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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, changing the culture of nursing through improvements in curriculum, culture and legislation. Each exemplifies the best in the profession as they work to improve the lives of 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 Community 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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We want to hear from you as well. Help us expand our content by sharing your story topics, and tell us how you appreciate the nurses in your life — either as a colleague, friend or patient. They deserve it.

Pamela Tarapchak

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Today, it’s a given that research and evidence-based practice are a part of every professional nurse’s portfolio.

But when Elisa Jang, MSN, RN, CNS, took the job of clinical practice manager at NorthBay Healthcare in 2005, she learned that most of the employees weren’t even familiar with the term evidence-based practice. Others didn’t think research needed to set the tone for hospital policies and procedures. She had her work cut out for her. Luckily, Jang had just the background for the job.

After graduating from a master’s program as a CNS, Jang stayed on at University of California San Francisco as the research coordinator for a clinical trial. She helped with recruiting, performed blood draws, collected data, updated a procedure manual and created a website. Some participants were given supplements while the control group was put on a heart healthy diet. Two of the five supplements were successful and made their way into journals.

After 3 years in the clinical trial, while also teaching part time, Jang started to get the itch to return to acute care and quickly found a home at NorthBay Healthcare.

When Jang learned of the knowledge gap surrounding evidence-based research, one of her first moves was to establish quarterly workshops. Each department would attend a presentation by the clinical practice manager. Slowly, momentum started to build.

“It helped that, at that time, the research movement started strengthening in other aspects of the medical profession,” Jang said. “The Joint Commission started using the language and people were becoming interested.”

Jang knew she’d need managers’ buy-in to make a culture change happen, and actively started building relationships.

Attending a national CNS conference in 2008 gave Jang the impetus to elevate NorthBay’s research culture into greatness. “It was here I learned that a lot of hospitals have a fellowship program that teaches nurses to conduct research, develop projects and implement the research in their department. I felt we were at the point where we were ready for something like that.”

She attended a week-long program at University of California Los Angeles on the particulars. Learning it would take 6 months to develop, Jang established the framework with a 2011 start date.

The fellowship is a yearlong commitment for staff nurses. The first 6 months entail 10 classes on conducting a literature review, reading research articles and participating on an evidence-based practice council. Each nurse is paired with an advanced practice nurse.

“I would’ve been happy to have had 10 people come to the informational meeting and we had 30,” she said. “It takes a lot of enthusiasm and passion to do this on top of your normal work and family responsibilities,” Jang commented. “We’re planning a new group every year. When people finish their projects, they present to their organization and others want to take on research.” It’s how a culture change comes about.

Healing America

It’s well known nurses are one of America’s most trusted professionals, and Susan Adams, PhD, RN, hopes that confidence will translate into votes. Adams is running for Congress, representing California’s newly reconfigured 2nd district encompassing the Marin County area. As a student, Washington was far from Adams’ plans. She started out as...
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
journalism major, but became pregnant at age 19. Knowing that a child would sideline her dreams of becoming a foreign correspondent, she changed her major to nursing.

Most of her career was spent in mother-baby units, labor and delivery, and ob/gyn. Adams went on to pursue a master’s and later a PhD.

While working in nursing education, Adams found herself in a predicament that shapes her policy view today. “I had a faculty position but my salary was abysmal,” she recalled. “I had loans to repay. If we want people to teach the next generation of advanced practice nurses, we have to pay them a wage comparable to what bedside nurses earn.”

When she found herself growing increasingly frustrated with the politics as usual within her district, Adams decided to throw her hat into the ring. Even though she knew she likely wouldn’t win, Adams first ran for an assembly seat in 1999. She was defeated, but said people paid attention when she spoke from the heart about the country’s broken healthcare system. She was elected as Marin County’s 1st District Supervisor in 2002 and has served 3 consecutive terms.

“In political work, you build communities, bring people together and implement plans to solve a problem,” Adams commented. “Sounds like the nursing process to me.”

Among Adams’ chief accomplishments is the creation of the Marin Health and Wellness Center. Using tobacco settlement funds, Adams was instrumental in creating access to affordable healthcare for all county residents. “In 3 years, the wellness center has gone from 10,000 to 100,000 patient visits,” she boasted. “It’s located in the heart of a challenged community but the vibrancy of this campus has recently attracted a local fresh grocer.”

Another of Adams’ pet projects is establishment of the Marin Medical Reserve, which received national recognition for vaccinating the entire county against H1N1 in a week’s time.

She’s also spearheaded the Mentally Ill Offenders Program, which diverted non-violent offenders into treatment rather than jail. With unmistakable pride, Adams noted it reduced emergency department psych visits by 55 percent.

Adams doesn’t shy away from taking a stance on other issues dominating the healthcare discussion.

On Medicare: “People tend to get heartburn when you mention a single payer system. We already have it, but only the oldest and sickest are in the pool. If we widen that and focus on more than end-stage care, we can cover everybody for less cost.”

