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From the Editor

Welcome to this special issue of ADVANCE for Nurses, which features some of the best articles we published in 2012.

At The Valley Hospital, Ridgewood, NJ, nurses constantly look to all sources for best practice ideas. “Seeking Fall Solutions” examines how they implemented about a rounding technique to help reduce fall rates.

“A New Home” looks at Elizabeth Seton Pediatric Center’s new home in Yonkers, NY, which offers innovative features, a nurse-driven design and a “green” environment to provide optimal patient care.

The Beacon Award for Excellence from the American Association of Critical-Care Nurses recognizes critical care units that do everything right to ensure patient safety, employee engagement and high-quality care. In “Constant Vigilance,” nurses on ICUs who have earned the award discuss what makes them among the best in the critical care arena.

ADVANCE’s annual Best Nursing Team awards program is gearing up for the coming year. In “2012 Best Nursing Team,” we look back at this year’s top teams and what made them great.

“The Magnet Journey” discusses how Magnet designation represents an organization’s continued commitment to quality outcomes, and why to be successful the hospital as a whole has to be dedicated to excellence.

“The Sixth Vital Sign” discusses how the subjective nature of pain has made understanding it and developing evidence-based protocols a challenge.

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Richard Krisher

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Cover photography Kyle Kidinski/John Ciuppa/ADVANCE/Thanks to Seton Medical Center/Design by Doris Mohr

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Hospital nurse managers of patient care units are responsible for monitoring unit statistics, including total fall rates, restraint rates and one-to-one usage. But when you have best practices already in place on your unit, where do you go from there?

At The Valley Hospital, Ridgewood, NJ, we constantly look to all sources for best practice ideas. Through professional sharing, we learned about a simple rounding technique to help reduce total fall and one-to-one rates.

In September 2010, our geriatric med/surg unit recorded the highest monthly total fall rate per 1,000 patient days. Immediately, the unit-based advanced practice nurse (APN) and I devised a plan to reduce that rate.

First, we asked one of the staff nurses to observe current practice. As a secret shopper, she observed the current practice of all staff. She took note of what the staff said, how they practiced, whether the falls-prevention protocol was followed and, if not, what barriers kept that from happening. Her observations included inconsistency with both our falls-prevention protocol and the practice of purposeful 3P (pain, potty and positioning) rounding. A performance-improvement process was set in motion.

Hall Monitors

We recognized including staff in the decision to try something new to improve our fall rate was necessary for buy-in. We created a unit Falls Task Force that included staff from all shifts.

Together, we brainstormed potential solutions to improve our increasing fall rate. One solution we recognized was 15-minute rounding. Differing from purposeful 3P rounding, this technique involves visualizing patients at least every 15 minutes to ensure they are safe.

Everyone is involved, including nurses, business associates, managers and unit-based APNs. All are assigned at 15-minute intervals around the clock to visualize the entire patient, including the feet.

How did we sell this to the staff? We realized this was an additional task to their already overwhelming workload. However, we were running out of options. With no other suggestions on the table, we strategized the rollout. Hearing the concerns from the staff about “another thing to do,” a pilot seemed to be the best option.
Pilot Program
The pilot for “Rounding on the 15,” as we call it, lasted one week. We created a rounding tool that assigned staff by 15-minute intervals. Depending on the shift, some staff was required to round more than once. A stopwatch was used to identify the ronder and keep a standard time.

Guidelines were set before the start of the pilot to maximize our best chances of success. It was emphasized if a patient needed help that would require staff to stay in the room for an extended period, they should call either the nurses’ assistant or the nurse to minimize rounding interruption. Float staff were also expected to participate in the rounding.

The pilot began on the day shift at 7:15 a.m. The manager accompanied the nurses’ assistant who was first assigned to demonstrate the task. Rounding was completed in 5 minutes for our 43-bed unit.

Staff was surprised at how quickly it was accomplished. We used a train-the-trainer observation method to teach staff how to complete the rounding, which continued around the clock for one week.

After the pilot, we sought feedback from the staff on this experience through an anonymous survey. Out of 22 surveys, only two staff members did not want to continue. It was noted no falls occurred during the pilot.

Fall in Falls
“Rounding on the 15” has continued since restarting in December 2010. We have continued to track total fall rates, restraint rates and one-to-one usage during this time.

