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# NursingNow

Communicate, Educate, Motivate!

A bi-monthly news publication written by nurses ... for nurses.

## From the Desk of the Vice President, Nursing Services

**Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services**

As I begin to write my first NURSING NOW article as the senior nurse executive, many thoughts run through my head. First and foremost, how do I begin to fill the shoes of my mentor and friend, Darcie Brazel? I know I speak for the majority of the nurses at Advocate Christ Medical Center and Hope Children's Hospital when I say that she has been nothing less than an amazing, inspirational leader who has led the department of nursing with wisdom and grace.



*Lynn Hennessy, MS, MBA, RN, NEA-BC*

In THE 5 LEVELS OF LEADERSHIP, required reading for all leaders across Christ Medical Center, the author and well-known expert on leadership, John Maxwell, describes the 5th level of leadership as the highest level, the "pinnacle," the most difficult to achieve. "Only naturally gifted leaders ever make it to this highest level. Level five leaders are set apart from level four by the mere fact they develop others to become level four leaders." The ability to develop other level four leaders is very difficult because it takes a lot of time and effort. Darcie took the time and effort to develop many of us in this organization. She had the uncanny ability to identify people's strengths, then advance and promote those strengths for the benefit of the individual and the entire organization.

As Maxwell asserts, "Level 5 leaders develop Level 5 organizations. They create opportunity that other leaders don't. They create a legacy in what they do. People follow

them because of who they are and what they represent. In other words, their leadership gains a positive reputation. As a result, Level 5 leaders often transcend their position, their organization and sometimes their industry."

Darcie most certainly was a level 5 leader. I cannot begin to list all of the accomplishments we have achieved, individually and collectively, due to her leadership. Magnet designation is probably the one that immediately comes to most people's minds, but there is so much more that Darcie contributed directly and indirectly to nursing at Christ Medical Center. Darcie often took risks and sailed into uncharted waters. She was an early adopter which is evident in the many accomplishments we were able to achieve well before most: our Magnet designation and re-designation, DYAD model, shared governance model, nursing research department, nurse residency program, BSN as the minimum degree for hire and mandatory certification testing of eligible nurses are just a few.

In The Future of Nursing: Leading Change, Advancing Health the Institute of Medicine (IOM) recently put forth eight recommendations:

- Remove scope of practice barriers
- Provide opportunities for nurses to improve practice environment and diffuse collaboration
- Implement nurse residency programs

- Increase proportion of RNs with BSN to 80 percent by 2020
- Double number of nurses with doctorates by 2020
- Ensure nurses engage in lifelong learning
- Prepare and enable nurses to lead change to advance health
- Build infrastructure to collect, analyze Health Care Workforce (HCW) data

Clearly, Darcie has set a solid foundation and positioned us well for the future, a future that is changing at lightning speed. In order to keep up with change and continue to positively impact patient care, we need to think outside the box, no longer relying on how we have done things.

Looking ahead, we will continue to improve all aspects of nursing, with the ultimate goal, of course, to provide our patients with world class care. We will continue to break barriers and exceed expectations. We will continue to make Darcie proud.

As your senior nurse leader, I commit to positively represent nursing at the executive table and expect nothing less than exceptional, compassionate care for every patient that sets foot into our institution, strong partnerships with our physicians, and collaboration and respect between all disciplines.



**Transformational Leadership**  
 Magnet Force: Quality of Nursing Leadership

## 2011 Daisy Award for Extraordinary Nursing Faculty: Honoring Exceptional Faculty and Their Impact on Student Nurses

**Elizabeth Kupczyk, MSN, RN, clinical affiliations liaison**

The Advocate Christ Medical Center and Hope Children's Hospital annual Deans' Dinner held at Silver Lake Country Club in September 2011 marked the first time a practice institution awarded a clinical instructor with the DAISY Award for Extraordinary Nursing Faculty. The DAISY faculty award was established to provide a mechanism for recognition of outstanding nursing faculty. The goal of this award is to recognize the dedication and commitment of nursing faculty in the hope that they will continue to inspire and mentor future nurses through their teaching. Christ Medical Center is the first practice institution in the country to grant this award. More commonly, schools of nursing award their respective faculty in the academic setting.

In launching the DAISY faculty award at the medical center, a nomination process was developed that included soliciting nominations from affiliating schools of nursing, students and units where faculty conduct clinical rotations. The DAISY faculty award honorees personify excellence in teaching which in turn results in the best patient outcomes. These faculty members consistently demonstrate excellence through their clinical expertise and extraordinary compassionate care, and they are recognized as outstanding role models in the nursing community.

The criteria for the DAISY Award for Extraordinary Nursing Faculty include:

- Serving as a role model of professional nursing;
- Demonstrating enthusiasm for teaching, learning and nursing that inspires and motivates students;

- Demonstrating an interest in and respect for learners;
- Using personal attributes (e.g.; caring, confidence, patience, integrity and flexibility) that facilitate learning;
- Being fair and unbiased in his/her treatment of individual students;
- Excellent interpersonal skills; and
- Developing collaborative working relationships with students and colleagues.

The recipient of the 2011 DAISY faculty award was invited to the Deans' Dinner under a "ruse" so as not to give any indication that an award was to be presented.



*Dr. Peggy Rice, EdD, APN, BC, dean, Lewis University; Julie Brady, MS, RN, faculty honoree, Lewis University; and Darcie Brazel, MSN, RN, NEA-BC, market chief nurse executive*

During the introduction of the DAISY Award for Extraordinary Nursing Faculty, the audience was awaiting in suspense for the recipient's name to be announced. It was a pleasure to announce Julie Brady, Lewis University clinical faculty. The look of amazement on her face was priceless! Dr. Peggy Rice, dean of Lewis University's College of Nursing and Health Professions, nominated faculty member, Julie Brady, MSN, RN, "as an example of clinical expertise and a professional role model for nursing students of Lewis University College of Nursing and Health Professions and nursing staff at Christ Medical Center." Julie has taught

clinical at Christ Medical Center for the last 14 years. In addition, she continues to practice at the bedside in order to share the most current evidence with her students.

Dr. Rice commented on the excellent clinical evaluations Julie receives year after year from students in addition to excellent evaluations by staff nurses from Christ

who serve in the capacity of role transition preceptors. Julie values lifelong learning and frequently contacts the university on behalf of preceptors to provide them with tuition reimbursement certificates.

Humbly accepting the honor, Julie cites the meaning of the DAISY award in her own words. "I have taught clinical for Lewis University at Advocate Christ Medical Center for the last 14 years. The students have had so many unique learning opportunities and have always had wonderful clinical experiences while at Advocate Christ Medical Center. Being a Magnet institution means that students experience firsthand true nursing leadership and a medical center that values exceptional patient care." Julie enjoys teaching in an institution that utilizes the latest evidence in providing patient care. Every day is an opportunity to learn something new and to improve the care delivered to patients.

To learn more about the DAISY foundation and to see DAISY faculty award honoree Julie Brady, please go to [www.DAISYfoundation.org](http://www.DAISYfoundation.org) and click on her name: <http://daisyfoundation.org/daisy-faculty-award/faculty-spotlight/JulieBrady>

The hallmark of this year's Deans' Dinner was the inception of the DAISY faculty award in recognition of how nursing faculty inspires and influence nurses of tomorrow. We value our partnerships with schools of nursing and look forward to your participation in future nominations. Congratulations Julie Brady, DAISY faculty award honoree 2011.



**Structural Empowerment**  
 Magnet Force: Professional Development; Image of Nursing





## Patient Safety

## Are You Prepared for a Disaster?

**Janet Finlon, BSN, RN, MA, NEA-BC, director, clinical operations of the neuroscience and bone and joint institutes; Irene Tranowski, MSN, CRRN, clinical practice partner, 6 south; and Dawn Walters, ADN, CRRN, assistant clinical manager, 6 south**

On August 29, 2005, Hurricane Katrina caused the evacuation of Memorial Medical Center in New Orleans, La.; on May 22, 2011 a tornado hit St. John's Regional Medical Center in Joplin, Mo., causing an evacuation. Following these major disasters, there has been an increased focus on disaster preparedness in hospitals and medical centers across the country.

On October 20, 2011, two evacuation drills

were simulated on 6 south, the rehabilitation unit at Advocate Christ Medical Center. The drills included involvement from many departments. Preplanning was necessary for the purpose of minimally disrupting patient care, attaining volunteers as patients, and informing patients and visitors. The planning team led by Janet Finlon, BSN, RN, MA, NEA-BC, director of clinical operations of the neuroscience and bone and joint institutes, included emergency management services (EMS), building operations, equipment processing and distribution (EPD), public relations, communication, nursing office, environmental services, security and safety. The plan included two drills involving all three shifts, one at 0600 and the other at 1430. The evacuation would be due to fire; a Code Red would be activated followed by a Code Triage Internal Standby. The command center would be activated. The evacuation would be simulated by moving patients, associates and records out of the building via the front door. Patients were made up of volunteer EMS students and associates from various departments. Patients were issued red wrist bands identifying who they were and mode of transfer. Wheelchairs, carts and beds were the planned modes of transportation from the unit. Signs were posted in the lobby to alert visitors and associates.



*Evacuation in action with Stefanie Powers, BSN, CRRN, nurse clinician II, 6 south.*

The first drill began at 0603 with a Code Red called. The fire progressed from smoke to flames and a Code Triage Standby was then initiated and evacuation had begun on the rehabilitation unit. The charge nurse took control, and patients were then evacuated horizontally to 6 east/west and then vertically to the outside of the hospital. A total of 34 patients were evacuated along with 17 associates and patient charts. Code Red all clear was called at 0634.

The second drill began at 1427, the fire alarm was pulled and a Code Red activated. Code Triage Standby was activated at 1435, 24 patients were evacuated along with 26 associates, two of the patients being actual patients that volunteered to participate, evacuated horizontally and then vertically to the outside of the building. Code Red all clear was called at 1458.

After completion of the morning drill, the following barriers were discussed with the command team:

- Not all associates were clear on their role during the evacuation;
- Obstacles that were encountered included:
  - Fire doors that needed to be opened
  - Cumbersomeness of moving beds
  - Rug in the main lobby;
  - Lack of knowledge of resources available such as linens, portable phones, incident command center personnel; and
  - Not enough evacuation tags on the unit.

The second drill again evidenced similar barriers as follows:

- Not all associates were aware of their role;
- There was inappropriate use of elevators;
- Fire doors were being held open too long (smoke could escape); and
- Tracking of patients and associates.

The recommendations resulting from both drills were as follows:

- Directors need to improve response/participation with drills;
- The tracking sheet for patients, visitors and associates needs enhancements;
- Fire doors should not be held opened for an extended period of time;
- Associates must follow instructions when told not to use elevators;
- Weather protection must be provided to evacuated patients if available;
- Education to leadership needs to be provided regarding Code Triage vs. Code Triage Standby, with sharing at staff meetings; and
- Evacuation drills for 6 south need to occur minimally once a year.

Many lessons were learned and improvements have already been made. Comments about the drill include "Great learning experience, never did this before;" patients who participated said they felt safer knowing that we are practicing for disasters and visitors' comments during drill were "Great idea ... good job."

What went well included communication of Code Red and Code Triage Standby, narcotics were secured, assistance from other departments during the afternoon drill, EPD provided wheelchairs, chairs with wheels from nursing station used to transport patients (innovation by staff), all staff and patients were accounted for after second drill, and plenty of evacuation tags were available. Both drills were a great learning experience for all participants.



**Exemplary Professional Practice**

*Magnet Force: Quality of Care*

## Magnet

## The Forces of Magnetism at Work on 7 East

**Theresa Zaplatosch, ADN, RN, assistant clinical manager, 7 east**

As a new unit 7 east began the Magnet journey in 2002 with the rest of the medical center. They quickly realized that each nurse would experience his/her own transformation as participants in the journey. The unit was able to grow and develop within the forces of Magnetism, quality of care and quality improvement, and professional development became the unit's focus.

Unit council encourages staff involvement to form unit practices and its primary goal is to improve the quality of patient care. Current 7 east unit council chair, Whitney Luke, BSN, RN, TNCC, nurse clinician II says, "When unit council meets, we explore ways to improve the care we give on 7 east." The 7 east council is now working towards improving the documentation of pain assessments and reassessments. For Shellie Chambers, BSN, RN, TNCC, Magnet means going above the standard care that other hospitals provide. She agrees with Luke that providing excellent care is our main priority. Shellie, along with the others on our unit, works to find innovative ways to provide outstanding, personalized care with compassion to the trauma patients and their families that are served.