On VA health: “Our veterans are driving hundreds of miles and that burdensome if you’re dealing with cancer or cardiac issues. We need an infusion of resources here.”

On telehealth: “Locally, through the Open Door Program, we’re getting healthcare into the home through teleconferencing by way of Johns Hopkins University and University of California San Diego.

On offsetting the cost of nursing education: “If we offer a services corps, nurses could work off their student loans in underserved areas. This could be expanded worldwide as viruses and illness are not contained within our borders.”
On encouraging more nurse politicians: “Just do it. Find mentors, write letters, work on a campaign and visit legislators. The more of us that get involved, the better healthcare is going to get.”

Robin Hocevar is senior regional editor at ADVANCE.

Cultivating Collaboration
An incident with a difficult physician, a fellow at the time, convinced Monica Cfkru, RN, that physicians might not understand the role, responsibilities and scope of practice of the professional nurse.

Cfkru, a staff nurse on E1, the blood and marrow transplant unit at Stanford Hospital & Clinics, decided to survey 25 physicians, and what she found was that few had a true understanding of the myriad roles nurses play. A literature review revealed similar situations in other organizations and underscored the need for interprofessional education between nurses and physicians.

Cfkru met with Clarence Braddock, MD, PhD, associate dean for medical education, who was immediately interested in implementing interprofessional education into the medical school curriculum. The outcome was the creation of an interdisciplinary performance crew consisting of seven professionals from various disciplines who would simulate a patient discharge scenario for first- and second-year medical students.

After the simulation, a question and answer session assesses students’ perceptions of communication and responsibilities among the professional. The overall goals of the class are to teach students there is no hierarchy during medical team communication and to demonstrate each discipline brings a unique perspective and expertise that together provide best patient outcomes.

To augment the interprofessional class, second-year medical students also have the opportunity to shadow a professional from one of the disciplines for several hours. The observation time allows for enhanced understanding of the power of collaboration between members of the multidisciplinary clinical team.

Cfkru continues to gather data on medical students’ level of learning before and after nurse shadowing. She remains focused on her goals of eliminating and addressing misconceptions or biases about the nursing role before medical students become physicians so every member of the team understands that communication, along with respect among clinical disciplines, is the key to success in improving patient outcomes.

In April 2011, Cfkru developed and established an interprofessional education program with the Stanford School of Medicine to help break down silos between physicians and nurses and help prevent patient errors due to poor communication.

A total of 250 medical students and 75 nursing students have been trained in the curriculum so far. Cfkru’s advice to other nurses: “If you have an idea you think is important and can help change nursing in a better way, speak up. The culture of nurses is not to speak up, but we are valuable and we need to speak up.”

Courtesy the Stanford Nursing Annual Report

A special message to our dedicated nurses
It’s Nurse Appreciation Week, and on behalf of the hospitals that make up HCA’s Far West Division, we would like to honor our nurses for their dedication and compassion they bring to each one of our facilities. Your continued quality and attention to patient care is so appreciated. We thank you!

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Monica Cfkru, RN, MSNc

Courtesy the Stanford Nursing Annual Report
Conserving blood in the preoperative and perioperative setting is vital to positive patient outcomes. To help, 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 also be helpful.

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. Burgert serves as 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. They’ve noted a clear evolution has occurred with the 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. “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.”

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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
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, 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, nurses are involved in hemostatic agents. However, “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.
Like countless other American facilities, Community Memorial Hospital in Ventura, CA, couldn’t find the magic bullet for reducing fall prevention.

They tried interventions like moving patients closer to the nurses’ station, employing expensive sitters, relying on tab alarms, but their numbers just didn’t seem to go down.

Robyn Popescu, BSN, RN, had been in nursing for 30 years and worked on the busy, 44-bed telemetry/progressive care unit. When she learned, in December 2010, the unit’s call light response time lingered at 2 minutes, 40 seconds, she connected the two problems.

“We have nursing technicians, but they get busy and that’s when patients have falls,” she said. “A lot of the times, patients will turn on their lights but then get tired of waiting. I thought, ‘what if we have one person to just deal with fall prevention?’ If we could get those lights answered in a timely manner, it would solve a lot of problems.”

Hospital administration took a chance and the Call Bell Tech program was launched. Following Popescu’s recommendations, one nurse tech answered all the call lights and performed anticipatory rounding on every shift.

**Culture Change**

At first, even Popescu thought the idea would flop.

“They didn’t give me any extra staff,” she recalled. “We normally have 3-4 techs on the floor at any given time so I had to take someone from the staff, leaving everyone with more patients. It was hard to convince staff that they’ll have patients but won’t have to answer their lights.”

Community Memorial launched the program on the night shift. Lo and behold, the call light times started diminishing, eventually...
hitting 30 seconds. When other modalities were added, like video monitoring, Popescu saw glimmers of a culture shift.

