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From the Editor

The role of a nurse is evolving beyond functioning as a bedside caregiver only. As healthcare embarks on change, nurses must be prepared for new challenges. In the article, “Instituting Nursing Excellence,” Bonnie Kass, MBA, BSN, RN, explores Huntington Memorial Hospital's Institute for Nursing Excellence and Innovation. Although the program is still in its early stages, its focus is to “further enhance training and preparation” for the nursing workforce.

In the compelling article, “Exercise Prescription for Cancer,” ADVANCE writer, Robin Hocevar, explains a recent research project completed at Philadelphia’s Thomas Jefferson University Hospitals and the Jefferson School of Nursing. Influenced by similar studies, researchers at Jefferson wanted to see if a walking regimen after pancreatic cancer surgery would improve recovery results in patients.

In addition, this issue includes articles on the nature of pain, new healthcare laws and HIV, and when and how body piercings should be removed when patients enter the emergency department.

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ADVANCE for Nurses is dedicated to informing our readers of news, industry trends and encouraging stories of nurses. This issue serves all of Southern California—from Santa Barbara to Kern counties and San Bernardino to San Diego counties. Go online to www.advanceweb.com/Nurses to find more resources to help improve your practice and keep your patients safe.

And don’t forget to become a member — it’s a free and easy way to inspire and connect with your colleagues. ❖

Pamela Tarapchak

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W
hile still the bedside caregiver who
patients trust and respect, today’s
nurses are taking on expanded roles both
within and outside the hospital setting. In
increasing numbers, nurses are pioneering
new treatment protocols, championing
quality-of-care improvements, spearheading
research innovation, advocating for patient
rights and, in many cases, serving as the
hospital spokesperson on some of the most
important issues of the day.

Nurses are impacting national healthcare
policy as well. Led by national nursing
associations, nurse academicians and
nursing leaders, nurses have had their
voices heard over the past decade on
key issues such as staffing levels, patient
satisfaction, patient safety, affordability,
access to care and quality of care.

Another factor in play here is the ongoing
national shortage of primary care (and in
some cases specialty) physicians. With the
Patient Protection and Affordable Care
Act adding more than 30 million insured
Americans to the system over the coming
2 years, it is estimated that by 2020 the
U.S. will face a shortage of at least 40,000
primary care doctors. One remedy will be to
turn to nurses who will be asked to do more
in diversified settings and bring additional
skills to the patient care environment.

Are Nurses Prepared?
To help make sure they are ready in our
community, Huntington Memorial Hospital
has launched an Institute for Nursing
Excellence and Innovation, designed to
further enhance training and preparation
for our nursing workforce. Last year,
Huntington Hospital became one of only
6 percent of hospitals in the U.S. to achieve
Magnet recognition — the “gold standard”
for nursing. The new Institute for Nursing
Excellence and Innovation is a key part of our
hospital’s Magnet sustainability plan, which
calls for developing and supporting a solid
infrastructure that will produce advances in
nursing innovation, evidence-based practice
and nursing research. The institute will also
help ensure nurses remain at the very heart
of patient care at Huntington Hospital and
an essential part of the hospital’s mission of
clinical and service excellence.

Nursing Excellence & Innovation
While still in the development stage, some
components of the institute are already
clear. One is the establishment of a Nurses
Scholars Program — the second generation
of a program that has already met with
great success at the hospital. In the program,
nurses just joining the Huntington team
are matched with seasoned members of
the nursing staff who provide one-on-one
mentoring, counseling and support.

In addition to preceptors for new nursing
graduates, the institute will offer specialty
training programs in critical care, emergency
medicine, obstetrics, neonatal intensive care,
surgery, pediatric intensive care and other
areas. These 25-week programs include 6
weeks of didactic classroom training followed
by clinical practice overseen by a preceptor.
Preceptors are experienced staff nurses
who serve as clinical/job role models and
resources to the newly hired and/or novice
nurse. By orienting the new nurse to the roles
and responsibilities of the job — including
formal and informal rules, customs, culture
and workplace norms — it is anticipated this
training will result in a cadre of nurse experts
highly trained in particularly complex fields.