*Pictured top row (left to right) are Reagan Perek, ADN, RN, registry; Christine Niemic, BSN, RN, nurse clinician II, Theresa Zaplatosch, ADN, RN, assistant clinical manager, enrolled in BSN program; Diana Wittle, ADN, RN, manager of clinical operations, enrolled in BSN program; Erin Oakes, BSN, RN, nurse clinician I; Shellie Chambers, BSN, RN, TNCC, registry. In the bottom row (left to right) are Laura Elliott, ADN, RN, TNCC, nurse clinician II; Diana Misura, CIMS; Whitney Luke, BSN, RN, TNCC, nurse clinician II, medical-surgical certification currently enrolled in MSN program; Angela Kirsch, PCA.*

Another force of Magnetism at work on 7 east is professional development.

"Education has become more important than ever on our unit," said Christine Niemic, BSN, RN, nurse clinician II. She noted that many of the nurses have either achieved specialty certification or have returned to school. Of the 34 registered nurses that call 7 east home, four have already obtained medical-surgical certification and 14 others have completed the Trauma Nurse Core Curriculum. Additionally, eight others are in bachelor's degree (BSN) completion programs, one nurse is currently enrolled in a master's degree (MSN) program, and one nurse recently obtained an MSN. Our nurses are not only ambitious students, but also educators, with 10 nurses completing the required clinical coach training to serve as mentors to new nurses.

The dedicated nurses on 7 east will continue to rise to meet the challenge to improve care, and will aim to exceed the goals which have been set ... excellent care.



**Exemplary Professional Practice**

*Magnet Force: Professional Models of Care, Interdisciplinary Relationships*



Research

# Internal Grants Available for Nurses

**Cheryl Lefaiver, PhD, RN, professional nurse researcher**

Did you know that internal grant funding is available for nurses working to improve patient care at Advocate Christ Medical Center and Hope Children's Hospital? Funds raised from the Chip In for Nursing Research golf outing are used to support three types of grants: Original Nursing Research, Evidence-Based Practice and Travel Grants. Full details and applications can be found on the Nursing Research intranet website: <http://cmconline.advocatehealth.com/page.cfm?id=1188>

- Here are a few tips if you decide to apply for grant funds:
- Get help early. Assistance is available from the Department of Nursing Science (Wendy Tuzik Micek, Cheryl Lefaiver); Department of Pediatric Research (Denise Angst); and in the Department of Research Services (Christopher Blair).
  - Signatures from the manager and director of the respective nursing units need to be received prior to submission. If other areas/departments are involved, additional signatures are required. Plan time to obtain signatures before submission.
  - Expect that preparation of the original nursing research application may take two to three months.

Applications are accepted at any time to the Nursing Research Council c/o Market Director of Nursing Science and Magnet (Wendy Tuzik Micek, PhD, RN). Applications can be found on the Nursing Research intranet site "Internal Funding for Nursing" and are peer-reviewed by members of the Christ Medical Center and Hope Children's Hospital Nursing Research Council.

Have you visited the Christ Medical Center Nursing Research website recently? A new addition includes a table of external funding opportunities and professional nursing conference calls for abstracts. Click on the link for "External Funding for Nursing." Also the number of journal clubs ongoing has increased greatly and past reviewed articles and their summaries are listed on the website. Check out the articles being read by staff,

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Nursing Now Research Articles

Nursing Research Council Charter

Nursing Research Council Members

Nursing Research Model

Nursing Research Process Flowchart

Nursing Research Project - How & Where Do I Start?

Nursing Research Recognition

Nursing Symposium Presentations

Student Project Determination Form

Research Resources

NRC

Nursing Research Council

As nurses, we have a duty to our patients and to our profession to research any and all pertinent data that may improve our patients' outcome or better utilize our skills. We all participate in research everyday. We measure, record, and evaluate endless data while we care for our patients. It is this data that becomes the beginning of the nursing research process.

Research does not need to be an elaborate process that overwhelms us; it can be simple and practical. Remember, we are all participants in this process together, and we can use it to help ourselves. Be a part of the team, ask questions, collect data and make a difference!

Link to Magnet ANCC Website:  
<http://www.nursingworld.org/ancc/magnet/index.html>

advance practice nurses and managers of clinical operations in their journal clubs; click on the link "Journal Club" <http://cmconline.advocatehealth.com/page.cfm?id=3129>

Questions about nursing research can be directed to Wendy Tuzik Micek at [wendy.micek@advocatehealth.com](mailto:wendy.micek@advocatehealth.com) or Cheryl Lefaiver at [cheryl.lefaiver@advocatehealth.com](mailto:cheryl.lefaiver@advocatehealth.com)

Any nurse with an idea and passion to change patient care is invited to apply for any of the above grants. We look forward to your grant submission!

New Knowledge,  
Innovations and Improvements

Magnet Force: Quality of Care,  
Research and Evidence Based Practice

Dyad Profile

## Pediatric Emergency Department Leadership Dyad

**Rebecca Gierling, BSN, RN, manager, clinical operations, pediatric emergency department, and Irene Tranowski, MSN, CRRN, clinical practice partner, 6 south**

The pediatric emergency department will be an official department for two years in February 2012. The department's dyad became complete in October 2011, when its new advanced practice nurse (APN) started at Advocate Christ Medical Center.

Rebecca Gierling, BSN, RN, is the manager of clinical operations in the pediatric emergency department. Becky became the manager one and a half years ago. She originally received her associate degree in nursing but went back to school for her bachelor's degree feeling she could have more of an impact on nursing by focusing on leadership skills. Prior to coming to Christ Medical Center, Becky had three years of management experience. She has always wanted to inspire nurses with the same passion for emergency nursing care that she has. She understands the importance of distinguishing the department as its own entity to both the staff as well as the hospital. Becky has begun to develop a vision for the department by developing specific goals and action plans. This has helped to provide a foundation for cohesive team work and confidence in pediatric specific skills.

Sarah Maciolek MS, APN, PCNS-BC is the APN for the pediatric emergency department. Sarah worked at Children's Memorial Hospital in Chicago prior to coming to Christ Medical Center as a registered nurse in its pediatric intensive care unit. Sarah recently graduated from the University of Illinois at Chicago with her master's of science in nursing and became board certified as a pediatric clinical nurse specialist.

Sarah is excited to start her career at Christ Medical Center and Hope Children's Hospital. Sarah has a strong pediatric background and views her role as having the responsibility to cultivate passion among the staff for specialized care of the pediatric patient. One of Sarah's goals for the staff is to facilitate internal and external educational opportunities to maintain a nursing staff that is practicing within the current trends of pediatric emergency medicine. Sarah's vision for the department is to be recognized by the community as experts in the treatment of pediatric emergencies.

Becky and Sarah as a dyad have developed similar goals and visions for the department. They feel the dyad model compliments their differences by providing the most comprehensive leadership for the staff to achieve excellent outcomes for the pediatric patient based on evidence-based practice. Although this is the first time both Becky and Sarah have worked in a dyad model they look forward to the ever evolving collaborative relationship.



*Pediatric emergency department Dyad: Sarah Maciolek, MS, APN, PCNS-BC, and Rebecca Gierling, BSN, RN, manager of clinical operations.*

Transformational Leadership

Magnet Force: Quality of Nursing Leadership



# And the Winners are ... 3rd Quarter Daisy Award Winners

"Unsung heroes," and "Angels on our shoulders" ... these are some of the terms used by Tena Barnes to describe a Daisy Award Winner. In each issue of *Nursing Now*, Advocate Christ Medical Center and Hope Children's Hospital celebrates the achievements of these standout associates.

## Charlie Rasmason, BSN, RN, nurse clinician II, adult surgical heart unit

Charlie received three Daisy award nominations. The common theme in each nomination was Charlie's level of compassion.

The statements below were taken off cards sent to Charlie by families of patients under his care.

"We feel comfortable and at ease when you are caring for our mother, and watching over her. God bless you."

"You are one wonderful and exceptional human being, and care giver! You are an angel, and we are so blessed to have met you!"

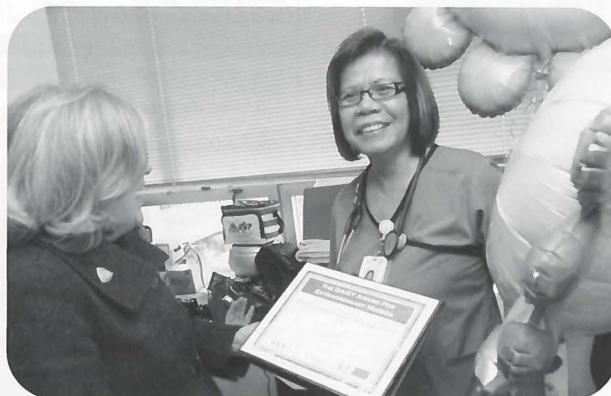
Charlie is truly an example of a Daisy nurse!



Charlie Rasmason, BSN, RN, nurse clinician II, adult surgical heart unit, with Wendy Micek, PhD, RN, market director nursing science and Magnet.

## Corazon Gobenciong, BSN, RN, CCRN, nurse clinician III, centralized telemetry center

Cosette consistently goes above and beyond to keep our patients safe. She shares her experience in dialysis and ICU with others in a positive manner to encourage others to follow up to date evidence-based care. She is a true team player consistently encouraging others to do the right thing for the right reasons.



Darcie Brazel, MSN, RN, NEA-BC, market chief nurse executive, with Corazon Gobenciong BSN, RN, nurse clinician III, centralized telemetry center.

She allowed us to sit with him and hold his hand and take turns laying with him in his bed. She was so supportive and spent a lot of time talking with us, but also let us have our privacy when we needed it. Heather made an excruciating night bearable. We never felt alone and knew he was in wonderful hands with Heather as his nurse."



Sandra Clark, MSN, RN, director of pediatric services, with Heather Evans, BSN, RN, nurse clinician III, pediatric intensive care unit.

## Heather Evans, BSN, RN, nurse clinician III, pediatric intensive care unit

The excerpt below was taken from Heather's Daisy award nomination.

"I had an encounter with Heather over seven years ago, but have never forgotten her. She was our skilled nurse for our little boy the last night of his life on earth. She was so kind to us that night. Heather never once asked us to move out of her way or step out of the room."



**Exemplary Professional Practice**  
Magnet Force: Quality of Care

## Daisy Award Nominees

### Third Quarter, 2011

Nursing Team, 7 east  
"Athenia," 3 east  
Margarette Buhr, 8 south  
Kate Burdett, L&D  
Kara Finnigan, 4 east/west

Sandy Flood, SINI  
Jessica Mancari, Radiology PCC  
"Marlene," 3 east  
Michelle Melia, 4east/west  
Joan Mizwicki, Radiology PCC  
Cathy Sals, Imaging  
Tim Shelby

Nancy Sorensen, SINI  
Darlene Trendl, 6 east/west  
Jen A., 4 Hope  
Deena Martin, 4 Hope  
Barb Mayher, NICU  
Karen Peterson, Peds Cardiac Care Lab  
Trish Kinahan, 2 Hope

## Special Services/Cultural Diversity

# Attendees to Focus on Cultural Diversity

## Susan Cusack, BSN, RN-BC, manager, clinical operations, 7 west

The annual Magnet Conference was held October 3 to 6, 2011, in Baltimore, Md. Each year, attendees are given the opportunity to work on a group project to strengthen Magnet initiatives at Advocate Christ Medical Center. This year the 2011 Magnet attendees decided to focus on cultural diversity for our project. Cultural diversity means not only ethnic diversity, but also age, gender and disabilities. Our Magnet group will create a video of diverse nurses throughout the Christ Medical Center. We have asked that nurses would speak about how their diversity

enhances the nursing care that they provide. In addition, we will have a large map displayed which highlights all of the various areas in the world from which our nurses come from. Differences are an absolute positive when it comes to caring for our patients, so we look forward to hearing about how this enhances nursing at Christ Medical Center and Hope Children's Hospital!



**Exemplary Professional Practice**

Magnet Force: Quality of Care



2011 Magnet Conference group.

# NursingNow

Communicate, Educate, Motivate!

Nursing Now is published for nurses at Advocate Christ Medical Center and Hope Children's Hospital. Readers are encouraged to submit stories, suggestions and ideas. Editor reserves the right to edit and/or refuse submissions.



Advocate  
Christ Medical Center  
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Inspiring medicine. Changing lives.

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Cheryl Lefaiver, PhD, RN, nurse researcher/educator

Joanne Mazurski, education coordinator, clinical education and research

Irene Tranowski, MSN, RN, CRRN, clinical practice partner, 6 south



Clinical Feature

# Protecting Our Patients: Focus on Treatment of Hypoglycemia

**Donna Ellis, MS, APN, Diabetes Advanced Practice Nurse**

In August 2011, the Diabetes Task Force began an Advocate initiative to improve the safety of patients at Christ Medical Center. Based upon data collection in 2010 and 2011 it was determined that there was a need to address the treatment of hypoglycemia. On average, six percent of the daily point of care blood glucose tests performed result in readings less than 70 mg/dl. According to the American Diabetes Association, a result of less than 70 mg/dl is defined as hypoglycemia. This amounts to 600 to 700 events per month at Christ Medical Center. Hypoglycemia symptoms may range from mild to severe and if left untreated may lead to serious injuries. Hospitalized people who have diabetes are at greater risk of hypoglycemia due to their acute illness, variability in oral food intake and changes in their treatment plans.