We assume because patients are being visualized at least every 15 minutes, we should experience a reduction in all of these rates. Our results have been outstanding. Our total fall rate per 1,000 patient days, which includes all falls, has been reduced by 24 percent since 2010.

Our restraint rates per 1,000 patient days have declined by 11 percent compared to 2010. Our one-to-one rate by full-time employees has also declined over the past year by 50 percent.

Due to the phenomenal success, other departments throughout the hospital have decided to adopt the 15-minute rounding. Staff who floated to our unit shared this initiative with their departments, assuring them that it took little effort and gave them peace of mind.

Families and visitors on our unit were comforted when they heard what we were doing because we informed them to establish trust.

❖

Lora Bognar is advanced practice nurse and Lynnelle Tampac is nurse manager of the ACE Unit, both at The Valley Hospital, Ridgewood, NJ.

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Elizabeth Seton Pediatric Center, a specialty nursing facility for medically fragile children with complex clinical conditions and disabilities, has made Manhattan its home for the past 20 years, but March 2012 marks the opening of its new facility in Yonkers, NY.

The 137-bed, 165,000-square-foot, four-story building is located on 6½ acres in Westchester County and opened March 4, 2012. It was designed around a culture change model, with family- and resident-centered care as the focus of each decision.

The task of finding a new home was not taken lightly, spanning several years and including visits to more than 200 sites. The Yonkers campus was chosen, according to Judy Bianca, MPH, BSN, RN, NE-BC, director of nursing, because it “proved to be the best choice for our children, offering the opportunity to create a design that places the family front and center, combining quality care with elements of childhood.”

Once the site was selected, the planning process began, during which the nursing staff led the charge to ensure the design would provide the best possible resident outcomes.

**Designed by Nurses**

The nursing staff was consulted each step of the way in order to create an environment that would best serve the patients and their loved ones, as well as a welcome and efficient place for staff to work. Nurses offered their opinions on how the building should be designed and the features they thought would be most valuable to the children and their families.

“Staff was very appreciative to give their own feedback,” team leader Edwin Araujo, BSN, RN, said. “We have been following a culture change model for more than 5 years and so the idea of children and parents being first is the focus of every staff member.”

Each nursing unit or “neighborhood” has a child-friendly name to create a warm environment for the children who make Elizabeth Seton Pediatric Center their home.

**Non-Traditional Approach**

A primary goal throughout the design process was to pull staff out of offices and place them among the residents. “We do not have a traditional nursing station. We have many non-traditional ones that we call touch-down stations, where nurses can chart and do their patients’ write-ups by the residents’ room,” Bianca said.

These stations provide nurses with access to records while maintaining a close proximity to the residents they serve. Staff of all disciplines will be able to use generic stations found throughout the neighborhoods.

**2 Plus 2**

Comprised of double rooms, the 2 Plus 2 suites are designed so children have both privacy and companionship, with proximal staff able to see and hear each child. Each child is situated next to a window, has a family visiting zone, personal space and a care zone.

“Certain populations are best cared for in a four-bedded room, for instance, infants, so we created 2 Plus 2 suites,” Bianca said. “We really felt strongly that small babies from NICUs and PICUs should not be alone in single rooms. And so this design offered a more simulated NICU/PICU atmosphere, a nursery if you will.”
For the Children
Aside from freshly designed resident rooms and amenities, children and their families have access to a wide range of specialty features.

The new facility includes an aquatic therapy pool, chapel-meditation room, music and art rooms, dining-play-family rooms, a sensory spa room, gymnasium, the Big Dipper Café dining room, and centers for physical, occupational and speech therapy.

When building the facility, staff agreed each child should have direct access to the outdoors. Therefore, there are five terraces in the neighborhoods, therapy gardens, and two playgrounds.

Social and physical stimulation is as critical, as is educational support. Housed on the first floor of the new building is the John A. Coleman School. There are 14 classrooms available to the children, whether they attend all day or only part time. Other children attend a local school, off-site.

‘Green’ Design
A conscious effort was made during every stage of design and implementation to ensure the new facility was eco-friendly. Such attention to the environment also supports healthier living conditions for residents, families and staff.

The facility is equipped with bamboo flooring, which is recyclable in many places, with ample air exchanges, opportunities to use water in a different way in the gardens, and “green” disinfection agents and cleaning supplies.

Every design decision was made based on the well-being of the children, which has resulted in a facility that will provide exceptional care and an environment in which everyone involved will be proud to be a part of.