Through the institute, the hospital will also
expand its nursing education offerings to
increase the number of nurses with degrees
and specialty certification in their chosen
fields. In particular, the hospital has launched
an on-site BSN program in collaboration with
Western Governor’s University. Through a
combination of online classes, 100 hours of simulation lab work and 120 hours of bedside clinical rotations, students will have access to Huntington-based faculty, including clinical coaches (staff RNs) and a clinical instructor (staff master’s-prepared nurse) who will provide oversight to the student and support for the clinical coaches.

Nursing education will also be supported through encouraging — and through the institute helping to fund — individual nurses to present and speak at regional and national conferences. Such efforts serve to empower the individual nurse; bring heightened attention and prestige to our hospital; and, most importantly, contribute to the overall “atmosphere of excellence” we strive to instill at Huntington.

Another primary goal of the institute is to support the continued growth of nursing research at Huntington Hospital by funding a doctoral-prepared nurse researcher and a nursing research fellowship. With their help, three nursing research studies are already under way. In the first study Huntington Hospital is one of 15 hospitals nationally to participate in a research collaborative related to quality and safety in the hospital environment. The second study involves the impact of medication errors, and the third is a pilot study to validate “concern” as a predictor of patient risk for decline.

Commitment to Nursing

The creation of the Institute for Nursing Excellence and Innovation is just one part of the hospital’s overall commitment to nurses and the nursing profession. Our clinical leadership council, for example, focuses on efforts to improve operational efficiency and effectiveness at the unit levels. We have also recently developed a patient education council and patient education steering committee that are now responsible for managing patient education materials across the continuum while promoting wellness and preventing future illness. At the same time, nursing is playing a major role in the hospital’s design and implementation of a new information technology system, which will significantly enhance the hospital’s digital capabilities in all areas.

By equipping nurses with the skills and tools they need to do their jobs better, we can enhance patient outcomes, reduce healthcare costs, and expand the nursing profession in ways that will serve our community now and in the future. The Huntington Institute for Nursing Excellence and Innovation has the potential to impact the hospital, the community and nursing practice more broadly and will hopefully serve as a model for other hospitals at a time of increased emphasis on healthcare quality and cost efficiency.

Bonnie Kass is vice president, patient care services, and chief nursing executive at Huntington Memorial Hospital in Pasadena, CA.

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EOE Drug Free Workplace
Body piercing is the practice of creating a puncture into the skin to create an opening for devices such as jewelry, an apparatus or implanted item. Microdermal implants, a new body modification, appear as surface piercings that look like jewelry stuck to the skin.1

Body piercing has been accepted as a common practice among older adolescents and young adults with some estimates that up to 56 percent of those ages 17-25 have one or more devices in place.2 Despite the mainstream nature of these body modification practices, however, associated risks can have rare and life-threatening complications. Clinicians must be aware of the anatomical location of body jewelry and how to remove it in emergency situations.

In modern society, the profile of a person with body piercings has often been associated with gangs, artists or cults. But, when examined, one research study found the majority of males with genital piercings were well-educated, with a middle-class income, in a heterosexual relationship and an average age of 36 years old.4 However, data on females with genital piercings found a large percentage have experienced depression and physical or emotional abuse in their lives.5 Whatever the reasons, worldwide, body piercing professionals find their crafts in demand by people of any age, race, religion, sex and socioeconomic level.3

Jewelry Types & Removal
The popularity of body piercing has led to an increased need for education within the general population and healthcare profession. Knowledge of various types of jewelry, proper removal, anatomical locations and associated complications such as infections, allergic reactions and interference with diagnostic testing or surgery are important areas for the healthcare professional to understand. Encouraging the patient to remove devices before diagnostic testing should be a standard practice in hospitals and emergent care areas.

The most common types of jewelry are studs, screws, hoops, captive rings, barbells, open circular barbells and nostril screws. Studs and screws can be removed by disconnecting the back with a straight pulling motion or by unscrewing the head of the stud. Remove hoops by unsnapping the latch or pulling it apart.