Simple carbohydrates such as fruit juice are a recommended treatment for hypoglycemia. One four-ounce cup of juice has adequate carbohydrates to achieve the recommended 15 grams of carbohydrate needed to elevate blood glucose. When given alone, juice will raise blood glucose levels in about 15 minutes. Retesting prior to 15 minutes will not reflect the full effect of treatment.

Treating hypoglycemia with foods other than simple carbohydrates or combining juice and foods will delay the glucose elevating benefit of the juice, prolonging the episode of hypoglycemia. Likewise, it is important not to over treat hypoglycemia. Over treatment may result in hyperglycemia. It is not necessary to add sugar to the juice; this may lead to hyperglycemia, especially if the event is near mealtime.

Documentation of treatment of hypoglycemia is the initial focus of the Diabetes Task Force. For most inpatient care areas documentation of treatment is completed in one of two areas of the electronic medical record:

- **View Adult Quick Chart:** Use this section to chart the treatment of hypoglycemia with apple juice. A brief comment is added at the top of the column that displays the blood glucose results. This links the blood glucose result and the treatment given.
- **Medication Administration Record (MAR):** If hypoglycemia is treated with intravenous dextrose or subcutaneous glucagon the medication should be charted on the MAR. The unit pharmacist can assist

you if there is no entry for the medication on the MAR. ■ The patient's response to treatment is charted in a PIEP note.

Frequent or repeated hypoglycemia should prompt a review of the treatment plan to identify possible causes such as poor food intake, missed meals or excessive doses of medications. Physicians, nurses and dieticians must work together to provide a treatment plan that is flexible enough for the patient's needs in an acute care setting.

The Diabetes Task Force will continue to focus on hypoglycemia treatment and prevention throughout 2012. Look forward to more staff education and opportunities to improve practice and keep our patients safe!



## Exemplary Professional Practice

Magnet Force: Quality of Care

Conference Highlights

## Nurses Out and About

**Kathy Koch, MSN, RN, manager, clinical operations, 7 south; Irene Tranowski, MSN, CRRN, clinical practice partner, 6 south; and Kim Duback, BSN, RN, CPN, nurse clinician II, 4 Hope**

### American Organization of Nurse Executives (AONE) Conference

*Kathy Koch, MSN, RN, manager of clinical operations, 7 south*

From September 19 to September 22, 2011, associates from the 7 south Center for Care Innovation and Transformation (CCIT) team attended the National CCIT meeting held in San Antonio, Texas. The CCIT initiative is sponsored by the American Organization of Nurse Executives (AONE) which seeks to shape the future of healthcare through best practice benchmarking. The 7 south CCIT team presented their featured innovation at the meeting. The unit addressed the Quietness of the Environment and shared their best practices. The team provided tools for quality improvement for all levels of nurse leaders—from novice to experienced—and was able to link the work for health care leaders who are examining and planning for the implementation of health care reform.

### Rehabilitation Nursing Annual Education Conference

*Irene Tranowski, MSN, CRRN, clinical practice partner, 6 south*

The 37th Annual Education Conference for Rehabilitation Nurses was held in Las Vegas, Nev.,

November 2-9, 2011. The conference was attended by approximately 970 rehabilitation nurses from across the country. Diane LaPorta, BSN, CRRN, manager of admission, 6 south, did a poster presentation entitled "Recovery Audit Contractor (RAC) Response: A Multidisciplinary Approach." The poster described what the rehabilitation team at Advocate Christ Medical Center has put into place to prepare for the RAC audits. This included forms that have been developed for the psychiatrists and audit tools for each discipline. Irene Tranowski, MSN, CRRN, clinical practice partner, 6 south, did a paper presentation on certification advocates. The purpose was to describe the role of the certification advocate at Christ Medical Center, the tool kit developed and the outcome of increased certified rehabilitation nurses on 6 south.

### Edward Hospital's Eighth Annual Evidence-Based Practice Conference

*Kim Duback, BSN, RN, CPN, nurse clinician II, 4 Hope*

On October 29, 2011 Kim Duback, BSN, RN, CPN, nurse clinician II, 4 Hope, presented at Edward Hospital's Eighth Annual Evidence-Based Practice Conference. Kim presented a research project that she is currently involved in along with Ginny Fowler, MS, APN, CPNP, and Denise Angst, PhD, RN, director pediatric research. The research project is called "Perceptions of Family Centered Care in

the Inpatient Pediatric Setting." Family centered care (FCC) has been recognized in the literature as an ideal model of delivering care to inpatient pediatric patients. In FCC, there is an emphasis on supporting family decision-making, sharing health information with patients and families, and fostering respect for family preferences and decisions. Current research shows, when health care is delivered in an FCC model, there is improved quality of care, outcomes and satisfaction. However, limited research has examined parental and nursing perceptions of FCC. The aim of the study was to examine perceptions of parents or legal guardians and pediatric nurses on how well FCC is delivered on our inpatient pediatric unit, 4 Hope.



## Structural Empowerment

Magnet Force: Professional Development

Professional Organizations

## American Association of Heart Failure Nurses

**Carol Pisano BSN, RN, CCRN, manager, heart failure clinic**

The American Association of Heart Failure Nurses (AAHFN) is a specialty organization dedicated to advancing nursing education, clinical practice and research to improve heart failure patient outcomes. Heart failure is the association's exclusive interest and passion. Their goal is to set the standards for heart failure nursing care. The AAHFN serves as the interface for sharing ideas, translating research findings into practice and setting priorities for the future. The organization welcomes and values all professionals involved in heart failure and focus on patients across all environments of care from the hospital, to the clinic, to home.

### What are some of the benefits to joining AAHFN?

- Subscription to the CONNECTION and access to other AAHFN educational materials
- Communities of Practice
- Subscription to the bimonthly official journal of AAHFN, HEART AND LUNG: THE JOURNAL OF ACUTE AND CRITICAL CARE
- Free access to the latest clinical data and slide presentation for heart failure management
- Access to the members-only message board
- Savings on registration fees for the annual meeting and other activities
- Access to free and discounted continuing education programs and webinars
- Access to awards, grants and scholarships
- Discounts on text books
- Membership is \$75 a year

The 8th Annual AAHFN Heart Failure Nursing Conference will be held at the Sheraton in Chicago this year from June 28 to 30. It is a comprehensive conference offering three educational tracks: Cornerstones, Advanced and Global. There are pre-conference workshops on Advance Therapies and Disease Management Programs. This year will be the second sitting for the Certified Heart Failure Nurse (CHFNC) certification exam. Last year more than 300 nurses achieved this certification which validates specialized knowledge in heart failure and commitment to provide optimal patient care.

AAHFN acknowledges the remaining gaps between knowledge and practice regarding optimal evidence-based therapies for heart failure patients. They work to facilitate a true understanding of this potentially devastating condition as well as the therapies and preventive measures that can offer improved quality of life and a better life expectancy for heart failure patients. Additional information on AAHFN and the heart failure nurse certification exam can be found at [www.aahfn.org](http://www.aahfn.org) or by calling 888-45-AAHFN. For more news on the 2012 annual meeting, visit the AAHFN Conference website at [www.aahfn2012conference.com](http://www.aahfn2012conference.com).



## Structural Empowerment

Magnet Force: Professional Development



## PCPC Corner

# Professional Clinical Practice Council (PCPC) November Meeting Update

**Susan Cusack, BSN, RN-BC, manager, clinical operations, 7 west**

On November 17, 2011, unit council chairs from clinical departments' hospital-wide convened for a Professional Clinical Practice Council (PCPC) retreat. The theme was "Medical Center Under Construction" in part to celebrate the construction going on at Advocate Christ Medical Center. Darcie Brazel, MSN, RN, NEA-BC, market chief nurse executive, spoke about the importance of shared governance to Magnet hospitals.

Sandra Clark, MSN, RN, director support of the PCPC reviewed unit council expectations. These include monthly meetings, membership target aimed at between four and 15 members, and having a chair and co-chair. Sandra reviewed the expectation that at least 75 percent of members attend meetings regularly, and that all meetings have a written agenda. Active member participation and management support are two contributors to a successful council.

January McNeal, BSN, RN nurse clinician III,

3 east/west, is the outgoing PCPC chair. She spoke about all that has been accomplished from PCPC this past year.

These include policy and procedure committee input, uniform subcommittee, certification liaison support, staffing committee collaboration, Chip in for Nursing Research Golf Outing, and journal clubs, both at the unit level and in PCPC.

January then passed the torch to her co-chair, Elizabeth Kupczyk, MSN, RN, clinical affiliations liaison, clinical education, incoming PCPC chair. Elizabeth Kupczyk took over as chair of the PCPC while Ryan Gagnon, BSN, RN, nurse clinician III, pediatric emergency department, will serve as co-chair.

PCPC goals for 2012 were reviewed, which include focusing on clinical projects and continuing to prepare for

our Magnet re-designation. PCPC also heard about new discharge initiatives from Latonia Walker, MSN, RN,

director of care management, and unit council charter, roles and responsibilities were reviewed by Jennifer Connor, BSN, RNC, manager of clinical operations, 2 Hope, manager support. Each department had the opportunity to work on its own goals. Deb Desmond, leadership development consultant, organizational development provided guidance as each chair, co-chair, manager, and APN from all of the departments worked on goals for their units. Other topics discussed that day were certification updates, journal club surveys, uniform committee updates, and health care

reform. This retreat was a wonderful day for our PCPC members to gather, celebrate wins, and gain even more support on how to make their own unit council an excellent one.



From left to right are Sandra Clark, MSN, RN, director pediatric service, director support; Darcie Brazel, MSN, RN, NEA-BC, market chief nurse executive; January McNeal, BSN, RN, nurse clinician III, 3 east/west, outgoing PCPC chair; Elizabeth Kupczyk, MSN, RN, clinical affiliations liaison, clinical education, incoming PCPC chair; Ryan Gagnon, BSN, RN, nurse clinician III, pediatric emergency room, incoming PCPC co-chair; and Jennifer Connor, BSN, RNC, manager, 2 Hope, manager support.



Pictured from left to right are Elizabeth Kupczyk, MSN, RN, clinical affiliations liaison, clinical education, incoming PCPC chair; Susan Cusack, BSN, RN-BC, manager, 7 west; January McNeal, BSN, RN, nurse clinician III, outgoing PCPC chair; and Nancy Hernandez, BSN, RN-BC, nurse clinician II, 7 west unit council chair.



**Exemplary Professional Practice**  
Magnet Force: Interdisciplinary Relationships

## Ask the Expert

Do you have a clinical question related to patient care? Submit your question to Nursing Now and we will share it with the appropriate clinician for a response. You may fax your question to ext. 41-5640, or e-mail to Nursing.Now.CMC@advocatehealth.com.

## Beta Blocker Therapy in Heart Failure (HF) Patients

**Catherine McAvoy, BSN, RN, nurse clinician III, heart and vascular quality team**

*What is the newest Joint Commission performance standard for treatment of HF patients?*

The Joint Commission's newest performance standard for treatment of HF patients is that patients with an ejection fraction less than 40 percent be discharged home on an evidence-based beta blocker or a documented contraindication noted in the medical record. The only beta blockers considered to be evidenced-based medicine for HF are the following three agents: carvedilol (Coreg), metoprolol succinate (Toprol XL), or bisoprolol (Zebeta).

*Why is the Joint Commission restricting the type of beta blocker prescribed in HF patients?*

The recommendation to switch from non-evidenced based beta blockers to evidence-based beta blockers is the result of multiple, randomized clinical trials demonstrating that the use of these three agents decreases all cause mortality and reduces the risk of hospitalization for cardiac events. The clinical trials conducted were U.S Carvedilol HF Study, COPERNICUS, Merit-HF, Comet and CIBIS-II.

*What are important safety considerations when starting or titrating beta blockers in HF patients?*

Close monitoring of the patient's clinical status during initiation of beta blocker therapy is important because the negative inotropic effect of beta blockers may cause further reduction in systolic function with the start of therapy. It is estimated that 20 to 30 percent of HF patients experience some adverse effects with upward titration (1). Beta blocker therapy should not be initiated when the patient is in acute, decompensated HF. Therapy should be started when a patient is euvoletic and hemodynamically stable. However, if the patient presents with HF and has been previously taking beta blocker therapy before their exacerbation, therapy may be continued following hospital admission. Beta blocker therapy should be started at a low dose and titrated up gradually to a target dose. It is suggested that the dose should be increased every two weeks until the target dose is achieved. It is important to educate the patient and family of the benefits and side-effects of therapy. HF patients often stop taking beta blockers because it makes them more fatigued or they start experiencing worsening symptoms. Instruct your patients that these side-effects are transient and can be managed with careful monitoring and appropriate patient follow-up with their health care providers.

