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The website offers information and resources for readers looking to improve their healthcare environment. In “Going Green,” Beth Puliti profiles the website, including its foundation, mission and future endeavors.

In “ICU Salary Model,” four nurses discuss their facility’s approach to converting to a salary model in the ICU at Hunterdon Medical Center in Flemington, NJ. Using a Johns Hopkins model as a guide, the hospital developed a “salary model that would increase RN autonomy, accountability and job satisfaction.”

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From the Editor

Pamela Tarapchak

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➤ Nurses Book Club
➤ And more!

From the Editor

Embracing on a new chapter of healthcare initiatives, Go Green Healthcare Inc., a Chicago- and New York-based company, launched GoGreenHealthcare.org in April 2012. A group of pioneering experts in healthcare, architecture, engineering and environmental fields wanted to create a place that “would serve as a source of information on eco-friendly healthcare.”

The website offers information and resources for readers looking to improve their healthcare environment. In “Going Green,” Beth Puliti profiles the website, including its foundation, mission and future endeavors.

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Cover photography: Jeffrey Leeser/ADVANCE / thanks to Mercy Medical Center, Baltimore / John Ciuppa / design by Doris Mohr

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You’ll notice we’ve included a few QR codes. These “quick response” codes work much like a bar scanner. To use them, download an app to your smartphone (like ScanLife or QuickMark). Open up the app, zoom in on the code, and you instantly have access to ADVANCE for Nurses content.
Twenty years ago, David M. Sileo, MS, RN, ACNP, had “an awakening.” The critical care nurse, along with a group of other nurses at the Hospital of the University of Pennsylvania in Philadelphia, was given the task to come up with a money-saving idea. The group chose to focus on trash as their main initiative.

“I started looking at the amount of trash that is generated in a hospital,” he recalled. “Even the amount of trash in one room in one unit is just amazing. That’s what really opened my eyes. Hospitals are really quite the toxic trash generators.”

They were right. Hospitals produce a great deal of garbage — from paper and food to hazardous chemicals and infectious waste. Another aspect of their environmental footprint is energy use. Hospitals require an outstanding amount of energy to operate 24 hours a day, 7 days a week.

In fact, while healthcare facilities use twice as much energy as the average office building on a per-square-foot basis, hospitals use even more.¹ A study published in 2009 in JAMA calculated hospitals generated about 215 million metric tons of carbon-dioxide equivalent.²

Why, one might ask, should the medical industry take the time to carefully separate waste or worry about climate change? Because, as the World Health Organization notes, it “will inevitably affect the basic requirements for maintaining health: clean air and water, sufficient food and adequate shelter.”³

To help hospitals in their quest to keep their patients — as well as the planet — healthy, a group of experts who have a combined 50 years in various healthcare settings created GoGreenHealthcare.org, a virtual portal to all things green in healthcare. “We take care of people — and we need to be able to take care of our planet, too,” said Sileo, one of the founders of GoGreenhealthcare.org.

The Mission

Sileo noted that the website — which launched this past Earth Day (April 22) — has a large audience consisting mainly of people interested in the “greenovation” of the healthcare arena: architects, facility engineers, waste management specialists, healthcare practitioners, students, academics, researchers and more.

“We want to engage everyone,” explained Sileo. “This is a site where the architect meets the doctor and the facility engineer meets the nurse.”

With a mission to provide content and information on science, practice and innovations in sustainable initiatives, GoGreenHealthcare.org aspires to motivate others to reconsider the clinical setting environment in favor of safer working facilities, reduced use of environmental resources and improved patient care outcomes. The site is updated by a group of various professionals and advisors working on a pro bono basis because they believe in the importance of this mission.

Gail Feltham, president of Shore Strategies Health, which is managing the editorial and media operations at GoGreenHealthcare.org, remarked that a survey of healthcare professionals revealed they weren’t aware of what they could be doing to benefit healthcare.