Over the course of a year, the program started to take off. Much of the success is due to the anticipatory rounding component, said Popescu. “We recognized a few people who were really good at rounding and added it to their duties, in addition to answering call lights,” she said. “The goal was for the lights to not even go on. These people weren’t assigned any patients but continuously circulated and provided excellent customer service.”

Earliest Intervention

With call light response times dropping dramatically, Popescu decided it was time to implement the next phase of the program. The Hot List highlighted patients with the highest fall risk and enhanced hand-off communication to improve their care.

“I recognized that 33 percent of falls took place in conjunction with bathroom visits,” she said. “People would walk to the bathroom and wouldn’t ring their bells afterward. Our nurses identified a combination of risk factors like age, previous fall history, medication side effects. We closed the communication gap between nurses and nurse techs, who previously didn’t have the background information on their patients.”

A critical component of The Hot List was reviewing case studies of patients who had fallen. Popescu compiled a document with the logistics of each fall and presented her findings at staff meetings.

It was during this process that Community Memorial nurses learned the extent that patients were removing their tab alarms. The nurses brainstormed that they could reduce their fall rate by using bed pad alarms in addition to the tab alarms and were proven correct.

“It’s pretty effective,” said Popescu. “If you raise your body from the bed, the alarm goes off. The problem is, if you only use bed pad alarms, there’s a delay time and it only takes a second to fall. Using the combination allowed us to close the time delay gap. If the patient is thinking of going to the bathroom and pulls off the tab alarm before getting out of bed, we are alerted with a warning.”

Those extra seconds have paid off. Since The Hot List was introduced, only one of the high risk patients has fallen.

Technology further came into play with the use of video monitoring. Each three-patient room was equipped with a video camera, and a telemetry tech watched heart rhythms for the entire floor at once.

Although it was hard for the staff to get used to the video monitoring, the evidence is encouraging. Popescu said the cameras have prevented three falls and saved substantial amounts of money in sitter fees.

The bottom line? “Our patients now feel safer under our care,” Popescu simplified.

Robin Hocevar is senior regional editor at ADVANCE.
Nurses at NorthBay Healthcare share their thoughts on shared governance

Shared governance is a great opportunity to have the hospital staff and leaders gather in one place to discuss all the important issues taking place. It is a great way for the staff to communicate and have a voice in changing and improving issues in the organization and hospital.

Robert Fogliasso, BSN, RN
Clinical Nurse II, Emergency Department
NorthBay Medical Center
Fairfield, CA

[Shared governance] gives me the opportunity to see the big picture within my organization. I’m able to meet and speak directly with RNs from other departments to discuss issues with respect to our departments. With these discussions, we can work to improve and maintain patient safety of the highest standards and build rapport.

Michael Rios, BSN, RN
Administrative Coordinator, CCS
VacaValley Hospital, Vacaville, CA

Nursing shared governance is important to me because it gives me the opportunity to voice my concerns for both my nursing profession and as an advocate for my patients. It has provided me with the opportunity to experience my profession from different perspectives, from inpatient care through current projects in legislature. It has broadened my perspectives of the different areas nurses practice in and the influence we have as a united profession!

Jennifer Veler, RN
Clinical Nurse IV, ICU
VacaValley Hospital, Vacaville, CA

[Shared governance] is a collaborative effort in making decisions to influence positive changes to better serve everybody we touch.

Carol L. Brower, RN, BSN
Clinical Nurse IV, ICU
NorthBay Medical Center, Fairfield, CA

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Robert Fogliasso, BSN, RN
Clinical Nurse II, Emergency Department
NorthBay Medical Center
Fairfield, CA

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What You Can Do about Nurses Hurting Nurses
➤ Learn more about relational aggression/female bullying, and how it impacts the nursing profession across generations and genders. In this session, you’ll learn to develop your own action plan so you can transform your work environment.
Presented by Cheryl Dellasega, PhD, GNP, author/nurse practitioner/professor

July 10, 2-3 pm ET
Disaster Preparedness for the Bedside Nurse
➤ This session will help prepare registered nurses in acute-care settings to respond to a variety of disaster situations that impact hospitals. You’ll learn more about the nurse’s general role during a disaster response, as well as how to protect and manage critical patient records.
Presented by Charlene Romer, PhD, MSN, and Tony Hebda, PhD, MNEd, MS

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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 said.

“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.”

“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’Neill 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.
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The Bachelor of Science in Nursing and Master of Science in Nursing programs are accredited by the Commission on Collegiate Nursing Education (CCNE). One Dupont Circle, NW, Suite 530, Washington, DC 20036-1120. 202.881.5791; www.aacn.nche.edu. The University’s central administration is located at 4301 E. Elephant St., Phoenix, AZ 85040. © 2012 University of Phoenix, Inc. All rights reserved.