Caution must be used when considering beta blocker therapy in patients with bradycardia or bronchospastic lung disease.

*What should I do if my patient has HF and is not receiving a beta blocker or is not receiving the recommended type of beta blocker?*

The first step is recognizing the indication for an evidence-based beta blocker and address it with the patient's physician prior to discharge (if there is no contraindication documented in the patient's medical record). In addition, the Heart and Vascular nurses are available as resources for nursing consultation and can also follow up with the appropriate physician as needed.

*Who are the Heart and Vascular nurses and how do I reach them?*

The Heart and Vascular Quality Team (HVQ) is an expansion and merging of the former "Get with the Guidelines" Heart Failure and Acute MI Team along with a specialized team dedicated to chart audits, performance improvements, and publicly reported data for our hospital. The HVQ team works to ensure all core measures as set forth by The Joint Commission and Centers for Medicare and Medicaid Services (CMS) are met with goals always set at 100 percent. This ensures improved outcomes, decreased mortality and decreased readmissions. The HVQ team also educates patients and families on disease processes and risk reduction along with self management plan of care to follow at home. During education the HVQ team assesses patients for health literacy, depression and other barriers to self management and discuss with physician and ancillary staff who work as a team to ensure every patient is discharged home with proper resources for patients and families to follow their plan of care. Signs are posted on all units with team member's names and numbers. If you are unsure what RN is working your floor that day call extension 41-5017.

Where can I find additional resources on this subject?

- The Heart and Vascular Quality Nursing team
- Heart Failure resource binder located on each patient care unit

The following web sites:

- [www.americanheart.org/getwiththeguidelines](http://www.americanheart.org/getwiththeguidelines)
- [www.clevelandclinicmeded.com/medicalpubs/...heart-failure](http://www.clevelandclinicmeded.com/medicalpubs/...heart-failure)
- [www.eurheartj.oxfordjournals.org/content/30/18/2186.full.pdf](http://www.eurheartj.oxfordjournals.org/content/30/18/2186.full.pdf)
- [www.heart.org/quality](http://www.heart.org/quality)
- [www.heartfailureguideline.org](http://www.heartfailureguideline.org)

1. Cockcroft, J. October tenth, 2010. The Latest Generation of Beta-Blockers. New Pharmacologic Properties. Retrieved from [www.texasheart.org](http://www.texasheart.org)



**Structural Empowerment**

Magnet Force: Exemplary Professional Practice, Quality of Care Patient Safety



Risky Business

# Understanding Legal Obligations

Martha Winter, RNC, MJ, director, risk management

There are so many dilemmas in patient care. Ethical issues: the conflict between the patients’s right to self-determination versus health care’s desire to prevent harm. Safety challenges: can I detain the post-procedure patient who insists on driving home against instructions? What do I do if the designated driver appears intoxicated? What are my obligations in caring for a police custody or hold patient? Confidentiality: when law enforcement is demanding information, do I provide it or should I protect the patient’s health information? Are there Health Insurance Portability and Accountability Act (HIPAA) ramifications? Too many situations for one article to address but when faced with these situations, do you know where to find resources?

Ethical issues

Consider providing care for the patient who wants to refuse lifesaving treatment but his family and physician disagree. A policy is available for exploring ethical issues, it is CMC 01.007.007 Ethics Committee Guidelines/Policy. This document provides all associates with guidance on how to request Ethics Committee advice, a multidisciplinary approach.

Authority to detain

There is no authority under federal law for health care providers to detain patients against their will and state law

defines only false imprisonment. Associates need to be aware of department policies. Patients should be notified when scheduling cases if they will need to be accompanied by a responsible person to provide transportation home. Document all conversations advising the risk and those of patient refusal. Perhaps procedures will need to be rescheduled if transportation will not be available. Circumstances can escalate this situation. A suspected impaired individual, who indicates he will be driving, should be reported to Public Safety and police may be notified. Responsibility to protect from harm or imminent danger can be transferred to an officer with the authority to prevent the harm. Consult your chain of command and risk management associate as needed.

Confidentiality

CMC 01.057.907 is the policy entitled “HIPAA-Release of Protected Health Information to Law Enforcement Policy.” It provides direction for compliance with police request. Health care providers must comply with requests, specific and limited in scope to purpose, presented by court order, warrant, subpoena or authorized immediate investigative demand. The responsibility to keep patient matters confidential can be overridden if an investigation is necessary to determine violation of law and/or prevent imminent danger. This does not allow for social conversations with police that are above and beyond that necessary to perform your job

Law enforcement patient concerns

CMC 01.060.005 is the policy entitled “Police Hold and Prisoners Policy.” It provides direction in caring for patients under arrest or where a request to detain has been provided. There is a clear distinction between police matters and patient care. It is the responsibility of the police to control the patient under custody. The arrested patient receives the same respectful care provided to all patients. It is important to be alert, confident and purposeful with direct eye contact. Public safety should be aware of every prisoner patient admitted. The hospital has no legal obligation regarding police holds or patients that are not under police arrest. However, in an effort to support community safety and preserve police relationships it is hospital policy to notify public safety of the imminent discharge of patients with a pending police investigation, as requested.

What is the bottom line for clinicians? When a health care provider encounters situations regarding legal obligations, be aware of related hospital policies; always consult your chain of command; and consider public safety and risk management involvement.



Exemplary Professional Practice  
Magnet Force: Quality of Care

# Evidence Based Nursing

Debbie O’Connell, MSN, RN-BC, director, clinical education

This summer Advocate Christ Medical Center and Hope Children’s Hospital will access all nursing procedures through Lippincott Nursing Procedures and Skills (LNPS). LNPS is an evidence-based reference that will improve the speed of access to critical health care information. The on-line reference provides step-by-step instructions for performing nursing procedures. Advantages to using Lippincott include:

- Provides nurses with accurate, referenced, up-to-date information at the point of care
- Standardizes procedures/care across Advocate Health Care
- Ensures that hospital’s procedures are documented and available to all nurses at all times
- Provides annual review by competent clinical experts

- Provides skill lists and competency tests for each procedure
- Advocate Health Care made the commitment to LNPS as a system-wide reference when they noted there was significant variation within Advocate on the quantity and quality of nursing procedures. The chief nurse executives agreed to move forward on a standard evidence-based nursing procedure format.
- In 2011, three Advocate sites began the process of reviewing and comparing the Advocate site procedure and the Lippincott procedure. Lippincott currently has over 1200 procedures with more added each quarter. It was decided, however, that Advocate would begin with 400 procedures. These include medical-surgical, critical care, maternal/neonatal, pediatrics and pediatric critical care. The remainder will be phased in over the year.

At Christ Medical Center and Hope Children’s Hospital, the Policy and Procedure Committee, chaired by Elizabeth Kupczyk, MSN, RN and Tina Davis-Larkin, APN, MSN, RNC, will serve as content experts and identify any gaps in practice. This project is led by Dawn Horn, RN, MS, APN, CCRN, ACNS-BC, 8 South, Neuroscience Unit, Meggan Mikal, APRN, MS, PCNS-BC, CPN, CHPPN, 2 Hope and Elizabeth Kupczyk, MSN, RN, clinical affiliations liaison and PCPC chair.

As we are closer to the “go-live” all nurses will have the opportunity to complete on-line education that demonstrates how to access and use the procedures. All procedures currently on the Advocate Policy and Procedure website will either be archived or linked to Lippincott. It will truly be a one-stop reference. If you would like a demonstration, go to <http://procedures.lww.com>.

# Educational Events

ACLS

April 26, 8:15 a.m. to 3 p.m., EMS Academy  
EMS Academy 5220 W. 105th St., Oak Lawn, IL

ACLS Renewal Course

May 11, 7:30 to 11:30 a.m., 0614  
May 11, noon to 4 p.m., 0614

Nursing Research Council Meeting

April 24, 11 a.m. to noon, 0629 A/B  
May 22, 11 a.m. to noon, 0629 A/B

APN/CPP Council Meeting

April 18 1 to 2:30 p.m., 0629 A/B  
May 16, 1 to 2:30 p.m., 0629 A/B

Basics of LEAN

April 3, 9 to 11 a.m., HR Conference Room  
May 2, 9 to 11 a.m., 0637

Care Management Education

April 19, 1 to 3 p.m., 0636 A/B  
May 17, 1 to 3 p.m., 0636 A/B

Clinical Coach Course

April 4, 8 a.m. to 12:30 p.m., CE classroom  
April 18, 2 to 6:30 p.m., CE classroom  
May 2, 8 a.m. to 12:30 p.m., CE classroom  
May 16, 2 to 6:30 p.m., CE classroom

Ethics for Lunch

April 11, An Evening of Ethics,” 5 to 7:00 p.m., 0629 A/B  
April 28, noon to 1 p.m., 0629 A/B

Magnet Advisory Council

April 24, 9 to 10 a.m., 0637  
May 22, 9 to 10 a.m., 0614

Neurovascular Conference

April 26, 1 to 2 p.m., 0636  
May 24, 1 to 2 p.m., 0636

Nursing Grand Rounds-Pediatrics

April 10, 11 a.m. to noon, 0629 AB  
May 5, Ped Palliative Care Conference (all day), Auditorium

Nursing Residency

June 2011 Cohort  
April 5, 7:30 a.m. to 3:30 p.m., Clinical Ed. Dept.  
May 17, 7:30 a.m. to 3:30 p.m., Clinical Ed. Dept.

August 2011 Cohort

April 17, 7:30 to 11:30 a.m., Clinical Ed. Dept.  
May 15, 7:30 to 11:30 a.m., Clinical Ed. Dept.

October 2011 Cohort

April 6, 7:30 to 11:30 a.m., Clinical Ed Dept  
May 31, 7:30 to 11:30 a.m., Clinical Ed Dept

January 2012 Cohort

April 10, 7:30 to 11:30 a.m., Clinical Ed. Dept.  
May 3, 7:30 to 11:30 a.m., Clinical Ed. Dept.

March 2012 Cohort

May 1, 7 to 11:30 a.m., Clinical Ed. Dept.  
May 30, 7 to 11:30 a.m., Clinical Ed. Dept.

May/June 2012 Cohort  
May 31, 7 to 3:30 p.m., 0629 A/B

Pediatric Advanced Life Support (PALS)

EMS Academy, 5220 W. 105th St.  
April 20, 8 a.m. to 5 p.m., EMS Academy  
May 11, 8 a.m. to 5 p.m., EMS Academy

Psychiatric Grand Rounds

April 11, DSMIV, 11 a.m. to noon, 0613  
May 9, “A Day with your Brain,” (all day program.), 0629

Professional Clinical Practice Council

May 17, 7:30 a.m. to 4:00 p.m., 0629 A/B

Preceptor Allied Health

April 23, 8:00 a.m. to 12:00 p.m., Clinical Ed. Dept.

Save the Date!

- April 11, An Evening of Ethics, 5 to 7 p.m., 0629 A/B
- April 17, Exemplary Professional Practice In Action: Research & Education, ACMC Conf Center
- May 5, Pediatric Palliative Care Conference (all day) Auditorium
- May 9, A Day with your Brain (all day), 0629

Steps Application Deadlines

June 1

Steps Nursing Forum

April 2, 8 to 10 a.m., 0636 A  
April 9, 1:30 to 3:30 p.m., 0613



Structural Empowerment  
Magnet Force: Professional Develop.m.ent



Education

# What’s New with Cardiopulmonary Resuscitation (CPR): The 2010 Guidelines?

Loretta Benton, MS, RN, professional nurse educator, clinical education

American Heart Association (AHA) instructors were very busy in 2011 as the new 2010 Guidelines were released. Over 120 Basic Life Support (BLS) instructors at Advocate Christ Medical Center and Advocate Hope Children’s Hospital completed the guidelines update online which was a different teaching methodology as compared to past update sessions.

According to the AHA, “The 2010 AHA Guidelines for CPR and Emergency Cardiovascular Care (ECC) were based on an international evidence evaluation process that involved hundreds of international resuscitation scientists and experts who evaluated, discussed, and debated thousands of peer-reviewed publications.” Based on the rigorous evaluation process and due diligence of the participants involved in this process, changes for the BLS, Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS) programs emerged in the form of new guidelines. The process of evaluating the resuscitation literature every five years is based upon a decision made in 2000 by the AHA.

Some of the major changes for the BLS program are as follows:

- A change in CPR sequence from Airway-Breathing-Circulation/Chest Compressions (A-B-C) to Chest Compressions-Airway-Breathing (C-A-B).
- A change in compression depth for all groups. For the adult, the sternum should be compressed at least two inches, for the child about two inches, and for the infant about 1 ½ inches.
- Chest compression rate now needs to be at least 100/minute.