“Whether you’re a nurse, a pharmacist, a technician or an administrative assistant in the hospital — whoever you are, whatever your role is, if each one of us steps back and starts to initiate some of these best practices in our daily lives, I think we’ll start migrating toward a greener environment,” she said.

Feltham added that numerous hospital campuses are initiating a smoke-free environment and making it available for hospital employees to ride their bicycles to work. Some are also providing preferred parking for people who drive hybrid automobiles.

“Our mission is to educate, raise awareness and really engage with people to get them to start initiating these best practices in
their careers and their daily home life, even if it means bringing in a reusable lunch bag each day or drinking out of a BPA-free water bottle,” she said. “It’s a step in the right direction.”

The Framework
As a source of eco-friendly healthcare information, GoGreenHealthcare.org offers visitors sustainable healthcare initiatives rooted in five distinct areas: clinical care, products and pharmaceuticals, architecture and design, healthcare campus and urban initiatives. Sileo said the “Clinical Care” section offers information that both directly and indirectly relates to the patient.

“For example, what goes into the patient, what touches the patient, what the patient sees, smells, eats,” he listed. “The bottom line is better integrative patient care.” Research has steadily demonstrated improved patient outcomes when the environment of the care setting is taken into consideration.

The next category, “Products and Pharmaceuticals,” discusses green products. “We really feel that our OR and ICU nurses, as well as all levels of practitioners, are really going to find interest in those types of stories. Healthcare practitioners are on this earth to take care of people, and they will hopefully begin to choose products that are greener or less toxic,” said Sileo.

The “Architecture and Design” section offers information on a more environmentally-friendly way of designing healthcare facilities and hospitals. Leadership in Energy and Environmental Design standards and certification are discussed in depth here. Sileo believes architects, lighting technicians, landscape architects and others will find the information within this section especially helpful.

“Architects who are charged with designing a new wing on a hospital can come here and find out the science behind light and immunomodulation, for instance. The translation of science to architecture can be conceptualized here,” he said.

The “Healthcare Campus” section focuses on bigger systems, such as power plants, water remediation, air conditioning and waste management. “Patients, families and care providers are exposed to potentially dangerous settings, albeit the risk is low, we need to continually improve our engineering controls,” he said. “Healthcare campus is about mitigating toxic danger to the patient, staff and family,” said Sileo.

“Urban Initiatives,” the final section, connects medical centers with the green initiatives of their urban environments. The section offers content relative to the community around medical centers — green designs, healthier places, community centers, transportation, etc. The Grass Route section within Urban Initiatives will feature green maps, greener routes and comprehensive guides to multiple transportation systems.

“We want to be able to offer information about the greenest, cleanest routes of transportation for patients, family and staff,” said Sileo. The five district areas start with the patient in the Clinical Care section and end with the community in Urban Initiatives, which in turn circles back to the patient again.

The Future of Healthcare
When asked why it’s important to practice sustainable healthcare initiatives, Sileo was straightforward. “As an industry, healthcare contributes considerably to the CO2 footprint. By starting on a micro level and focusing on the patient, we need to all be more cognizant of the consequences. We try to heal, we try to make things better, we try to prevent. We have a chance to be more preventive here. I think it’s an obligation of healthcare workers to get more involved this way,” said Sileo.

Ultimately, it all comes back to doing no harm to the patient, he said. Clinicians might not be able to help using drugs and therapies that may be toxic to the patient. What they can do is strive to mitigate exposure and toxicity, and encourage future research on decreasing adverse effects.

Feltham recalled a quote by the lead singer of the rock band U2. “Bono says, ‘I still haven’t found what I’m looking for.’ At the end of the day, neither have we. There is still so much work to be done — and we’re here to provide a forum where great ideas of healthcare professionals are heard, acknowledged and communicated,” she concluded.

GoGreenHealthcare.org is accepting article contributions. E-mail your submission to editorial@gogreenhealthcare.org.

