy of evidence-based management for geriatric patients and those with multiple comorbidities within the nursing home setting. Regardless, providers often divert from evidence-based practice (EBP) in lieu of practices based on tradition and experience. Paternalistic provider philosophy and practice that excludes patients and/or surrogate decision makers may violate ethical principles. In addition, NPs must consider legal consequences of practices based on tradition without supporting evidence. Management of heart failure and treatment of dementia-related behaviors in the long-term care setting are well-cited examples for which divergence from EBP is common.

Heart Failure
Angiotensin-converting enzyme (ACE) inhibitors and beta-blockers are often misused or underused in the treatment of long-term care patients with heart failure. Unless contraindicated (heart block, bradycardia, hypotension, severe respiratory disease), beta-blockers are efficacious for patients with recent or remote history of MI.

Dementia
In 2011, a federal audit of Medicare claims found more than half of the prescriptions for second-generation “atypical” antipsychotics were written off label, without supporting documentation of indication.

Contrary to recommendations and black box warnings, use of psychotropic medications remains prevalent in the nursing home setting for dementia-related behaviors (e.g., agitation, repetitive questioning, wandering).

Use of first- and second-generation antipsychotics may increase the risk of stroke and premature mortality in patients with dementia. Adverse effects such as increased sedation, extrapyramidal side effects and anticholinergic side effects are common and increase the risk of fall-related injury.

Alternatives for Practice
Awareness of personal biases and objective evaluation of treatment benefits and burdens — with collaboration — guides best practice (see Table).

Geriatric considerations for heart failure management include dosage adjustments for advanced age and moderate to severe renal impairment.

Electrolyte levels and renal function (e.g., potassium, sodium, blood urea nitrogen, creatinine) should be monitored with initiation or dosage adjustments. Titration of beta-blockers should be based on heart rate, blood pressure and clinical response, with dosage adjustments no more often than every 2 weeks.

Symptoms that warrant psychotropics for dementia-related behaviors include impaired functional ability, danger to self or other residents, and interference with provision of personal care.

In addition, music, pet therapy and aromatherapy may provide nonpharmacologic relief for agitation. Evaluate acute and chronic conditions and sensory deficits that may increase agitation.

Implications for Practice
NPs have an ethical and legal responsibility to discuss and document all treatment options, including the benefits and burdens of each option, with geriatric residents and/or surrogate decision makers. Documentation of rationale for divergence, including contraindications for treatment options, is essential.

Appropriate EBP using a collaborative decision-making process exemplifies best practice. Evidence-based disease management has the potential to improve clinical outcomes, quality of medical and nursing care, establish evidence-based standards of care, and decrease unnecessary healthcare expenditures.

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

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Reasons for Divergence From Evidence-Based Heart Failure Management

- **Professional** philosophy of care
- **Lack of knowledge** of recommendations
- **Lack of confidence** in dosing for geriatric residents
- **Fear** of iatrogenic harm
- **Reluctance** to change treatment plans in stable asymptomatic patients
- **Selection** bias toward younger patients

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