- Elimination of the “Look, Listen, and Feel” step for breathing.
- Refinements of the immediate recognition and activation of the emergency response system (EMS) for health care providers. The rescuer checks for response while also checking for absence of breathing or no normal breathing or only gasping. The rescuer spends no more than 10 seconds performing this assessment. If no response and not breathing, etc. the rescuer activates EMS and obtains an automated external defibrillator (AED) or sends someone to do this.
- Use of an AED for infants for trained health care providers.
- Increased emphasis on performing high-quality CPR, which means compressing at the appropriate depth, maintaining the appropriate rate, and allowing for chest recoil with every compression delivered.
- Increased emphasis on the avoidance of excessive ventilations and minimizing interruptions in chest compressions to less than 10 seconds.
- More focus on team approach for the health care providers.
- Use of cricoids pressure no longer being taught to health care providers.

The new guidelines changes have been incorporated in both the traditional classroom and online courses. There is no change in the length of time BLS, ACLS and PALS cards will expire. Thus, a BLS card is valid for two years from the issue date on the AHA card. There is no

grace period; this means that once a card expires the individual will need to attend a new course.

An individual taking the Healthcare Provider Online course must make sure that he/she completes all three parts of the course within the timeframe specified by AHA as well as ensure that his /her own BLS recognition does not expire before completing the entire course. For example, a student takes part one online in September and the student’s card expires in October. The student must complete part two and part three in October in order to maintain renewal status; otherwise the student’s BLS status is considered expired per AHA.

As individuals come up for BLS renewal they will be trained on the new 2010 AHA guidelines. In addition, BLS resources are available for associates in the Christ Medical Center library.

**References**  
American Heart Association. (October 2010). Highlights of the 2010 American Heart Association Guidelines for CPR and ECC. Retrieved from [http://guidelines.ecc.org/pdf/90\\_1043\\_ECC\\_2010\\_Guidelines\\_Highlights\\_noRecycle.pdf](http://guidelines.ecc.org/pdf/90_1043_ECC_2010_Guidelines_Highlights_noRecycle.pdf) (2010) 2010 American Heart Association Guidelines for CPR and ECC, Circulation 122(18), S923.

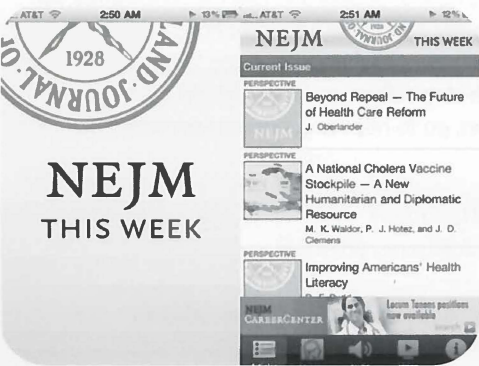


**Structural Empowerment**  
Magnet Force: Professional Development

## Free Apps for Medical Professionals

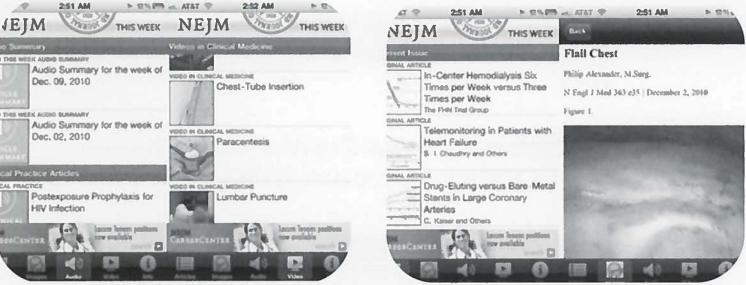
Excerpted from iMedicalApps

In the previous issue of NURSING NOW the top two applications were highlighted. These apps were Medscape and Micromedex. This issue highlights numbers three to five. Most of these applications are available for all versions of mobile phones.

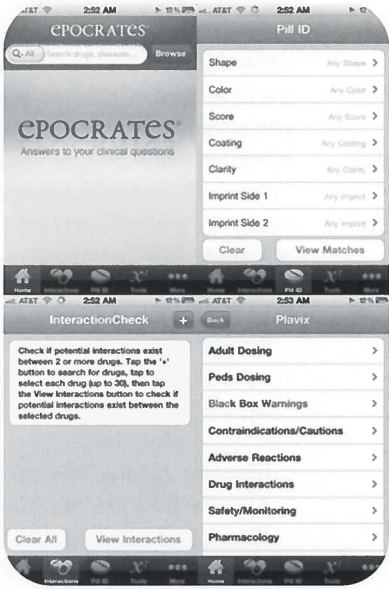


**New England Journal of Medicine (NEJM)**  
The NEJM app is clearly a must have for all health care professionals. The app allows you to access the last 7 days worth of published articles, along with images of various medical conditions and videos on how to perform procedures such as LPs and chest tubes.

Where this app is essential though is with the weekly audio summaries and the selection of four full text audio reads of clinical practice articles. Note: you can access the weekly audio summaries via podcast format as well. This type of content access in mobile form is great for keeping abreast of



changing clinical practices while driving back and forth to work or when having downtime in the wards.



**Epocrates**  
There is no denying Epocrates is one of the best medical reference tools in the mobile format. The free version of Epocrates, Epocrates Rx, provides great content: Drug monographs and health plan formularies, drug interaction tool, pill identifier, medical calculator, and a new addition: Medical News and handpicked clinical articles. Various premium versions of Epocrates also exist.



**Exemplary Professional Practice**  
Magnet Force: Quality of Care; Professional Models of Care

## Outpatient Satisfaction Results

The outpatient advancing excellence committee would like to recognize the recipients of the reward and recognition in the 4th quarter of 2011 for outpatient satisfaction

- 90% or above for October-December 2011**
1. Lockport OP Rehab (99%)
  2. Lockport Pain Clinic (99%)
  3. Lockport Radiology (99%)
  4. MRI (99%)
  5. Heart Failure Clinic (99%)
  6. Tinley OPTherapy (99%)
  7. Pain Clinic (93%)

- Outpatient Satisfaction Star**
- Pain Clinic went from 26% third quarter to 93% for fourth quarter (67% difference)
- Honorable Mention**
- Nuclear Medicine went from 15% third quarter to 74% fourth quarter (59% difference)
  - Cardiac Cath went from 21% third quarter to 69% fourth quarter (48% difference)



**Exemplary Professional Practice**  
Magnet Force: Quality of Care



## Spotlight On

## Clinical Excellence in the Neuroscience Institute

**Lynn Curran, BSN, RN, professional nurse educator, clinical education**

A patient of Dr. Schaible assigned to you is admitted to your unit. Imaging reports from the emergency department show intracranial hemorrhage. The patient's pupils are dilated and there is decreased level of consciousness.

Another patient is diagnosed with a brain tumor. The patient presents with mental status changes. Dr. Schaffer is on consult for an enhancing lesion demonstrated by the computed tomography (CT) scan.

In addition to notifying the neurosurgeons, nursing should now also contact the appropriate Neuroscience Advance Practice Nurse (APN) for emergencies, consults and changes in patient status. The APNs of the Neuroscience Institute are Dawn Merman, MSN, RN, ACNP-BC, CCRN, CNRN, and Lorri McCourt-O'Donnell, MSN, RN, ACNP-BC, CNRN. Their role has evolved as a result of the increased volume of neurosurgeries and neuro-endovascular interventional radiology procedures.

Their patient population has grown to include neurosurgical patients, patients with brain and spinal tumors, traumatic brain injuries, spinal cord injuries,

cerebral aneurysms, arterial venous malformations (AVMs), pituitary tumors, and stroke patients that require intra-arterial thrombolysis or intracranial stenting.

Dawn and Lorrie are a resource for assisting in the coordination of patient care and communicate with nurses, physical therapy, occupational therapy, speech language pathology, rehabilitation services and care coordinators. They are there to help the process of the patient becoming more mobilized, accelerating discharge and decreasing length of stay. Their role also includes daily rounding on neurosurgical patients while helping to develop a plan of care in collaboration with neurosurgeons and the neuro-endovascular radiologist. Part of their rounding protocol is to follow up with new post-op patients or those patients that have a change in neurological exams or complications.

When a new patient is received, Dawn or Lorri may do a complete neurosurgical history and physical assessment on patients (consults) if not yet done by a neurosurgeon or neuro-endovascular radiologist. They may also perform preoperative history and physicals as determined by physicians. Patient and family information, education and support are provided as reinforcement for discharge



*Advance Practice Nurses for the Neuroscience Institute Dawn Merman, MSN, RN, ACNP-BC, CCRN, CNRN, and Lorri McCourt-O'Donnell, MSN, RN, ACNP-BC, CNRN.*

planning or other patient needs such as prescriptions.

If nursing needs to contact Dawn or Lorri, no order is needed, and it is important to have all patient information available including neurological status, medications, labs, imaging studies, etc. Very often, time is of the essence, and it is extremely important for nursing to call them as soon as a change in neurological status is noted so they may come and assess the patient. They are a tremendous resource for nurses, patients, and their families to promote best patient outcomes.

Their contact information is as follows:

Dawn Merman works with Dr. K. Schiabe, Dr. A. Amine, and Dr. C. Lippman and can be reached at pager number 41-2749.

Lorri McCourt-O'Donnell works with Dr. L. Schaffer, Dr. K. Waldron, and Dr. T. Grobelny (neurovascular interventional radiologist) and can be reached at pager number 41-3769.



### Exemplary Professional Practice

Magnet Force: Quality of Care

## In the News

### Certifications:

- CPN: Linda Avila, BS, RN, nurse clinician II; Desiree Carney, ADN, RN, nurse clinician II; Kelly Pujo, BSN, RN, nurse clinician II; and Julie Busich, BSN, RN, nurse clinician II, 4 Hope
- CCRN: Charmaine Pelayo, BSN, RN, nurse clinician II; Kristie Oblak, BSN, RN, assistant clinical manager; Carol Sayers, BSN, RN, assistant clinical manager; Julie White, BSN, RN, nurse clinician II, surgical vascular thoracic intensive care; Sheena Schau, ADN, RN, nurse clinician II; and Rainer Duque, BS, BSN, RN, nurse clinician II, medical intensive cardiac care unit
- OCN: Kelly Kupiec, ADN, RN, nurse clinician II, 3 south
- PCCN: Kiley Munger, BSN, RN, CCN, nurse clinician I, 9 east/west; Mary Grace Samardzich, BSN, RN, nurse clinician III, heart failure clinic; Susan March, ADN, RN, nurse clinician II; and Cynthia White, ADN, RN, nurse clinician II, 9 south
- CMS: Lisa Ataee, BSN, RN, assistant clinical manager; Michael Esperanza, ADN, RN, assistant clinical manager; Vincent Estrada, BSN, RN, assistant clinical manager; Christine Kieitka, BSN, RN, assistant clinical manager; Mary Kosinski, ADN, RN, assistant clinical manager; and Christine Tucker, BSN, RN, nurse clinician II, 7 south
- RN-BC, Neonatal Intensive Care: Lisa Bandstra, BSN, RN, nurse clinician II; Lisa Bubis, BSN, RN, nurse clinician II; Shelly DeVos, ADN, RN, nurse clinician II; Lisa Forde, ADN, RN, nursing registry; Sue Hollandsworth, ADN, RN, nurse clinician II; Kari Hollendoner, BSN, RN, nurse clinician II; Brittany Kane, BSN, RN, nurse clinician II; Debra Rampick, RN, nurse clinician II; Barb Sabbs, ADN, RN, nurse clinician II; Beverly Saylor, BSN, RN, nurse clinician II; Elizabeth Shewmake, BSN, RN, nurse clinician II; Sonya Trimble, BS, RN, nurse clinician II; Susan Vella, ADN, RN, nurse clinician II; Micki Benedict, BSN, RN, nursing registry; and Tamara Marco, RN, Nurse Clinician II, neonatal intensive care unit.
- RN-BC, Case Management: Colleen Bandurski, BSN, RN, care manager; Mary Clark, BSN, RN, manager; MaryColleen Hyerczyk, BSN, RN, care manager; Darlene McGreal, BSN, RN, care manager; Susan Manske, BSN, RN, care manager; and Reenie Neylon, BSN, RN, care manager, case management
- RN-BC, Progressive Care: Pat Menke, BSN, RN, nurse clinician III; and Sue Dedic, BSN, RN, nurse clinician III, heart failure clinic

- RN-BC, Medical-Surgical: Sophie Kwak, BSN, RN, 8 south; Ryane Schuman, BSN, RN-C, nurse clinician II, 7 East; Lindsey Bailey, BSN RN-C, assistant clinical manager; Whitney Luke, BSN, RN-C, nurse clinician II; Dana Rooda, BSN, RN, CNOR, surgical clinical nurse reviewer, 7 east; Kathleen Naughton, BSN, RN-C, nurse clinician III, ventricular access device; Jillian Helleman, BSN, RN, nurse clinician II, 3 east/west; Dawn Neumann, BSN, assistant clinical manager; and Diane Zervos, BSN, nurse clinician II, 8 south.
- RN-BC, Nurse Executive Advanced: Janet Finlon, MA, RN, director, clinical operations, Neurosciences, Bone and Joint Institutes

### Promotions

- Lindsey Bailey, BSN, RN-C, promoted to assistant clinical manager on 7 east
- Mary Beth Partyka, MSN, APN, ANP-BC (pain management) recently accepted a position with Midwest Anesthesiologists. Mary Beth will be functioning in the role of adult nurse practitioner working collaboratively with the pain management physicians to provide care for chronic pain patients.