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

Beth Puliti is a frequent contributor to ADVANCE.
In 2009, nearly 40 million people, or one in eight Americans, were over the age of 65.1 By 2030, these older adults will make up 19 percent of the population (about 72.1 million people).2 This growing, aging population is one reason joint replacements are on the rise.

“Baby boomers are aging and individuals are no longer willing to put up with pain and dysfunction as they age,” noted Melissa Verdi BSN, RN, staff nurse for Richard H. Rothman, MD, PhD, at the Rothman Institute Orthopaedics in Pennsylvania and New Jersey.

Total hip and knee replacements decrease pain and improve function, which in turn improves the quality of life for patients with arthritis. Following surgery, the goal of both the patient and surgeon is to resume daily activities along with low impact sports without pain, remarked Verdi.

Nurses, who are involved in the care of patients with joint replacement from the preoperative period through the recovery phase, have seen their role change throughout the years.

Joint Replacement Upsurge
According to Jennifer Smith, MSN, RN, APN-C, director of the Orthopedic Program of Excellence at Virtua in Marlton, NJ, two main benefits, namely pain alleviation and mobility restoration, result from joint replacement surgery, allowing people to return to an active lifestyle.

She offered two additional trends contributing to the increase in joint replacements: obesity and more active lifestyles.

For starters, being overweight puts an increased amount of stress on joints over time and the cartilage begins to break down due to years of added stress, Smith explained.

Also, adults are remaining much more physically active later in life; and often they have old knee or hip injuries that contribute to the development of osteoarthritis.

Shivi Dixit, MSN, RN, CMSRN, orthopedic service line manager, St. Joseph Hospital, Orange, CA, mentioned the “Baby Boomer Effect” (a disproportionate number of people hitting retirement age at the same time) as well as an increased awareness of the benefits of the joint replacement as other potential contributors to the increase in joint replacements.

“People in general are living longer and are more active for a longer period of time,” said Dixit.

New procedures, such as the quadriceps tendon sparing knee replacements and anterior approach hip replacements performed at Virtua, enable some patients to be discharged the same day as their surgery. Almost all patients are able to forgo a rehab center, go directly home and be back to work in weeks as opposed to months after surgery.

Greater Nurse Involvement
Smith noted that Virtua appoints a nurse navigator to a patient from the time he is scheduled for surgery, guiding the patient through the preadmission process and educating the patient about what to expect during their hospital stay and recovery process.

“In addition to the care the nurse provides while the patient is in the hospital, home care and rehab nurses play a key role in the patient’s recovery after they have been discharged from the hospital,” she said.

Dixit remarked that a nurse’s primary role includes preparing patients for surgery, as well as the education of patients and their families on the postoperative recovery period.

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preoperative role is to prepare patients for surgery by educating them on their procedure and the care they will be given so they know what to expect during and after surgery.

“One of the core values we live and work by at St. Joseph Hospital is respecting the dignity of our patients, and making sure each patient is properly prepared for their surgery physically, mentally and emotionally,” disclosed Dixit. “The preoperative education also helps to build a personal relationship between our nurses and patients, which in turn helps relieve patient anxiety and makes recovery easier.”

In the past, nurses have had little involvement with patients preoperatively; now the nurse navigator works to develop a relationship with the patient. Preoperative education has changed the dynamic of care that nurses can provide.

In this information age, patients often come to the hospital well-prepared with questions and a base knowledge of the procedure. The Internet usually plays a key role in the knowledge obtained, acknowledged Dixit. “Many patients try to reconcile the information learned on the Internet with the information they get in the preoperative education sessions, and the nurses need to be equally as prepared to answer any questions and address any concerns the patient may have,” said Dixit.

Changes in Processes & Protocols

Though the basics of the nursing role remain, i.e., clinical, emotional and spiritual care, communication patterns through electronic methods have been a big change for nursing and patients to get used to, noted Kanoe Allen, MSN-CNS, RN, PHN, chief nursing officer at Hoag Orthopedic Institute in Irvine, CA.