Catlin Nalley is editorial assistant at ADVANCE.
Fans of the popular Harry Potter book series will recognize Professor Mad-Eye Moody’s never-ending refrain of “constant vigilance!” Perhaps Moody was once an ICU nurse. Constant vigilance is a key requirement when caring for critically ill patients — where infection is an ever-present fear, stress can tear down nursing morale, and complacency can have deadly consequences.

Since 2003, the American Association of Critical-Care Nurses (AACN) has helped units maintain this constant vigilance through the Beacon Award for Excellence. The award — and the process of applying for it — provides a roadmap for nursing units to follow in order to improve care. “The application is kind of a 360-degree evaluation of the whole unit,” said Pam Harmon, BSN, RN-C, ICU nurse manager at St. Peter’s University Hospital in New Brunswick, NJ. “You’re reviewing yourself from all angles.”

Lighting the Way
Harmon’s ICU recently received its third Beacon award — one of only 10 in the U.S. to do so. Still, she says, “The Beacon application is never perfect. It continually makes you better.”

As her unit has achieved goals, they continue to set the notches higher. As an example, 2 years ago, 65 percent of nurses on the unit were certified in critical care, compared to a 40 percent national average, Harmon said. Today, they are pushing 75 percent, and counting.

Nurses get excited about Beacon — and that’s a good thing, said Dawn Mattera, BSN, RN, PCCN, unit director of telemetry and intermediate care at Holy Name Medical Center in Teaneck, NJ. For Rhode Island Hospital, Providence, which earned a silver Beacon in 2011 (its second award), the Beacon award process literally turned its cardiothoracic ICU around from a unit struggling with 39 percent turnover, low morale, high distrust and a revolving door of managers. When a new nurse manager came on board in 2008, she suggested the unit strive for the Beacon.

Case in Point
Over the years, Harmon’s ICU has worked hard on leadership, staffing and engagement to create a supportive environment for nurses — with the result that there is now a waiting list of nurses wanting to work in the ICU.
Nurses participate in professional councils where they discuss clinical issues and come up with solutions to improve outcomes, they do self-scheduling, and they round not just on patients — it’s also done on staff. Leaders reward and recognize nursing staff when someone has gone above and beyond.

At Rhode Island Hospital, the ICU started a mentoring program for new nurses, pairing them with an experienced nurse for a year, which helped novices develop a nurturing relationship with a professional of whom they can ask questions, without feeling like a bother.

Improved Outcomes

And when staff are engaged, outcomes improve. “The bedside nurse is the expert,” Harmon said. “They know best, and they know what’s going to work.” When these nurses have a voice and are empowered, they are able to identify problems, as well as solutions.

But, cautioned Tracy, “It’s not good enough to have excellent patient outcomes. [For Beacon], they want to see exactly how you achieved these outcomes and what you have in place to continually evaluate and change your practice.”

One process at Holy Name — discussing safety issues at monthly staff meetings — has already uncovered two small changes to improve patient care. Patients typically have daily portable chest X-rays at 5:30 a.m., and at times, chest tubes were dislodged because of patient movements. A process was put in place to ensure patients had an adequate level of sedation, and a nurse is now present during the X-ray to help maintain the airway.

At Rhode Island Hospital, staff has worked hard on standardizing care based on current research and best practices — and are continuing to do so.

Noise control was one issue the St. Peter’s staff looked at early in its Beacon journey, and which has become a larger issue as it has become the subject of more research. Staff noticed the ICU could be very loud, with visitors coming in and out and monitors constantly beeping, so they completed a study to identify peak “loud” hours, and put in place a 2-hour “quiet time” to give patients a period of rest and healing. Patient outcomes improved, and there was another unforeseen benefit: Nurses were happier too.

And that may be the greatest benefit of the Beacon journey: identifying nursing satisfaction and patient outcomes do go hand in hand. When units start to think that way, and identify processes to build nursing professionalism as well as improve patient outcomes and infection rates, it’s a win-win on both sides.

Danielle Wong Moores is a frequent contributor to ADVANCE.
RUNNER-UP:  
Eyes Of The Storm  ➤  When New York City Mayor Michael Bloomberg made the announcement on Aug. 25, 2011, that hospitals located in Zone A must evacuate patients by 8 p.m. the next day, nurses at Coney Island Hospital, Brooklyn, NY, demonstrated their exceptional adaptability skills.