Devices slightly more difficult to remove are captive rings and barbells. Barbells can be unscrewed and separated into two pieces for removal. Captive rings consist of a circular ring with a ball and usually requires a special type of small pliers for removal. Hence the term “captive,” which defines the name of the device. The ball is first removed and then the ring is opened with special pliers. Equipment to remove piercings, such as ring opening pliers and bolt cutters, should be available for use in diagnostic areas as well as the ED by trained individuals so risks can be minimized.

Commonly pierced body parts include earlobes and cartilage, tragus, nose, septum, edge and distal portion, eyebrow, tongue, lips, navel, nipples and genitalia.24 Because piercings can be found almost anywhere on the body, it is important for healthcare professionals to do a thorough health history and physical assessment during a patient’s admission to determine if any permanent jewelry or devices are in place.

Implanted devices, which alter the shape or form of the body, are
Redlands, CA — Hanging in the lobby of Redlands Community Hospital (RCH), located in Redlands, CA, are several crafted quilts. Each is a testament to the skill, passion and creativity of the quilter who constructed complex designs piece by piece with fabric and thread. The quilts are illustrative of the efforts of the hospital’s nursing department to fully integrate Jean Watson’s Caring Science into the fabric of their nursing practice.

At RCH, the nursing department has interwoven the “caritas” principals of Caring Science into their nursing practice to create a culture of healing compassion. The leaves of the tree symbolize the nurturing energy of caring, which bears the fruit of positive outcomes.

Each department selects a member to send to Caring Advocates committee. These members are responsible for coaching and role modeling caring behaviors, which includes the use of complementary therapies to enhance the caring toolbox of the bedside nurse.

In addition to music, guided imagery and distraction therapies, there are other tools included, which are used to connect the patient and the nurse in caring moments. Some of the contributions that have been generated from this group include:

- Aromatherapy (pre- and post-operative areas): The use of aroma provides an environment of healing; lavender provides a calm, relaxing space pre-surgery and peppermint encourages wakefulness and decreases nausea.
- Therapeutic Touch: This is used in the NICU where infants can be calmed without overstimulating.
- Celtic Art Therapy: This is a non-drug system to allow the brain to pass into a state of “relaxed awareness.”
- Massage: Every area uses massage to relax and calm patients and to decrease pain. All staff members are encouraged to use this technique on their patients.

Serenity rooms give staff a reflective space. “The serenity rooms are not break rooms; they are a quiet space for staff members to center and replenish themselves. If a nurse does not care for herself, she cannot fully care for others. If you are empty, you have nothing to give,” Spilsbury said. Staff are encouraged to be alone and take a reprieve from stress.

The white boards in each patient room have space for staff names and daily goals. Patients can share who they are as a person. The information on the “All About Me” space encourages interaction between patients and staff, connecting them in a human way. Staff members are encouraged to be emotionally present and open to what is meaningful in patients’ lives.

A “Quiet Time” has been established in the afternoon to provide healing and rest time for patients. This is a partnership between nursing and the ancillary departments where the healthcare team is expected to complete their work with a heightened sense of noiselessness.

RCH has created a work environment to support nurses as they piece together a “caring quilt” of their own design. As the nursing department strives to interweave the science of caring into its clinical practice, they are creating a lasting and caring treasure for its future nurses.

For more information on open nursing positions, contact Lauren Spilsbury at LAS@redlandshospital.org.
ED/Trauma

popular and should be noted they may interfere with diagnostic images or radiologic films. While not permanent, magnetic body jewelry should also be considered in the physical assessment. If the patient is unable to respond or if concerns are aroused after completing an explanation of risks associated with specific imaging, examining for any hidden objects not mentioned during the initial history may be indicated. Healthcare personnel must remember to remain professional in all aspects of assessment and care.