“Postoperatively, our orthopedic care has advanced dramatically from 10 years ago. Our patients spend a much shorter time in the hospital, with fewer restrictions on movement and are, overall, a very active group,” Allen commented.

Because the length of stay for these types of procedures is getting shorter, nurses have to start working toward discharge planning and mobilization right after surgery. A sooner discharge also means nurses may only have a few hours instead of days with the patient.

“Most patients are also going directly home instead of a rehab center and because of this, patients and their families must be well-educated prior to discharge,” Smith explained.

Allen believes it is crucial for nurses to keep abreast of all the changes in techniques and care changes through ongoing education. One way that acknowledges the orthopedic nursing expertise is certification, she said. The National Association of Orthopaedic Nurses offers a specialty certification, known as Orthopedic Nursing Certified.

Building a Personal Relationship

Patient education must discuss what to expect during hospitalization as well as when the patient goes home. At Hoag Orthopedic Institute, this takes place during a preop class.

“Patients who undergo elective joint replacement may have quite a bit of anxiety,” Allen acknowledged, noting this all must be done in a matter of just a couple of days.

“Anxiety makes it difficult to retain information, so a lot of reminders may be needed. It is challenging to provide great pain control, ambulate patients, meet their other clinical and psychosocial needs, and then provide patient self-care education so they are safe to go home.”

When taking care of patients who have undergone less-invasive operations, the responsibilities of nurses remain more or less the same.

“It is always our duty to ensure that patients are prepared and knowledgeable about their procedure and comfortable through every step of the process,” said Dixit.

The personal relationship that was built during preoperative sessions helps tremendously when patients come out of the operating room and begin postoperative care. At this time, the nursing staff reinforces the information learned before the procedure and ensures the patient understands the importance of dressing changes and symptoms to watch for following discharge.
For Shawn Coltharp of Paducah, KY, Sept. 1, 2007, was supposed to be joyful. It was Labor Day weekend, and Coltharp had gathered with her family for an informal reunion at a local restaurant, awaiting the arrival of her 27-year-old daughter, Hillary.

But Hillary never arrived.

While driving on Interstate 24 toward the restaurant, Hillary lost control of her Volkswagen Cabrio convertible. The car rolled several times; Hillary was thrown from her seat and landed in the emergency lane on the other side of the highway some 80 feet away.

She had been texting.

Although devastated by the news, her mother wasn’t entirely surprised.

“She had the behaviors of a distracted driver all her life — grabbing for CDs, putting on makeup and texting,” said Coltharp, who was quick to confess to her own weaknesses. “I, too, was one who was slightly distracted. I certainly had my own behaviors that needed to be put in check.”

Long Road to Recovery

Hillary was alone in the car, but not at the crash scene.

“She was fortunate beyond belief,” Coltharp said.

A state trooper saw the dust from the crash over the crest of a hill and radioed for an ambulance even before he arrived on the scene. A nurse and physician driving in front of Hillary witnessed the crash in the rearview mirror and turned around immediately to help. Hillary also remembers three angels with her as she lay on the side of the road, telepathically telling her she would survive.

Amazingly, she did.

“She had a 5 percent chance to live,” remembered her mother. “She had a lot of broken bones and a terrible head injury to her right temporal lobe. Of course, when you fly through the air like that and crash on the pavement…”

Hillary was flown 150 miles to Vanderbilt University Medical Center in Nashville, TN, where physicians monitored a subdural hematoma and later performed a craniotomy. Six weeks later, she was transferred to Cardinal Hill Rehabilitation Hospital in Lexington, KY, where she stayed for another 6 weeks and relearned basics like swallowing and eating.

“She had to grow up all over again, from learning how to breathe, swallow, toilet train, eat … everything,” Coltharp said. “She had to start life over.”