The nursing staff began preparing patients for transfer the evening of Aug. 25. On the morning of August 26, nurses were ready to begin sending patients to other facilities. Coney Island Hospital was able to successfully transfer approximately 270 patients before the 8 p.m. deadline Mayor Bloomberg had given.

Nurses left their homes not knowing the effects Hurricane Irene was going to have on the city, their hospital or their homes. These nurses made arrangements to travel to healthcare facilities they had never worked at before.

WINNER:  
Behavioral Health, Visiting Nurse Service of New York  ➤  What began 5 years ago as a pilot program to address depression in the home care setting has since grown into a multifaceted program serving seven regions thanks to a dedicated team of Visiting Nurse Service of New York (VNSNY) nurses.

The one-of-a-kind program, which serves all five boroughs and Westchester and Nassau counties, offers a unique collaboration between acute care nursing and behavioral health specialty services.

The members of the 23-nurse team have varying expertise and experience levels, from seasoned veterans to new graduates. Despite their differing backgrounds, each team member shares one important quality: dedication to behavioral health.

Patients are introduced to the program in two ways. Preexisting VNSNY cases are brought to the team’s attention when the on-duty nurse notices the patient may be experiencing behavioral health symptoms, most often depression, according to Meg Sherlock, MA, PMHCNHS-BC, clinical director.

Other patients come to the program directly from inpatient psychiatric facilities. They are seen within 1 day of discharge to their home. Each nurse carries a caseload of approximately 23-25 patients.

The team includes two psychiatrists who are available for consultation visits in the home. The nurses identify whether the patient is taking medication. Then the patient’s physician is called to discuss a potential consultation by the team’s psychiatrist.

The program, which has already undergone enormous expansion in the past 2 years, plans to continue to spread its reach.

RUNNER-UP:  
Calm In The Chaos  ➤  In early November 2011 around midnight, Danbury Hospital, Danbury, CT, received calls from several paramedics within minutes of each other; they were enroute to a mass casualty incident on a nearby interstate.

The crash victims — students from a religious school — were physically and emotionally traumatized. The entire nursing team became respectful of the children’s religious beliefs, conscious of their physical injuries, and accepting of their emotional injuries.
Since the time of this incident, the adaptability to cultural differences continues to be a focus of continuing care at Danbury.

**RUNNER-UP**

**Practice Makes Perfect**

➤ In summer 2011, shortly after the opening of the new Alexandra & Steven Cohen Pediatric Emergency Department at Morgan Stanley Children’s Hospital of New York, the Mock Code Thursdays (MCT) program began in earnest.

Since then, dozens of staff have participated in weekly MCT exercises. Each week, a pediatric ED fellow and a nurse work together to develop a scenario and invite staff — physicians and nurses, along with respiratory therapists, pharmacists, radiology techs, unit assistants, child life specialists, social workers and translators.

Simulations may be for a seizure, cardiac, respiratory distress or even a gunshot wound. When the scenario is done, the team debriefs, discussing what worked well and what didn’t.

After months of MCTs, communication during codes has increased tremendously. During a real code the room is quiet, organized and everyone knows his or her role and how to perform quickly and effectively, with consistency and confidence. Real progress has been made.

**RUNNER-UP**

**Patients Come First**

➤ The 4th and 5th floor chemotherapy nurses at the Memorial Sloan-Kettering Cancer Center, New York, NY, make up one group of skilled, professional and compassionate nurses, specializing in gastrointestinal, melanoma, sarcoma and neurological oncology chemotherapy administration. Even though they operate in separate areas, the floors are considered “sister floors” and therefore work as one unit.

This large staff — 34 nurses and three patient care technicians — with a high volume of patients is prepared to adapt to any kind of situation to better suit the patients.

“As our environment and patients’ needs change, our role as nurses changes with it. However, we have no problem in voicing our opinions to advocate for our patients. We are always addressing the need for ways to better care for our patients,” writes Diana Tam, BSN, RN, in the essay to ADVANCE.

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The Magnet Journey

Magnet-designated hospitals are considered the best of the best with an environment where staff are engaged and patients are satisfied

By Catlin Nalley

Hospitals across the country are prompted to pursue Magnet status for a variety of reasons, but the common thread throughout is a desire to build an environment that promotes high staff engagement and quality patient care.

The vision of Magnet, which was developed by the American Nurses Credentialing Center, is these organizations will serve as the fount of knowledge and expertise for the delivery of nursing care globally.