### Presentations

- Karen Bogdan, MS, RN, CCRN, CNML, manager, clinical operations, Margaret Steinmetz, MS, RN, Outcome Specialist, and Cindy Furiasse, ADN, RN, Nurse Clinician II, medical intensive cardiac care unit, presented "Managing Alcohol Withdrawal in Hospitalized Patients" at the Fourth Annual Innovations in Quality and Patient Safety on October 21, 2011.
- Kimberly Duback, BSN, RN, CPN, nurse clinician II, 4 Hope was a speaker at the 8th Annual Evidence-Based Practice Conference at Edward Hospital on October 29, 2011.
- Diane LaPorta, BSN, RN, CRRN, manager of rehabilitation admissions and discharge presented at the Association of Rehabilitation Nurses (ARN) 37th National Conference in Las Vegas, Nev., Nov. 1-5, 2011. The poster presentation was entitled "Recovery Audit Contractors (RAC), Are You Ready?"
- Diane Laporta, BSN, RN, CRRN, manager of rehabilitation Admissions and Discharge presented to the Northern Illinois Association of Rehabilitation Nurses (NIARN) on Nov. 16 at Marionjoy on "CMS Fiscal Year, 2012 Proposed Rule."
- Dawn Horn, RN, MS, CCRN, ACNS-BC, APN, 8 South presented at the Stroke Survivors Empowering Each Other (SSEEO) Annual Stroke Conference on Oct. 8, 2011. Dawn's topic was "Life is Tough But People Are Tougher."

- Valerie Gonzalez, BSN, RN, CRRN, manager, clinical operations, 6 south, presented on Nov. 16, 2011 at the Northern Illinois Association of Rehabilitation Nurses on FIM in Motion.
- Irene Tranowski, MSN, CRRN, clinical practice partner, 6 south, presented "Certification Advocates" at the 37th Annual Educational Conference of the Association of Rehabilitation Nurses in Las Vegas, Nev., Nov. 1-5, 2011.

### External Awards/Recognition

- Wendy Tuzik Micek, PhD, RN, market director, nursing science and magnet, received the Power of Nursing Leadership Sage Award in 2011.

### Degree Completion

- BSN, Lewis University: Kristin Lesinske, RN, nurse clinician II, medical intensive cardiac care unit; and Adekemi Sojebi, RN, assistant clinical manager, 3 east/west
- BS, Elmhurst College: Ryan Yamat, RN, nurse clinician II, medical intensive cardiac care unit

### Graduate Degree Completion

- MSN, Governors State University: Jennifer Vermeulen, RN, CCRN, nurse clinician II; and Sherron Johnson, RN, nurse clinician II, medical intensive care unit

### MVP nominations

- Deena Martin, ADN, RN, nurse clinician II, 4 Hope won the winner for excellence award for September, 2011 for contacting the Charles Tillman Foundation and obtaining a locker full of iPads and Playstations for Hope Children's Hospital.



### Structural Empowerment

Magnet Force: Professional Development



## Book Review

## 21 Peaceful Nurses: Essays on a Spiritually Guided Practice

Authors: Doris Popovich, RN, MA &amp; Joan Cantwell, RN, MA

Reviewed by: Elizabeth Anderson RN, CRN, nurse clinician II, radiology

**21 Peaceful Nurses: Essays on a Spiritually Guided Practice; Popovich, D. J., & Cantwell, J. (2006). Denver, Colo., Outskirts Press.**

21 PEACEFUL NURSES is a collection of short essays written by nurses for nurses. Each essay is an actual account of an experience that touched the life of a nurse while they cared for their patient. The stories are unique and each shares a heartfelt message with realistic suggestions on how to incorporate spirituality into your practice. The focus of the book is using spiritual fitness to obtain a balanced nursing practice.

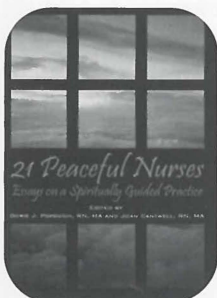
21 PEACEFUL NURSES encourage nurses to take a deeper look into their practice to find or rekindle the

spiritual reward in our service. Popovich and Cantwell have put together 21 essays that collectively capture the true spirit of nursing. They chose stories that unveil the inner meaning of the care we give every day to our patients. By revealing the inner meaning they suggest that we can begin or continue to nurture our own spiritual growth and achieve a peaceful balanced practice.

Nursing is a unique multidimensional profession, combining the science of health care along with the art of caring. Long after other health care professionals have completed their part in the patient's care, nurses remain at the patient's side, translating medical jargon into a comprehensible language so patients can understand what is happening to them. Nurses evaluate the effectiveness of treatments and give emotional support to patients and their families. Not only do we provide physical care for our patients, but we also nurture our

patient's spiritual health in an effort to provide the best care possible. Nurses give so much of themselves in their work that, at times, nursing can be draining both physically and emotionally. We may forget what our profession truly represents: compassion, human dignity, dedication, integrity, stewardship, leadership and service excellence. After reading these stories, I laughed, smiled and shed a tear or two of pride to be part of such a wonderful caring profession.

This book can be found on-line at multiple book stores. It is available in paperback ranging in price from \$9 to \$15, depending if bought new or used.



Structural Empowerment

Magnet Force: Image of Nursing

## Portraits of Excellence

*The nurses featured in this section were recently nominated for the 2011 Joyce Woytek Award for Nursing Excellence.*

**Laura Gill, BSN, RN, adult surgical heart unit**

A strong supporter of education, patient safety and patient satisfaction, Laura has frequently been recognized by patients and families alike. She has assumed responsibility for ensuring that the unit uses equipment and supplies in effective ways. Her efforts have led the unit to be more cost-effective and much less wasteful with supplies. Laura mentors new nurses in the unit and is a member of the unit's education enrichment team and, in that role, has helped in the re-design of the new 5-P handoff tool. She is active in the community, performing blood pressure screenings at her church and volunteering as an expert for "Night with a Nurse."

**Nancy Hernandez, BSN, RN, 7-west**

Trained to be a charge nurse and consistently recognized by co-workers and patients as a prime example of Advocate values and philosophy, Nancy serves on the 7-west unit council, as well as the education, wound care and patient satisfaction committees. She works as a clinical coach for new nurses and is skilled in caring for critically ill patients with complex problems. She was nominated for an MVP in partnership when the husband of a patient experienced breathing problems and, as a result of Nancy's encouragement, was encouraged to go to the emergency department where he was determined to have a saturation level of only 70 percent.

**Mary Golden, ECRN, emergency department**

A nurse for the past 33 years and an emergency department nurses for 30 years, Mary began her hospital career as a candy striper at age 14. During her years at Christ Medical Center, she has served on multiple committees, including the one that helped plan the development of the current emergency department. She also served on the team that developed computerized charting for the emergency department. A valuable mentor to all department and emergency services staff, Mary assists the outcomes coordinator in reviewing hospital indicators and serves as a champion for high department achievement in the pneumonia and sepsis clinical bundles.

**Sue Huron, BSN, RN, surgery**

A member of the pediatric open heart surgery team, Sue leads education for the operating room nurses and pediatric surgical heart unit nurses on how to begin emergency extracorporeal membrane oxygenation (ECMO). She also serves as a cardiopulmonary resuscitation instructor, frequently returning to the medical center on a weekend day or one of her off days to help complete CPR training for associates. Outside the OR, Sue has a strong commitment to the community. She collects cans in the department for recycling and donates the money raised to families in need and leads an adopt-a-family initiative during the December holiday season.

**Grace Hamoy, BSN, RN, CCRN, surgical vascular thoracic unit**

Grace offers a warm and welcoming demeanor that immediately puts families and patients at ease. Her exceptional patient care often prompts families to call her an "angel" at the bedside. The ultimate team player, Grace forgoes breaks so that co-workers can use their allotted time or stays late, if necessary, to help make sure the work gets done. Her ability to explain complex pathophysiology in a relatively simple way makes her an excellent mentor for staff. In fact, her recent success in achieving critical care nursing (CCRN) certification has prompted other team members to work toward the same goal.

**Peggy Jagielski, RN, 4-Hope**

A volunteer for such community projects as "Kids Expo" and the annual "Camp Quality" for youngsters with cancer, Peggy is a role model, who is respected by all members of the team. She serves as a preceptor to new nurses and is a mentor and coach to all members of the team. Peggy is flexible with her schedule and assignments. If a fellow team member is having a difficult time, she offers assistance without waiting to be asked. She just recently assumed the chairmanship of the unit council, and, in this position, has already organized a successful bake sale and a candlelight bowling event.

**Laura Harden, BSN, RNC, neonatal intensive care unit**

Laura's commitment to excellence and compassion is best demonstrated in her interaction with parents of patients. She creates a lifelong relationship with families, eases parents' worries, makes sure parents bond with their infant and encourages their involvement in decisions affecting their child's care. It's the little things—like putting a bow in an infant's hair or dressing a baby in a special outfit before parents visit—that endear Laura to families. One of the first nurses to achieve nurse clinician III status, Laura is a respected preceptor who developed a two-day cardiac education program for the NICU staff.

**Amy Janousek, BSN, RN, 4-Hope**

Always wearing a smile and displaying a positive attitude, Amy is a great example of an Advocate MVP. In fact, she has been nominated repeatedly by staff and patients' families for MVP awards and the HERO Award. She cares for complex patients with ease, is flexible with her schedule and is a team player.



Structural Empowerment

Magnet Force: Image of Nursing



Nurse Recognition

STEPS Promotions, Certification and Research Recognized

In addition to recognizing STEPS promotions and nursing certifications, the nurse recognition ceremony recognizes nurses who have recently completed their nursing degree, institutional review board application approval and nurses acknowledged for other reasons.

NCIII STEPs Promotions

- PICU: Kristin Coleman, Jenna Parsley and Magdeline Lee
- NICU: Brittany Kane
- MICCU: Marta Mialkowska
- PSHU: Amanda Eble

Daisy Award

- Heather Evans, PICU
- Corazon Gobenciong, CTC
- Charlie Rasmason, ASHU

Newly Certified Nurses

- 2 Hope: Kelly Gidley, CPN; Laura Griffith, CPN; Beth Kairis, CPN; Margie Maziarka, CPN; Mary Murray, CPN; and Kimberly Sheely, CPN
- 4 Hope: Linda Avila, CPN; Julie Busich, CPN; and Kelly Pujo, CPN
- 4 East/West: Terri Madison, RN-BC
- 6 East/West: Maria Anderson, ONC; Lea Good, ONC; Denise Haygood, ONC; Kathy Luzzi, ONC; Julie Miller, ONC; Kathy Moretti, ONC; and Diane Okrzesik, ONC
- 6 South: Leila Fortu, CRRN; and JoEllen Riley, CRRN
- 7 East: Whitney Luke, RN-BC; and Dana Rooda, CNOR
- 7 South: Lisa Ataee, CMSRN; Mike Esperanza, CMSRN; and Christin Kieltyka, CMSRN
- 7 West: Vanessa Narag-Lichner, RN-BC; and Natalie Morrison, RN-BC

- 8 South: Sonya Brawley, RN-BC; Emilie Dacer, RN-BC; Suzette Gibbons, RN-BC; Sophie Kwak, RN-BC; Jennifer Pedretti, RN-BC; Beata Rajaska, CMS RN; and Karen Uribe, RN-BC
- 9 east/west: Kiley Munger, PCCN
- ASHU: Ruth Newsom, CCRN
- Care Management: Colleen Bandurski, RN-BC; Mary Clark, RN-BC; MaryColleen Hyerczyk, RN-BC; Beth Kelly, CCDS; Mary Krowlikowski, CCDS; Karen Allan Leake, RN-BC; Susan Manske, RN-BC; Darlene McGreal, RN-BC; Theresa Naughton, RN-BC; Reenie Neylon, RN-BC; Shaunetta Pitts, RN-BC; Deborah Villaseñor, RN-BC; and Sheryl Walton, CMSA
- CHF Clinic: Diane Byrne, PCCN; and Eileen Golden, PCCN
- Critical Care: Susan Massatt, NEA-BC
- Emergency Department: Gail Gill, CEN; Jen Hoffman, CEN; Jeff Redican, CEN; and Jen VanCura, CEN
- Epidemiology: Mary Diamond, CIC
- Heart & Vascular Quality: Kathleen Lash, CCRN
- Hemodialysis: Pamela Betcher, CDN; and Melissa Nesmith-Vester, CNN
- Labor & Delivery: Hazel Canavan, RNC-OB
- MICCU: Sheena Schau, CCRN
- Neurosciences & Bone & Joint Institutes: Janet Finlon, NEA-BC
- NICU: Michaelynn Benedict, NIC-BC; Lisa Bubis, NIC-BC; Shelly DeVos, NIC-BC; Tracey Dowding, NIC-BC; Brittany Kane, NIC-BC; Tamra Marco, NIC-BC; Mary Murphy, NIC-BC; Debra Rampick, NIC-BC; Beverly Saylor, NIC-BC; Elizabeth Shewmake, NIC-BC; Ilene Sternquist, NIC-BC; Sonja Trimble, NIC-BC; and Susan Vella, NIC-BC