Five years later, Hillary has made significant progress. She lives independently in an apartment attached to her parents’ house and can perform most activities of daily living without assistance. She receives physical, occupational and speech therapy almost every day. She no longer drives.

“She is still very significantly brain-injured, but I’m not sure you would know it. You would think she’s very innocent and vulnerable, a bit like an early high schooler,” Coltharp said.

“I think she’s going to carve out a life, but not like the life she would have had before.”

A Troubling Trend

Coltharp describes distracted driving as this generation’s chronic disease. Many would agree.

Defined as any activity that takes a driver’s attention away from the road, distracted driving includes everything from talking to passengers, changing the radio station, reading directions, eating, grooming and driving under the influence.

Within the past 5 years or so, smart phones have added another potentially deadly temptation to drivers prone to distraction: navigating a virtual world while driving some 4,000 pounds of vehicle through our real one.

The facts are disturbing. According to distraction.gov: driving while using a cell phone cuts your amount of brain activity associated with driving by more than a third; reading a text while driving takes your eyes off the road an average of 4.6 seconds — at 55 mph, that’s equivalent to driving the length of an entire football field blind; and when you use a hand-held device while driving, you are four times more likely to experience a crash serious enough to injure yourself.

The website also reports that, in 2010, 3,092 people were killed and an estimated 416,000 were injured in crashes involving distracted drivers. According to the emergency and trauma nurses who spoke with ADVANCE, however, the statistics are likely low since many drivers don’t own up to bad driving habits afterward.

“It’s the iceberg effect,” said Janice Titano, BSN, RN, CEN, CCRN, emergency department nurse at the Hospital of the University of Pennsylvania, Philadelphia. “You see the statistics, but what lies beneath is what’s really going on.”

Titano and ED colleague Heather Matthew, MSN, RN, CEN, presented on the subject at this spring’s American Association of
Critical-Care Nurses Southeastern Pennsylvania chapter's Trends conference. Matthew became interested in the subject 2 years ago shortly after the birth of her daughter. She'd attend playgroups and, afterward, bristled at a phenomenon she noticed occurring in the parking lot.

“When we would leave, I'd see other moms put their babies in the car. I started to notice that even before they pulled away, they had their cell phones in their hands. I thought, that's a lot of coordination going on there. And with a 6-month-old in the car, that can't be safe,” Matthew remembered.

The observations impacted her practice in the ED. “I recently started to ask my patients who were in a motor vehicle crash if they were using their cell phone,” she said. “Problem is, no one's going to admit to that. In Pennsylvania, it's a traffic violation. And people are not so willing to admit to that.”

Speaking Out
During National Trauma Awareness Month in May, nurses in the trauma center at Vanderbilt University led a Decide to Drive: Arrive Alive! campaign, an initiative of the Society of Trauma Nurses.

To raise awareness of the dangers associated with distracted driving, nurses signed pledge cards to drive distraction-free for the month. Pledge cards were also circulated throughout the hospital to encourage other drivers to take the pledge and spread the message.

At the beginning of the month, 85 or so pledge cards signed by staff hung on a bulletin board in the break room. On the honor system, participants who had fallen short of the pledge took down their cards as the days passed. By the end of May, only about a dozen pledge cards remained.

Despite the number of broken pledges, campaign organizer Sondra Blount, BSN, RN, considered the program a success. “I think it was effective to about a handful of staff that take care of these patients,” she said. “It may not be completely effective in stopping people from distracted driving, but it heightens their awareness of what exactly they are doing in their vehicle that may be distracting them from paying close attention to the roadways. Having just one more careful driver on the road is better than none.”

Blount was invited to speak to teenagers about distracted driving. Although the behavior is not limited to any specific group, drivers younger than 20 make up the largest proportion of distracted drivers, according to distraction.gov. In fact, 40 percent of teenagers report having been in a car when a driver used a cell phone in a way that put passengers in danger.

Getting the word out about the dangers of driving distracted is essential to save lives, said Matthew, adding that the videos on distraction.org are especially powerful teaching tools.