Collaborative Success

Every level of staff must be devoted to achieving this goal, from staff nurses to managers to CEO. The best results come from a collaborative environment, such as the one created at Yale-New Haven Hospital (YNHH), New Haven, CT.

YNHH earned its first designation last year and throughout its Magnet journey recognized the importance of the bedside nurse. As a result, a collaborative governance structure was implemented, where the practice is led by direct care staff.

“Originally, nursing leadership and interdisciplinary partners were determining what practice was, which didn’t truly allow the bedside nurse to own their practice, which is key when you were looking at the overall Magnet initiative,” said Lori Hubbard, BSN, RN, manager of the office of nursing excellence and Magnet program at YNHH.

Direct care staff is involved in every aspect of care and instrumental in creating positive change. Therefore, it is imperative they play a significant role in determining practice.

“The staff nurse’s input is just as important as one of the nurses executives’, so it is imperative that you create a culture of shared decision making,” said Leigh Anne McMahon, MSN, MHA, RN, NEA-BC, vice president of nursing and CNO at White Plains Hospital, White Plains, NY.

White Plains earned its first designation in April after a 5-year process that involved nurses at all levels as well as hospital-wide support.

Continuous Effort

Facilities that not only earn an initial Magnet designation but maintain it are the ones that recognize Magnet is not just an achievement to be gained and forgotten, but a journey requiring constant effort. Redesignation occurs every 4 years, but success depends on a year-round commitment to excellence and improvement.

“The day we were designated, I said, ‘OK, work begins on redesignation,’” said Sue Fitzsimons, PhD, RN, senior vice president of patient services and CNO at YNHH. “It is never over; it is continuously raising the bar throughout the whole organization.”

Building upon past success and recognizing shortcomings offers hospitals a better understanding of what needs to be improved upon and strengthens the foundation that Magnet has created.

“We continually complete a gap analysis and each time they become more difficult because the gaps are different,” said Maria Ducharme, MS, RN, NE-BC, senior vice president of patient care services and CNO at The Miriam Hospital, Providence, RI, a facility that was designated for the fourth time in 2010.

Constant Evolution

Just as the hospitals evolve, so do the Magnet standards, which must be taken into account when perusing redesignation.

The Miriam, which has held its Magnet designation since 1998, witnessed this evolution from the beginning.

“The first time we achieved Magnet designation, it was very much a learning process for the hospital,” Ducharme said. “The ANCC continuously examines best practices throughout the country and their standards become that much more rigorous and robust. With each designation and passage of time, the ANCC raises the bar.”

Constant change and reevaluation by hospitals and the ANCC’s Magnet organization alike stimulate discussion and reflection, but it can be challenging for hospitals that are constantly expected to meet rising expectations.

Patient Outcomes

Outcomes are stressed, especially when a facility has received multiple designations. It is expected the practices and programs are in place, so a greater emphasis is placed on optimizing their impact.

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“When each designation, we are expected to be a more fully matured Magnet organization with a staff that continually and consistently understands and exemplifies what it means to make decisions at the staff level,” Ducharme said.

“Most recently, the process has been very outcome-oriented,
focusing on how the environment and support of nurses impacts patient care,” she noted. Magnet demands accountability and a dedication to providing exceptional patient care. Hospitals who maintain Magnet are considered examples of excellence, which can be seen in the day-to-day culture.

Benefits to All
While the nursing team is at the center of any Magnet designation, hospitals recognize that the benefits go far beyond it. Positive outcomes are fostered, which leads to an organization where staff and patients can find comfort. The environment Magnet creates through constant improvement is one where staff is engaged and satisfied. And when staff is happy, the patient experience is better. “Patients appreciate the difference Magnet designation makes and have said ‘we wouldn’t go to any hospital, but here,’” said Erin Dellagrotta, BSN, RN, BC, cardiac unit staff nurse at The Miriam. “We hold ourselves in a higher regard; we like working here and the patients like coming here.”

Catlin Nalley is editorial assistant at ADVANCE.