When to Remove

Most body jewelry is specifically designed to stay in place, making it more difficult to remove rather than inadvertently fall out during a procedure or surgery. However, jewelry left in place may cause difficulty with placement of devices such as a cervical collar or urinary catheter. Jewelry or devices left in place can interfere with an MRI, creating artifact and/or distortion, or even injuring the patient. Piercings left in place during surgery can interfere with electrocautery, causing burns or disruption of the procedure.1

Proactively removing jewelry prior to diagnostic procedures or surgery saves the patient from a potential adverse event and encourages safe practice. A practice recommended by the American Academy of Dermatology is to use nonmetallic retainers or catheters to keep the pierced tract open during surgery, or to cover with a clear occlusive dressing before a procedure.7,8

Clinicians may be concerned about possible aspiration of jewelry during intubation or airway management. However, some practitioners believe if the patient can walk, talk and sleep with tongue jewelry in place, they can probably be intubated with it.9

Tongue piercings bring their own set of complications to the patient from poor healing to excessive bleeding due to the high vascularity of the region. A frequent challenge to dentists and oral surgeons, tongue piercings are associated with chipped or fractured teeth, eating problems, speech impediments, ageusia and occasional ingestion. Swollen tongues can lead to airway occlusion and respiratory distress. Improper removal of a tongue piercing appliance can lead to problems with airway management or accidental aspiration of the jewelry.

One study noted that, between 2002 and 2008, nearly 25,000 oral piercing injuries presented to EDs throughout the U.S. The predominant age group was 14-22 years old. Injuries to lips, tongue and teeth were the most prevalent, with infections accounting for 42 percent of complications. Thirty-nine percent of complications were associated with inability to remove oral piercing.10 Patients with oral piercings are also at risk for receding gums and should be counseled to make regular dental screening visits.10

Body jewelry may interfere with diagnostic imaging, especially if it is in direct view of the area scanned, so consider removal or repositioning the patient to decrease artifact.11 Generally, if not in the direct area being examined, an X-ray or CT scan should not be affected. But for MRI procedures, follow the policies of the institution, which should mimic the guidelines of the American College of Radiology. Most institutions recommend removal of jewelry or any metal device before an MRI to prevent complications. Using a synthetic catheter to substitute in place for jewelry to keep the pierced tract open may be an alternative for the patient. Documenting in the medical record the site where jewelry has been removed and the condition of the surrounding skin is important for trending of any changes that occur.

Complications

Piercings bring a host of complications such as pain, persistent bleeding, delayed healing, infection, keloid formation, granulomas, hypertrophic scarring, rejection or migration of jewelry, structural body tissue defects, superficial nerve involvement, allergic reactions, dermatitis, tooth injuries, perichondritis of the ear pinna, endocarditis, acute glomerulonephritis, angioedema, and pelvic inflammatory disease.2 Skin tears developing during transfer activities from carts to bed can become problematic.3 Changes in urine flow as a result of genital piercing through the penis and urethra may also occur.4

Ranging from local to severe systemic infections such as osteomyelitis, toxic shock syndrome and bacteremia, specific infectious organisms have been associated with various piercing sites. Streptococcus and Staphylococcus aureus are common organisms that infect piercings.12 Pseudomonas aeruginosa, S. Aureus and group A beta-hemolytic strep infections are associated with ear piercings. Tongue and mouth infections are linked to Haemophilus aphrophilus or S. aureus, while genital piercings are associated with Escherichia coli or Klebsiella pneumoniae.13 Signs and symptoms of infections may include tenderness or pain, excessive swelling, odor, erythema and purulent discharge. Additional systemic symptoms include fever, fatigue, mental status changes, shortness of breath and tachycardia. Rare but life-threatening complications such as endocarditis, viral hepatitis, septic shock and cerebral abscess can occur.12,13

Allergic reactions to metals can cause dermatitis, rashes and dangerous pulmonary complications such as inflammation and wheezing. Infectious bloodborne pathogens such as HIV or hepatitis can occur if patients are exposed to contaminated blood or improperly sterilized body piercing equipment. Healthcare providers should practice safe care by adhering to universal precautions when caring for any patient, with or without piercings. Patient education can be as simple as explaining proper hand hygiene techniques. Referring the patient to pamphlets provided by professional piercing organizations that encourage safe practices can reinforce additional education. Examples of these can be found at www.safepiercing.org.