“I want nurses to educate their staff. I want them to educate their teenagers. I want them to educate all the people they love,” Matthew said. “Nursing is a very powerful force. And if we can do something to prevent injury, we should because that's our job.”

Kicking the Habit
Despite all her family has been through as a result of Hillary's crash, Coltharp admitted to checking a voice-dictated text while driving just months ago. Looking down to correct a word, she nearly lost control of her car and went off the road. Habits can be hard to break.

“Humans are not very good at regulating their behavior when someone's not watching us. When you're in your car, you are in your own little world,” Titanoto said. “When something's tempting you and you feel an urge to do it, the stoplight in your head disappears and you just sort of reach for the phone. It's addictive.”

Many drivers need a wake-up call for lasting change. Titanoto explained. On a rainy day several years ago, Titanoto pulled something out of her purse while exiting a parking lot and sideswiped a pole.

“I swear, I looked down for like 3 seconds going 5 mph and I never saw the pole,” she said. “I remember that. It's etched in my mind.”

That experience, combined with all she's learned from researching distracted driving, has prompted her to turn off her Bluetooth and put her cell phone in the back seat while driving.

Coltharp said her recent close call changed her habits for good. “That was it. I realized I was falsely secure with a voice text message phone, and that I'd never do it again,” she said.

“I believe this with all my heart: If you are a distracted driver, whatever that distraction, you will be in a car crash. I don't have a doubt in this world.”

Jolynn Tumolo is a frequent contributor to ADVANCE.

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Truvada for Preventing HIV Transmission

Drug used as prophylaxis against sexually acquired HIV infection  

By Grace Earl, PharmD, BCPS

A new approach to preventing HIV transmission is pre-exposure prophylaxis (PrEP) by prescribing antiretroviral medications in individuals not infected with HIV. The FDA approved Truvada, a combination of emtricitabine and tenofovir disoproxil fumarate, for prevention of uninfected individuals at high risk for contracting the disease. A boxed warning alerts prescribers to confirm HIV-negative status before initiating the drug, and again every 3 months.

Clinical Trials
Two clinical trials were conducted and evaluated the combination drug for its ability to prevent HIV transmission. The global Preexposure Prophylaxis Initiative (iPrEx study) enrolled 2,499 HIV-negative men or transgendered women who have sex with men. New HIV infection occurred in 36 subjects in the Truvada group (n = 1251) and 64 in the placebo group (n = 1248) for a 44 percent relative risk reduction. Self-reported medication adherence was lower in the Truvada group than the placebo group at week 8 (89 percent versus 92 percent), and condom use increased.

The “Partners PrEP study” enrolled heterosexual couples in Africa with one HIV-positive partner (n = 4,758). The HIV-1 susceptible partner was randomized to receive either tenofovir, emtricitabine-tenofovir or placebo. The route of HIV transmission was vaginal penetration. Protection against HIV transmission was 73 percent with Truvada.

Mechanism of Action
Truvada was approved for treatment of HIV-1 infection in 2004. It is a combination of tenofovir, a nucleotide reverse transcriptase inhibitor (NRTI) and emtricitabine, a nucleoside reverse transcriptase inhibitor. It is recommended for use with other antiretroviral drugs in adults and children over 12.

Tenofovir is a competitive inhibitor of viral reverse transcriptase enzymes involved in producing viral DNA; tenofovir is phosphorylated to an active form, tenofovir diphosphate, which is incorporated into viral DNA causing chain termination. Emtricitabine, a chemical analog related to lamivudine, undergoes phosphorylation and has a similar mechanism in terminating DNA viral synthesis.

Dosage, Costs, Pharmacokinetics
CDC recommends prescribing a 90-day supply to encourage follow-ups and confirm negative HIV status. The dose should be one tablet daily taken with or without food. Each tablet has 200 mg of emtricitabine and 300 mg of tenofovir. Dose is also based on weight and kidney function; patients weighing less than 35 kg or with reduced creatinine clearance should be monitored.