- Pediatric Emergency Department: Marie Gannon, CPEN; and Lindsay Vickers, CPEN
- PSHU: Krista Sieling, CCRN
- Procedure Recovery: Teresita Antonio, PCCN
- Quality & Regulatory Compliance: Colleen Perez, NEA-BC
- SVTU: Alex Dertz, CCRN; Suzanne Heslop, CCRN; Kristie Oblak, CCRN; Carol Sayers, CCRN; and Julie White, CCRN
- VAD Team: Kathleen Naughton, CMS
- Women Surgical/OB: Jennifer Henke, MNN
- Women's & Infants Health: Andrea Miller, NEA-BC

Degree Completion: Bachelor of Science Nursing

- ASHU: Will Spurlock, BSN
- Clinical Bed Management: Donna Lang, MSN
- Clinical Research: Roxanne Karnes, BSN
- Epidemiology: Adrienne Sheehan, MSN
- Radiology: Anne Williamson, BSN
- Surgery: Dan Altman, BSN; Colleen Betz, BSN; and Lisa Rochon, ADN
- SVTU: Suzanne Heslop, BSN, CCRN
- 6 South: Krystle Banzuela, BSN
- 7 East: Eleni Yamich, BSN

Nursing Research – IRB Submission

- DIAS-4, A randomized, double-blind, parallel-group placebo-controlled phase III study to evaluate the efficacy and safety of desmoteplase in subjects with acute ischemic stroke. Principal investigator: Melvin Wichter, MD; sub-investigators: Franco Campanella, DO;

- Arthur Itkin, MD, Abid Ali, MD; Dawn Merman, APN; Dolores Behrens, RN; Karen DeRe, RN; Isaac Mezo, MD; Jeannie Rhee, MD; Mohammadhamed Labbaf, MD; Mateo Calderon-Arnulphi, MD; Heeren Patel, MD; and Shaheen Umar, MD, Rolla Sweis, PharmD
- Project Walk. Principal investigator: Lori Short, BSN, RN-BC; sub-investigators: Fely Ong MSN, CCNC; Renee Isadore RN, BSN; and Virgie Tong, BSN, RN-BC
- Patient Outcomes with Radial Versus Femoral Approach in Cardiac Catheterization. Principal investigator: Sonia George, MSN, ACNC; sub investigator: Thomas Levin, MD
- Factors Related to Distress Among Multidisciplinary Cancer Clinic Patients. Principal investigator: in honor of the late Laurel A. Barbour, APN; sub-investigators: Debbie Sklaske, RN, APN; Patrice Stephens RN, APN; Patricia Mullenhoff, RN, APN; Rebecca Stout PhD; and James Weese, MD, Michele Goodier, MHA
- Brain Tissue Oxygen Monitoring in Pediatric Patients With severe Traumatic Brain Injury. Principal investigator: Laura Burokas, MS, APN; sub-investigators: Dimitrios Nikas, MD; and Dawn Anoman Murphy, BSN



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STEPS Case Study

# A Family’s Struggle to Find Answers and The Day That Changed Their Lives

Ryan M. Gagnon, BSN, RN, nurse clinician III, pediatric emergency department

### Patient Demographics

CD is a 4 year old male that lives at home with his mother, father, and 7-year-old brother. CD's past medical history has been predominately uneventful outside of his near term birth. Parents report that he has been healthy up until several months ago when he started experiencing abnormal neck posture and pain. Per CD's parents, he began experiencing intermittent events where his neck would be tilted to the right accompanied by short lived shooting pain on the same side. CD's parents reported these symptoms to his primary care physician who felt that it may be torticollis and asked that they keep a log to determine how often these events were occurring.

Approximately one week prior to CD's presentation to the pediatric emergency department he began vomiting intermittently and was started on amoxicillin by his primary care physician for a suspected sinus infection. At that time CD's primary care physician instructed his parents to observe for any visual changes, gait abnormalities, and/or headaches and to notify them if any of these symptoms were noted. After noting on several occasions that CD's right eye was wandering independently of his left, CD's mother again contacted his primary care physician who in turn referred CD to the pediatric emergency department for further evaluation.

### Nurse-Patient Relationship

Upon arrival to the pediatric emergency department CD was triaged with vital signs of BP 126/80, Pulse 105, Resp. 18, Temp. 36.7, O2 Sat 96% on room air, and pain 0 on Faces Scale. Patient was brought straight back from triage to a room where I assumed care of CD. Upon my initial assessment, CD was sitting quietly in his mother's lap while they explained his symptoms and their concerns in detail. When I asked his parents if they considered it normal for him to be shy, his parents said that he was a normally quiet and reserved child. I immediately started to build CD's trust by lowering myself down to his level and talking to him in language that a 4-year-old would understand. CD's parents were obviously concerned regarding what the possible causes of his condition could be. They were doing their best to hide their fears from their child.

CD's physical assessment showed that his neck was postured to the right and his chin deviated to the left. CD showed no signs of tenderness to his neck and had full ROM. CD's neurological assessment showed ataxia in the left upper extremity and had an up going babinski on the left. The remainder of his assessment was unremarkable.

At the completion of my assessment along with that of the resident and attending physician, a CT of brain with contrast was ordered. Prior to the CT, CD required that an intravenous catheter be inserted. Prior to starting the intravenous catheter I applied "no ouchie" LMX 4%

(topical anesthetic cream). I explained to CD that the magic cream would make it so that the poke would not hurt. Children have the right to pain-free procedures and whenever possible it is the nurse's responsibility to ensure that this right is upheld (McHuish & Payne, 2006). During the intravenous catheter insertion, we utilized an "I Spy" distraction toy and enlisted the help of his parents to distract him. Though we were unable to eliminate all of the pain associated with the procedure, we were able to dramatically decrease CD's pain experience with the procedure.

I accompanied CD along with his parents to the radiology department where the head CT was performed. The results of the CT showed a mass in the posterior fossa, left of the midline measuring 56 x 65mm most likely a pilocytic astrocytoma. I accompanied the physicians into the room when they were informed of the patient's diagnosis. After the initial diagnosis was provided, CD's parents were flooded with emotion, questions and fears. CD was unaware of what was going on due to his age but, could sense his parent's emotions. I played with CD and provided him with crayons, coloring pages, and toys to ease his fears and distract him from the emotions his parents were feeling. I was able to provide CD's parents support by listening to their concerns, answering many of their questions, and giving them a shoulder to cry on. I asked that the chaplain meet with the family prior to CD's admission the pediatric intensive care unit (PICU). Chaplain services have been proven to help promote hope in both patient's and their families (Ziel & Dautz, 2009). CD was transferred to the PICU, surgery was performed two days later for a total resection of the tumor. I was able to visit CD and his family every day during his stay in the PICU for continued support.

### Pathophysiology

"Brain tumor is a broad term encompassing tumors found within the brain or inside the skull compressing the brain. Some brain tumors are malignant, some benign. All however, can be life-threatening and require aggressive treatment." (Palmieri, 2007, p. 37). Cereballar pilocytic astrocytoma's are the most common type of brain tumor effecting children accounting for 35% of all brain tumors ("Cells tell the story," 2007).

The most common location of pilocytic astrocytomas is in the posterior fossa of the brain. Astrocytomas arise from astrocytes in the brain of unknown cause. (McCance, Huether, Brashers, & Rote, 2010, p. 686) Astrcytomas are usually well encapsulated tumors that are slow growing (McCance et al., 2010, p. 687). Symptoms are often associated with cerebellar astrocytomas include a head tilt, nystagmus, and limb ataxia on the side of the tumor (McCance et al., 2010, p. 687).

The primary treatment of pilocytic astrocytomas is resection of the tumor (McChance et al., 2010, p. 687). According to Fernandez et al. (2003), when total resection of the tumor is achieved the long term survival rate is virtually 100% however, when unable to re-sect the entire tumor survival rates drop to around 80%.

### Personal Critique and Reflection

I chose this patient for my case study because of the unique presentation and diagnosis of the patient. This case was different from so many cases that we see in the Pediatric Emergency Department each day. This was not your typical upper respiratory illness, rule out appendicitis, or broken bone. During my initial assessment of the patient I developed a bond with the patient and his family and could feel CD's parents yearning for answers and alleviation of their concerns.

As a nurse in the pediatric emergency department, it is easy to overlook the simple clues or idiosyncrasies that a patient may present with because so many patients utilize us as a clinic for the common cold. This patient reminded me that we must take every complaint seriously to prevent us from overlooking a major diagnosis. An accurate and comprehensive nursing history and assessment can provide a pathway to better patient outcomes.

Though I was only able to care for CD for a short while during his emergency room stay, I was able to continue to support him and his family throughout their treatment journey in the hospital by visiting them each day in the PICU. I will keep this patient's symptoms, diagnosis, and treatment plan in the back of my mind each day as I care for patients in hopes that one day this knowledge will prevent a delay in the diagnosis of another child.

### References

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**Exemplary Professional Practice**  
Magnet Force: Quality of Care

# Introducing the New Patient Experience System and Transition Call Center

Have you heard the good news? Advocate is introducing a system-wide discharge call process, including launching a central Transition Call Center focused on inpatients discharged to home/home health and providing all departments making discharge calls with the new Patient Experience System (PES), which is standardized software to manage patient feedback. Why? Industry research clearly shows discharge call quality and completion impact overall patient satisfaction. We believe that by consistently conducting discharge calls across the system, we can better capture the voice of our customers and use this feedback to make positive changes that improve patient experience.

In March, we will begin a phased process to standardize all hospitals on one process, one tool and one call center for discharge calls.

- **One Process:** A standard process for discharge calls to guide our efforts as a system.
- **One Tool:** PES will help all departments making discharge calls better collect and manage patient feedback.

- **One Call Center:** A centralized Transition Call Center to ensure consistent quality of calls to inpatients discharged to home and home health.

Through this approach, we plan to achieve a call attempt rate of 100% and a call completion rate of 75%. Research shows that by improving our call attempt and completion rates, we can have a positive impact on HCAHPS and reduce readmissions. In addition, this approach will enable all associates to benefit from the insights we receive from consistent patient feedback – without nurse managers and unit staff personally contacting discharged patients during their scheduled shifts.

The system-wide process, central Transition Call Center and standardized software are all based on industry best-practices. Plus, the approach has already been tested within several Advocate sites, so we know it works! The Transition Call Center will be staffed with a team of RN callers who will focus on calls to inpatients discharged to home and home health. RN callers will have

access to patient history and will be fully trained to conduct calls and facilitate dialogue with patients using best-practice questions. Inpatient units will start transitioning to the call center approach and new software in March.

Although non-inpatient departments will continue to follow their existing process for making calls, all departments making discharge calls will have access to the new software by the end of 2012.

Stay tuned for more information specific to Advocate Christ Medical Center. In the meantime, if you have questions, please contact Janet Finlon, RN, BSN, MA, NEA-BC.

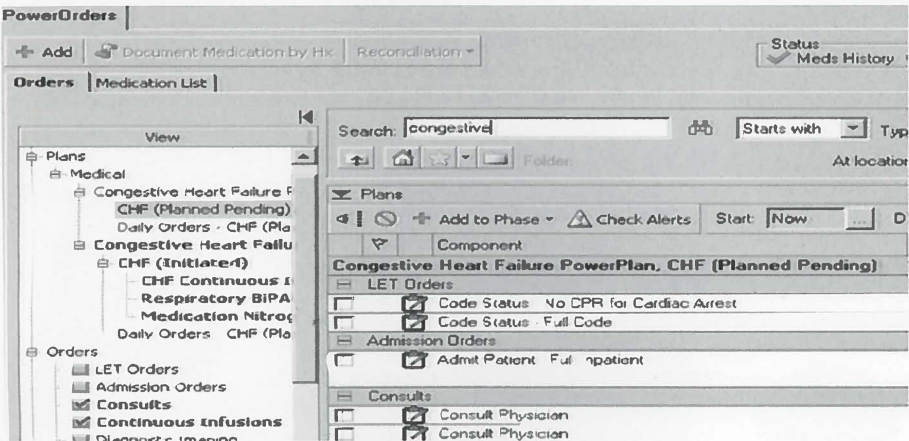



CareConnection

# Congestive Heart Failure (CHF) PowerPlan

Mary Fedor, BSN, RN, clinical informatics analyst


PowerPlan is a group of activities, expectations, decisions and evidence structured to guide and measure progress toward the achievement of a goal related to a problem or condition. Plans can also be designed to support a procedure or a process. PowerPlans support standardized evidence-based practice for treatment of a diagnosis, condition or problem. They are an alternative to single orderables or OrderSets. Our CHF PowerPlan became available in September 2011.