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

Sue Durkin is an advanced practice nurse, clinical nurse specialist, at Advocate Good Samaritan Hospital, Downers Grove, IL.

Engage in Technology

➤ In addition to critical thinking, today’s nurses must embrace technology. Visit Nursing Informatics & Technology: A Blog for All Levels of Users to learn more how to engage nurses in a dialogue about how technology is used in nursing. Join five accomplished RNs who lead the conversation on www.advanceweb.com/NurseBlogs.
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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1509 Wilson Terrace, Glendale, CA 91206  HEALTHCARE at a Higher Level
A far cry from the days when a diagnosis of HIV was considered a death sentence, HIV is universally accepted as a manageable condition. When the Affordable Care Act (ACA) is fully enacted, it will fill in the missing puzzle piece — insurance — that prevents so many from accessing the necessary care.

"Medicare, Medicaid and Ryan White have been the major programs that closed the gap for people with HIV," said Carmen Portillo, PhD, RN, director of nursing research training program on HIV Care and Prevention, University of California San Francisco. “Currently, 28 percent of people living with HIV are in an undetectable viral mode, which means in care and on a combination of medications reducing the virus to the point where it cannot be detected. It’s pretty astonishingly low considering the resources of the U.S."

**Improved Insurance Access**

With small percentages of patients with HIV owning private insurance, the biggest changes will be the removal of the pre-existing condition barrier to buying insurance and the expansion of Medicaid.

Beginning in 2014, individuals with HIV will be allowed to partake in health insurance exchanges at the state level. People with income up to 400 percent of the federal poverty level (up to about $45,000 for an individual and $92,000 for a family of four) will receive federal tax credits and subsidies designed to make insurance more affordable.

Many states are currently developing health insurance exchanges. According to the National Conference of State Legislatures, as of August, 10 states and the District of Columbia enacted legislation to establish state-based health insurance exchanges and four states have established a state-based exchange by executive order. Governors in New Jersey and New Mexico vetoed establishment bills passed by the legislature. Massachusetts and Utah passed laws prior to the ACA.

"Individuals living with HIV will now get some support in buying into these exchanges," said Susan Stringari-Murray, MS, RN, ANP, ACRN, AAHIVS, clinical professor and director, University of California San Francisco. "Not only will insurance be more available but it’ll be affordable." Stringari-Murray’s native California was the first state to establish a state-based exchange based on the ACA. Anecdotally, she and Portillo both speculate more patients with HIV in the San Francisco area are already seeking treatment in greater numbers, partly due to bridge measures including the removal of the pre-existing condition clause for those under age 19 and elimination of lifetime caps on insurance.

**Closing the Medicaid Gap**

With so few patients with HIV able to access private insurance in the past, many turned to Medicaid only to be denied. “To get Medicaid, you have to be disabled and it’s also means-tested,” said Stringari-Murray. “Even if they meet the income requirements, infected individuals may not meet the definition of disability. Patients had to be both poor and disabled." In the context of HIV, patients usually had to acquire an opportunistic infection like lymphoma or encephalopathy to be approved for Medicaid. Come 2014, states will be required to expand Medicaid eligibility to individuals with incomes up to 133 percent of the poverty level (estimated to be about $15,000 for an individual or $31,000 for a family of four).

Yet, even the Medicaid expansion is complicated. States have the option of opting out, as the Supreme Court ruled that the federal government cannot withhold funding from non-compliant states. In those cases, only new funding can be withheld. The federal government will pay for nearly all of the expansion, yet several states are refusing the funding on philosophical grounds.

Texas, Georgia and Florida governors have announced plans to refuse the Medicaid expansion funding and many other states won’t be addressing the issue until after the November election.