Liver function tests should be monitored. Accumulation of fat in the liver predisposes patients to additional hepatocellular injury. Cases of severe liver injury. Cases of severe hepatomegaly with steatosis have been reported with use, and have been fatal. It also undergoes renal elimination and the dose is adjusted for Clcr < 50 mL/min.

Drug Interactions & Side Effects
Tenofovir increases concentration of other antiretroviral agents, such as didanosine, by 44-60 percent; plus, other antiretrovirals can increase drug concentrations of tenofovir resulting in added toxicity. Closely monitor therapy when used with other nephrotoxic drugs, such as antibiotics and antivirals. Emtricitabine should not be used with lamivudine, another NRTI, due to toxicity.

Side effects due to gastrointestinal discomfort can lead to medication non-adherence. Moderate nausea was reported in the iPrEx study, with unintentional weight loss of 5 percent or more. Common side effects are diarrhea, dizziness, headache and fatigue. Patients also reported insomnia and abnormal dreams, and should be screened for depression. Check for skin rash, allergic reactions or angioedema. Redistribution of body fat, such as facial wasting causing a gaunt appearance, can occur.

FDA’s Boxed Warning regards lactic acidosis and severe liver injury. Cases of severe hepatomegaly with steatosis have been reported with use, and have been fatal. Accumulation of fat in the liver predisposes patients to additional hepatocellular injury. Liver function tests should be monitored. In patients with HIV and hepatitis B, acute worsening of hepatitis B occurred when Truvada was stopped. Follow patients and screen for hepatitis B; consider initiating targeted therapy when appropriate.

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

Grace Earl is an ambulatory care pharmacist at the University of the Sciences and her practice site is at Hahnemann University Hospital, Philadelphia.
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In the years prior to 1996, a widely fluctuating patient census presented a challenge when trying to safely staff the ICU at Hunterdon Medical Center, Flemington, NJ, within budget while still preserving staff satisfaction. Increased overtime expenditures and supporting staff with float nurses were realities during periods of high census. Floating ICU nurses to other units or having them use personal time off (PTO) during periods of low census did little to support their sense of job satisfaction or professionalism. These issues sparked the idea of converting to a salary model that would increase RN autonomy, accountability and job satisfaction.

Salary Model Is Born
Our chief nursing officer supported the concept of becoming a salaried unit. She presented the basic concepts of a salary model at the monthly Nurse Practice Council meeting, a forum in which nursing representatives from every nursing unit meet to discuss policies and procedures related to nursing practice.

Impressed by the presentation and feeling that it could be the answer to the ICU’s staffing dilemma and job dissatisfaction, the ICU council representative approached the ICU nurse director with the idea. Feeling the need to see the concepts in practice, this nurse, accompanied by the ICU nurse director, the CNO, a staff development instructor and a human resources representative, traveled to a conference sponsored by Johns Hopkins to see how it was operationalized in that organization’s critical care units.

Duly impressed by the Johns Hopkins salary model, the ICU nurse attendee presented what she learned to the remainder of the ICU staff. It was put to a vote and was passed.

Using the Johns Hopkins model as a guide, a group of ICU RNs representing each shift drafted bylaws. The bylaws consisted of the following components:
- Purpose;
- Membership; and
- Compensation.

How It Works
The ICU salary model was adopted and implemented in January 1996. It is a unit-based system of shared decision-making and group practice. This agreement made
between the ICU RNs and administration provides quality nursing care 24 hours a day for our 12-bed ICU in exchange for self-management and salary compensation.

ICU RNs who work at least 40 hours in a 2-week pay period become members of the salary model. Membership begins after successful completion of the ICU orientation program. Per-diem agency and in-house float pool RNs are not eligible for membership. The ICU staff elects Salary Model Committee members annually, one nurse from each shift. This ensures concerns from each shift are being addressed equally at the quarterly meetings. Any changes that are proposed to the bylaws are voted on by the committee members and communicated to the rest of the staff at monthly staff meetings.