Honor Roll
Magnet-designated healthcare organizations in the Northeast region

**CONNECTICUT**
- Middlesex Hospital, Middletown (2001)
- St. Vincent’s Medical Center, Bridgeport (2012)
- Yale-New Haven Hospital, New Haven (2011)

**MAINE**
- Acadia Hospital, Bangor (2003)
- Maine Medical Center, Portland (2006)
- Mid Coast Hospital, Brunswick (2009)

**MASSACHUSETTS**
- Baystate Medical Center, Springfield (2005)
- Boston Children’s Hospital, Boston (2008)
- Dana-Farber Cancer Institute, Boston (2005)
- Lahey Clinic, Burlington (2009)
- Lowell General Hospital, Lowell (2010)
- Massachusetts General Hospital, Boston (2003)
- South Shore Hospital, South Weymouth (2009)
- Winchester Hospital, Winchester (2003)

**NEW HAMPSHIRE**
- Dartmouth-Hitchcock Medical Center, Lebanon (2003)
- Southern New Hampshire Medical Center, Nashua (2006)
- St. Joseph Hospital, Nashua (2005)

**NEW JERSEY**
- AtlantiCare Regional Medical Center
  - City Campus, Atlantic City, Atlantic City (2004)
  - Mainland Campus, Pomona, Atlantic City (2004)
- Capital Health System
  - Fuld Campus, Trenton (2002)
  - Mercer Campus, Trenton (2002)
- CentraState Medical Center, Freehold (2005)
- Englewood Hospital & Medical Center, Englewood (2002)
- Hackensack University Medical Center, Hackensack (1995)
- Holy Name Medical Center, Teaneck (2009)
- Hunterdon Medical Center, Flemington (2008)
- Jersey City Medical Center, Jersey City (2008)
- Jersey Shore University Medical Center, Neptune (1997)
- Morristown Medical Center, Morristown (2001)
- Ocean Medical Center, Brick (1998)
- Raritan Bay Medical Center, Perth Amboy (2004)
- Riverview Medical Center, Red Bank (1998)
- Robert Wood Johnson University Hospital, New Brunswick (1997)
- Saint Joseph’s Regional Medical Center, Paterson (1999)
- Saint Peter’s University Hospital, New Brunswick (1998)
- Somerset Medical Center, Somerville (2011)
- South Jersey Healthcare
  - Bridgeton Health Center, Bridgeton (2008)
  - Elmer Hospital, Elmer (2008)
- Regional Medical Center, Vineland (2008)
- The Valley Hospital, Ridgewood (2003)
- University Medical Center of Princeton at Plainsboro, Plainsboro (2012)

**NEW YORK**
- Bassett Medical Center, Cooperstown (2004)
- F.F. Thompson Hospital, Canandaigua (2004)
- Good Samaritan Hospital Medical Center, West Islip (2006)
- Highland Hospital, Rochester (2011)
- Hudson Valley Hospital Center, Cortlandt Manor (2007)
- Huntington Hospital, Huntington (2004)
- NYU Hospitals Center Tisch Hospital and Rusk Institute for Rehabilitation Medicine, New York (2005)
- Northern Westchester Hospital, Mount Kisco (2012)
- Our Lady of Lourdes Memorial Hospital, Binghamton (2007)
- Rochester General Hospital, Rochester (2004)
- Roswell Park Cancer Institute, Buffalo (2010)
- St. Francis Hospital, Roslyn (2006)
- St. Peter’s Hospital, Albany (2005)
- The Mount Sinai Hospital, New York (2004)
- The Saratoga Hospital, Saratoga Springs (2004)
- University of Rochester Medical Center/Strong Memorial Hospital, Rochester (2004)
- White Plains Hospital, White Plains (2012)

**RHODE ISLAND**
- Newport Hospital, Newport (2004)
- The Miriam Hospital, Providence (1998)

**VERMONT**
- Rutland Regional Medical Center, Rutland (2010)
- Southwestern Vermont Medical Center, Bennington (2002)

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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, CRIES, Brief Pain Inventory, Coloured Analogue Scale, Alder Hey Triage Scale, COMFORT, CRIES, Brief Pain Inventory, the Wong-Baker Faces, Numerical Rating Scale, and many others. There is the FLACC, the Wong-Baker Faces, Numerical Rating Scale, COMFORT, CRIES, Brief Pain Inventory, Coloured Analogue Scale, Alder Hey Triage Scale, COMFORT, CRIES, Brief Pain Inventory, and more than 100 pain scales.

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 hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs in its last annual quality and safety report, and the Institute of Medicine called for hospitals that had excellent pain programs.

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, not 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 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. Guterl is a frequent contributor to ADVANCE.

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