“It’s a lot of money to pass up,” Dee Mahan, JD, director of Medicaid advocacy at Families USA, shared with ADVANCE. “What we’re hoping is that, as time goes on, there will be pressure on governors to change their minds. It happened in Wisconsin where the governor originally said no and is now on the fence. We’re foreseeing a battle between governors and legislatures in many states.”

Currently, the Ryan White Comprehensive AIDS Resources Emergency Act is the largest federal safety net program for patients with HIV and serves 50,000 each year. It’s unknown what changes the ACA will bring to this program. “I’ve been researching the affect
on Ryan White but couldn’t find anything,” said Portillo. “But, as the epidemic grows, the same amount of funding has to go further. As HIV becomes a chronic manageable disease, the number of people living with it increases. In San Francisco, our Ryan White funding has decreased over the past 5-10 years and I imagine this will continue.”

Test & Treat
In addition to complex payment changes, a number of changes are pending in the care models for patients with HIV — and providers are optimistic about treating HIV in a primary care setting. Providers in California have been educating the healthcare workforce to prepare for the influx of new patients with HIV. At Stringari-Murray’s clinic in San Francisco General Hospital Medical Center, a controversial test-and-treat program immediately links patients with a positive HIV diagnosis to antiretroviral drugs.

Critics argue expensive second-line drugs will become necessary if HIV resistant strains develop. UCSF’s David V Vlahov, PhD, RN, dean of the school of nursing, classified test-and-treat as ethical as well as practical.

“Treatment is prevention,” he noted. “It involves reducing risk to transmission to others. Today’s treatment is much more palatable. Patients used to have to take 28 pills a day and swallow some with milk. Now it’s very simplified. In reducing viral load, we know transmission rates will go down. HIV management depends upon getting identified, tested and treated. ACA provides a backbone for public health prevention.”

Robin Hocevar is senior regional editor at ADVANCE.
Best Practices

The Sixth Vital Sign

The subjective nature of pain has made understanding it and developing evidence-based protocols a challenge

By Gail O. Guterl

Pain may be the sixth vital sign, but it is certainly not the least.

Just look at how many organizations are devoted to researching and treating pain. There’s the American Pain Society, American Academy of Pain Medicine, American Academy of Pain Management, American Chronic Pain Association and the American Society for Pain Management Nursing (ASPMN), to name a few. Pain research facilities are cropping up all over the country, to say nothing of pain centers that treat patients with chronic pain.

As many professional organizations as there are for pain, there are more pain scales to classify patients’ pain. There is the FLACC, the Wong-Baker Faces, Numerical Rating Scale, COMFORT, Brief Pain Inventory, Coloured Analogue Scale, Alder Hey Triage Pain Score, McGill Pain Questionnaire and the Checklist of Nonverbal Indicators — the list goes on and on.

Healthcare groups are addressing pain as well. The Joint Commission recognized hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for a national pain program in a June 2011 position paper.1,2

“Every healthcare provider thinks about pain,” said Joyce S. Willens, PhD, RN-BC, president-elect of the ASPMN.

Conundrum

However, even 11 years into the 21st century, pain still presents many of the challenges it did centuries ago.

“If you don’t get pain treatment right, much else is going to work,” said Loretta Kaes, BSN, RN, BC-G, C-AL, director of quality assurance and clinical services at the Health Care Association of New Jersey, an organization that regularly updates its pain management best practices guideline.

“Pain is a mixed blessing. It can tell us when something is wrong, but when it becomes chronic it can make our lives unbearable,” said historian Marcia L. Meldrum, PhD, co-director of the John C. Liebeskind History of Pain Collection at the University of California, Los Angeles.

“At this point, physicians often don’t know what pain measurement means to an individual patient. We know that pain is what the patient says it is, but bottom line, there is no one single pain modality, no pain treatment that works for everyone, not even opioids,” she explained.

That presents a conundrum in establishing evidence-based practices for pain management, experts say.

“By its very nature, it is difficult to research and define which medications best alleviate what type of pain,” Meldrum told ADVANCE.