A salary model member’s hourly pay is calculated using the base salary plus compensation for on-call work, holiday shifts, PTO coverage, and required staff meetings and inservices. The salary model members’ hourly salaries are higher than the nursing staff on other units, but unlike those staff members, they don’t get paid extra when they work over their shift or come in for committee meeting or inservices.

Members’ compensation for this extra time spent at work is reflected in the salary model on-call book. This is an internal documentation system where members log their actual hours worked above or below scheduled hours. Committee hours are reflected here as well. Working over scheduled hours or coming in for a meeting is documented as positive hours. Leaving early or remaining home on-call for low patient census is negative hours. During times of low census, salary model members who have the least negative hours (had fewer opportunities to stay home on-call than their peers) are placed on-call for full pay.

One of the key advantages of the salary model is the members do not have to float outside of the ICU, and PTO is not used when nurses are placed on-call during periods of low census. The ICU nurses get paid their full salary whether they work or are placed on call. The catch is during periods of high census, the ICU is expected to cover itself. This is done through a mandatory backup on-call (BOC) system.

All ICU nurses are required to schedule themselves for 12 hours of BOC per month in addition to their regularly scheduled hours. This enables the unit to flex up when the census goes beyond mode. Nurses are not paid extra when they work their BOC, as this was part of the original salary calculation at the time of membership.

Budgetary Considerations
Providing quality patient care in a fiscally responsible manner is a continuous challenge in the current healthcare environment. Operating as a salaried unit presents the challenge of managing labor costs when the actual census is not equal to or greater than the budgeted census. The budgeted census is based on the previous year’s census and becomes the basis for developing required staffing levels.

During the recession in 2009, the salary program in the ICU came under serious scrutiny by the finance department. An internal audit was performed of the scheduling, staffing and compensation activity of the salary model members. The analysis revealed the ICU RN “stayed home” on average 1.3 days over the number of their required BOC days.

It is during times when others doubt the efficacy of the salary

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model that it is crucial to have the support of the ICU nurse director and the CNO. We have found other departments don’t fully understand the concept and find ourselves educating and re-educating, but we recognize this model is unusual in the direct care setting where census and acuity are in constant flux and the demand for staffing rises and falls acutely.

Recruitment & Retention
Our salary model has been in place for 16 years and continues to be a work in progress. We fine-tune it as we go along in an attempt to be flexible with the ICU’s needs.

Overall, it has been a success for the staff, administration and patients. In fact, we have found it to be a useful retention and recruitment tool. Our RN turnover rate is extremely low, ranging from 0 to 3.57 percent. Nurses leaving our ICU do so because of career advancement opportunities, not because of dissatisfaction with their job.

When our staff is asked what keeps them in our ICU, the salary model is one of the top three reasons. In interviewing potential new hires, one of our standard questions is, “Why do you want to come to Hunterdon Medical Center?” Inevitably, one of the first responses is, “Because I heard you have a salary program.”

A Shared Vision
The salary model has been a mutual success for both the ICU RNs and the Hunterdon Medical Center administration. It has allowed us to provide improved patient care along with increased RN autonomy, professional development, job satisfaction and professional accountability.

The Hunterdon Medical Center’s ICU salary model reflects our RNs’ shared vision and mission, and represents our core values of patient- and family-centered care. It provides the framework for achieving optimal clinical outcomes while achieving personal and professional satisfaction.

Cindy Krivoshik, Beth Ort, Marian Racco and Pureza Ruiz work in the ICU at Hunterdon Medical Center, Flemington, NJ.
I come from a long line of nurses. When I was a kid, the dinner table was alive with talk of helping patients and our coffee table was always piled with medical books. No surprise why I’m fascinated with science and health care technology, and wanted to continue the family tradition.

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