“After all you can’t inflict serious persistent pain on groups of people and ask them to assess their experiences. That’s not ethical.”

Attitudes Toward Pain

The issue is further clouded by cultural differences in pain perception, century-old prejudices regarding pain that linger today, and a lack of understanding of how exactly pain is relieved.

It is significant that the first definition for pain in Merriam Webster Dictionary is “punishment,” because, as Meldrum explained, until modern times, pain “was a faith-testing experience, a way to build character and very often considered a punishment for past misdeeds.”

“The World War II generation was raised to be stoic, buck up, don’t bother the doctor; people will think you’re weak if you complain,” Kaes observed, drawing upon her experience as an assisted living nurse.

“John Homans [MD, at the annual meeting of the New England Surgical Society in 1939] basically said those with

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chronic pain were defective in some way," Meldrum noted. "When people had pain that couldn't easily be managed, they became increasingly suspect."

But things began to change.

"As society became more secularized and religion became less dominant, we became less willing to accept pain as punishment," Meldrum said. "The rise of Romanticism brought a greater empathy for the suffering of others, such as slaves, children, abused wives and eventually animals, and that spilled over into attitudes toward pain."

During World War II and after, John J. Bonica’s work prompted the founding of the International Association for the Study of Pain. Bonica, an anesthesiologist, organized the first World Pain Congress 40 years ago. “That’s why the pain field is so interesting,” Meldrum told ADVANCE. “Most pain research has been done in the last 40 years. Most pain scales were developed after World War II.”

Probably the first significant development in pain control was aspirin in 1899. "For the first time, people could take a pill and feel better. And unlike opium or alcohol, aspirin didn’t make them fuzzy-headed," Meldrum said.

How Pain Works
Understanding the mechanism of pain is critical to creating medications and evidence-based pain protocols. The prevailing wisdom says pain sensation occurs when the nervous system conveys messages to the brain to, for example, pull your hand away when you touch your finger to a hot stove.

"If pain persists and the signals keep flooding the brain, they become integrated with all the other information transmitted via the nervous system, and can determine whether you have more pain,” Meldrum said. “The more you’re able to distract yourself from pain, the less severe it will seem and the more easily you’ll be able to get over the pain. If all the neural systems interact and the brain keeps directing attention to the pain, it can create neurotoxicity; your nerves will become hypersensitive in the affected part of the body."

A big breakthrough in pain knowledge came in 1965 when Ronald Melzack, and Patrick Wall proposed the gate control theory. “They described a gate in the spinal cord that could open or close to allow pain signals to go to the brain,” Meldrum explained. “Other sensory signals, or cognitive or affective inputs from the brain, open or close the gate. The idea is there is a pathway and if you interrupt the pathway, you can prevent the signals from reaching the brain; then the brain won’t react. This could be used to bring chronic pain under control.”

Scales, Research, Treatment
While pain research still is considered in its infancy, contemporary research is extensive and scientific, Meldrum said. “In the lab they are looking at MRIs and PET scans to determine what is happening in the brain of a person, at a certain level of pain. They are looking for a physiological sign of the level of pain, much as [blood pressure] is a measure of heart and circulatory health.”

In addition, researchers are seeking a pain gene, “probably multiple genes,” Meldrum continued. “If you can find some genetic predisposition to developing chronic pain and find a way to switch that gene off, just think how great that would be. This could be the Holy Grail of pain and probably will be discovered some day.”

Whatever research is under way, pain treatment using evidence-based protocols based on present knowledge has advanced considerably. "We are more vigilant," Willens said. "We teach patients to communicate their pain better so we can help them. And no one should be in pain."

Right now, resources to control pain include tools like pain medications, patient-controlled analgesia, neurostimulation, anesthetic nerve blocks, TENS (transcutaneous electrical nerve stimulation), physical therapy, relaxation methods, meditation, yoga and legislation.

Yes, legislation. "It’s a law in New Jersey that all healthcare providers at all levels must ask a patient about pain upon assessment," Kaes said. ❖

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

Gail O. Gutelr is a frequent contributor to ADVANCE.
Oncology

Exercise Prescription For Cancer

Thomas Jefferson researchers discover the benefits of walking regimens for surgical recovery

By Robin Hocevar

Researchers at Philadelphia’s Thomas Jefferson University Hospitals and the Jefferson School of Nursing set out to change the perception that patients with pancreatic cancer are too sick to exercise postop.

In the course of the research project, Theresa Yeo, PhD, CRNP, and Patricia Sauter, MSN, RN, ACSE, discovered that a walking regimen in the days and weeks following cancer surgery can significantly reduce the chronic fatigue that’s common after surgery.

“The surgery, the fatigue most patients experience is nothing like being tired from staying up too late the night before,” explained Yeo, associate professor of nursing at the Jefferson School of Nursing and associate director of the Jefferson Pancreas Tumor Registry at the hospital’s department of surgery. “It doesn’t go away with sleep. It hits patients in their daily activities — simple things like doing your personal hygiene in the morning, getting up and getting dressed, going from the bedroom to wherever you eat breakfast.”

Baby Steps

When Yeo attended an oncology conference and learned of success when patients started walking after breast cancer surgery, she asked the Johns Hopkins investigator if the results would be the same in patients with pancreatic cancer. Although pancreatic surgery is more involved, Yeo was given the go-ahead to modify the program for her own patient population.

Together with her colleagues, Yeo recruited 102 patients who had undergone surgical resection for pancreatic or peripancreatic cancer. Most study participants were Caucasian men and women ages 66 or 67 years old with stage IIA or stage IIB cancer. The patients had similar rates and types of chronic conditions and no conditions that severely limited mobility.

The team explained the need for postop exercise to the patients before the surgery, and on the first day of postop, nurses helped the patients stand and take their first steps.

“Since we discuss it with them before the surgery, patients know walking is an expectation,” said Sauter.

In the study, the patients were randomized into two groups just before hospital discharge: the usual care group went home with normal discharge instructions that did not include an exercise routine, while the intervention group was charged with walking for increasingly longer intervals each week for 3 months.

The first month included walking sessions of 20 minutes with 10 minutes to warm up and cool down. If patients felt any discomfort or shortness of breath while walking, they were instructed to slow down or stop. The goal was to increase walking time by 90 to 150 minutes each week by the end of the 3-month program.

Participants in the walking program logged their distances and times and discussed their exercise regimen with their providers at the 1-month follow-up visit. Researchers followed up with inquiries about their fatigue and pain level as well as side effects like diarrhea, insomnia or depression.

“The beauty of this program,” said Yeo, “is that walking doesn’t require any fancy equipment or a gym membership. Anyone can start just walking around the block.”

Improved Outcomes

When the numbers were tallied, even the investigators were surprised. Of the 85 percent of patients who reported moderate to severe fatigue after the surgery, the intervention walking group showed a 27 percent improvement in fatigue after 3 months. By comparison, the control group showed only 19 percent improvement. Additionally, 61 percent reported being depressed after the operation. Once walking got under way, that decreased to 9 percent.

“The surgery itself does cause depression,” said Sauter. “It’s a huge body change and the diagnosis is often uncertain. These improvements are phenomenal.”

Changing Perceptions

With such dramatic findings, the hospital has already changed patient discharge instructions to include moderate aerobic exercise recommendations. Yeo and Sauter hope their study helps shift the traditional mind-set away from the idea that patients with pancreatic cancer are too sick to exercise after surgery.

Along with this exercise discovery, the surgery itself now offers better chances of success due to technology and critical pathways. Enhanced 3-D imaging, less blood loss, improved anesthesia time and, perhaps most importantly, more careful selection of patients all play a part in surgical success stories for patients diagnosed with pancreatic cancer.

Though clinicians serving patients with this form of cancer are the last to jump on the exercise bandwagon, investigators hope the message will spread to encourage them to take up the cause and help survivors everywhere.

Robin Hocevar is senior regional editor at ADVANCE.

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