PowerPlans are indicated with a yellow  icon. Select Orders and “add” type in congestive and the Congestive Heart Failure PowerPlan comes up. Once the plan has been selected:

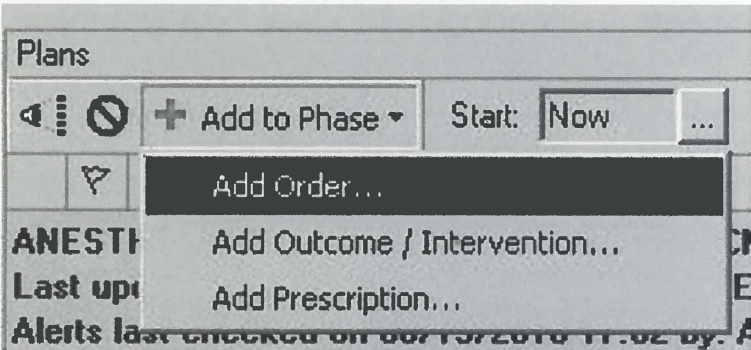
- Select desired orders
- Deselect undesired orders
- If orders are to be started now, click the Initiate button
- Orders display on the scratch pad. Complete order entry details
- Click Sign

- Within the body of the PowerPlan are orders for:
- Limitation of Emergency Treatment (LET) orders
  - Admit orders
  - Consults for physicians, CHF nurse, cardiac rehab, spiritual care, palliative care, nutrition, physical therapy (PT) evaluation, CHF clinic, and discharge planning evaluation
  - Continuous infusions- within this sub set are orders for milrinone critical or non-critical, titrated or non-titrated
  - Diagnostic imaging
  - Labs
  - Drug levels (digoxin)
  - Medications- in sub sets to include analgesics, lipid management, angiotensin receptor blockers, beta blockers, diuretics, potassium supplements, vasodilators, and nitrates to name a few
  - Nursing orders include daily weights, vital signs, intake and output (I & O), telemetry, activity, notify physician (MD) if., and patient education
  - Nutrition orders
  - Respiratory therapy oxygen PowerPlan
  - Respiratory BiPap/Cpap PowerPlans

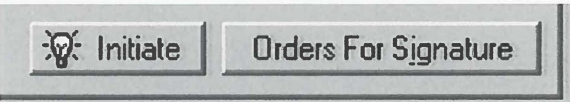
Orders with a down  arrow within the middle of the displayed sentence indicate there are more sentence choices. Select the order sentence and then the box to the left of the order will be automatically checked.



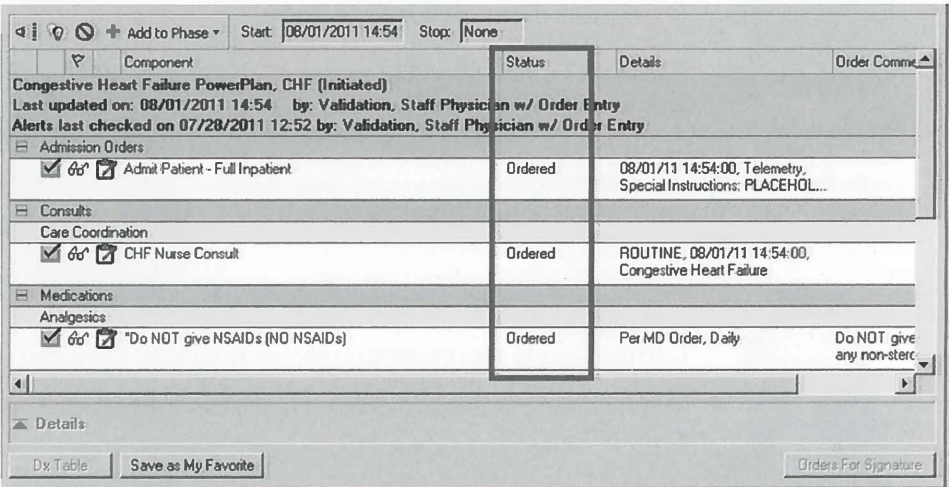
Orders not in the plan can be added from Order catalog and/or favorite folder utilizing “Add to Phase.”



Once all your order details are complete, click the Sign button in the lower right corner of the window. The orders will be in a processing status. Click the refresh button to get the PowerPlan to a planned state.



When the orders are signed, the orders drop into an ordered status.



The Joint Commission has recently changed the expectation for Advanced Disease Certification in Heart Failure requirements to include evidence-based beta blocker therapy for heart failure patients. This is supported by the American College of Cardiology (ACC) /American Heart Association (AHA) Clinical Practice Guidelines for Heart Failure Management. For patients who have heart failure and reduced left ventricular (LV) function, it has been suggested that these patients be placed on one of the three evidence-based beta blockers Carvedilol (Coreg), Toprol XL (Metoprolol Succinate), or Bisoprolol (Zebeta). These are located within the Power Plan under beta blockers.

## Phrase status meanings

- Planned: status in which the plan has been saved to a patient’s record but the orders have not been made available to the ancillary departments or the nurse activity list. The plan can be customized and saved in a planned state multiple times prior to the orders being sent to the ancillary departments. Orders that are in a phase that is planned will not have an order status.
- Initiated: status in which the orders have been made real and communicated to the ancillary departments and made available on the nurse activity list. Orders in a phase that is initiated will have an order status of ordered.

## References:

If one would like to learn more about Heart Failure Management, there is a link on the Advocate Christ Medical Center home page, go to Clinical Resources~ Heart Failure Management~ ACC/AHA Heart Failure Guidelines  
<http://cmconline.advocatehealth.com/documents/Clinical%20Resources/HeartFailureManagement.pdf>  
American Heart Association. [www.heart.org](http://www.heart.org)



New Knowledge, Innovations and Improvements  
Magnet Force: Quality of Care; Quality Improvement

## Clinical Coach Corner

Do you have a question or concern related to the Performance Based Development Systems (PBDS) Clinical Coach program? Submit your question to this e-mail address listed below:  
[cmc-clinical-coach@advocatehealth.com](mailto:cmc-clinical-coach@advocatehealth.com)  
We will share your question(s) with the PBDS Core Team for a response. Questions and the response will be published in NURSING Now in the Clinical Coach Corner.

## Book Reviews Wanted

Have you read any good books lately that you want to tell others about? The editorial board of Nursing Now is seeking interested nurses to write book reviews about fictional or non-fictional books related to nursing. Book selections can include any aspect of clinical care, administration, education, motivation, etc. The purpose of the review is to inform readers about the quality of the book and its content so that they can decide whether to read, use or purchase the book. The review should be approximately 300 - 500 words and written in an organized manner. We will expect you to be honest, succinct and tactful in your review. If you are interested in

submitting a book review, please contact Cheryl Lefaiver PhD, RN, to receive the guidelines and publication dates. We look forward to hearing from you!



Structural Empowerment  
Magnet Force: Professional Development



# Voices

"Voices" is a forum for you to voice your thoughts and opinions on fun, thought-provoking questions that affect your quality of work life. Our goal is to capture the diversity of our nursing staff—we can learn so much from each other! We hope that "Voices" provides you with some food for thought, or some topics for discussion with your colleagues. Enjoy!



**Angela Cox, BSN, RN, nurse clinician I, 9 south**

My plans for 2012 are to become more knowledgeable in my unit. I want to move from nurse clinician I to nurse clinician II. I plan on obtaining my progressive care certified nurse (PCCN) certification and to start graduate school in the fall of 2012. I plan to grow as a nurse, advocate and leader.

**Kenyaale D. Fanning RN, nurse clinician I, 4 east/west**

My plans for 2012 are to complete my bachelor of science in nursing (BSN) program and graduate in July 2012. I also plan to begin the medical/surgical certification. After a small break, I plan to start a master of science in nursing (MSN) program with future plans to teach.



**Precious Mendoza, RN, nurse clinician I, 6 east/west**

I am planning to start working on my nurse clinician II and start going to school for my bachelor's degree. I also want to continue teaching my dance classes. Last, but not the least, be totally close to being debt free!

**Suzanne Morris, RN, nurse clinician I, neonatal intensive care unit**

My plans are to start a bachelor's degree program at Purdue University and get my nurse clinician II.



**Katie Naegele, BSN, RN, nurse clinician II, emergency department**

My plans for 2012 include studying and passing the certification in emergency nursing (CEN) and visiting my grandparents in Florida for their 75th birthdays. I would like to continue to dedicate my time as chair of the unit council in the emergency department to keep associates engaged in decisions made in the workplace.



## What are your plans for 2012?



**Nikki Nino, RN, nurse clinician II, emergency department**

I will be completing my bachelor of science in nursing (BSN) in December 2012. I would like to travel more and spend more time with family and friends. I will also decide whether I will pursue a master's degree.

**Carrie Prendergast, BSN, RN, nurse clinician I, 9 south**

My plans for 2012 include taking a part in more unit activities. I will also take the progressive care certified nurse (PCCN) exam and become a nurse clinician II. I will start making plans for obtaining my master's degree.



**Janet Reyes, BSN, RN, nurse clinician I, surgery**

In the upcoming year I wish to expand my nursing skills in the perioperative field. I am very excited about having recently joined the adult open heart surgical team, and look forward to learning my new role so that I may become proficient in the care I provide to our patients. My goal is not only to meet our standard of care, but to exceed expectations so that our patients experience optimal outcomes, just as I would wish for any family member. As

I develop my role as a nurse, I also look forward to gaining the knowledge and experience needed to become a certified operating room (OR) nurse.



**Structural Empowerment**  
Magnet Force: Image of Nursing

## Share With Us!

Do you have a story to tell? Do you have an idea for a feature in NURSING NOW?

Write it down and send it via e-mail or fax to one of the editorial board members.

We want to hear from you!

E-MAIL: [debbie.oconnell@advocatehealth.com](mailto:debbie.oconnell@advocatehealth.com)

FAX: 41-5640



CONTACT HOUR EDUCATION

## Informed Consent in Clinical Research

Denise B. Angst, PhD, RN, director, Advocate Center for Pediatric Research, Advocate Health Care

Read the Contact Hour article and take the test at the end of the article.

1. Complete the entire answer form. (Answer forms may be photo copied.) DEADLINE: Answer sheets must be received in the Clinical Education Department no later than June 1, 2012.
2. Return the answer forms through in-house mail or fax  
MAIL: Clinical Education & Research Room 1030  
FAX: ext. 5640

**SCORES:** To earn 1 contact hour of continuing education, you must achieve a score of 80% (8 of 10 correct). Certificates indicating successful completion will bear the publication date of NURSING NOW. If you do not pass the test, your answer sheet will be returned for you to correct and resubmit prior to deadline.

**ACCREDITED:** NURSING NOW Contact Hours presentations are accredited as a provider of continuing education in nursing through the American Nurses Credentialing Center's Commission on Accreditation (ANCC); State of Illinois Board of Nursing, Advocate Health Care.

**CONTACT HOURS:** This CNE activity is being offered for 1.0 contact hour. The provider of the activity has disclosed in writing or verbally there is no conflict of interest declared by the planners and presenters/content specialists.

**QUESTIONS:** Contact Sue Barry at ext. 4409 or e-mail her at: Sue.Barry@advocatehealth.com

### Answers to the 2011 Volume 10, Issue 4 Contact Hour Quiz: "Learning the Technique of Research Critique"

1. Most clinical nurses use research reports as evidence to support their practice?  
a. True  
**b. False**
2. Of the following items, which were the barriers to research utilization as identified with the Attitudes and BARRIERS study at Advocate Christ Medical Center/Hope Children's Hospital?  
a. Insufficient time to read research  
b. Not enough education on how to search the evidence  
c. Not enough education to understand the components of the research report  
**d. All of the above**
3. In what way are articles approved for publication in a peer-reviewed journal?  
**a. By an independent panel of experts**  
b. By the Journal editor  
c. By University faculty  
d. Articles are not required to be approved prior to publication
4. What is the very first step in critiquing an article?  
a. Determining what the study problem was  
b. Finding each section of the report  
c. Considering the researcher's goals  
**d. Thoroughly reading all of the article**
5. In what section of the research report would the reader typically find a description of the study procedure?  
a. Background  
**b. Methods**  
c. Data Analysis  
d. Results
6. What are two elements of the study sample that should be evaluated during a critique of a research report?  
a. Study purpose & sample size  
b. Sample size & study location  
c. Randomization & study design  
**d. Inclusion criteria & study size**
7. What are the study variables being studied in the Meade et al. (2006) Rounding article?  
**a. Patient falls**  
b. Nursing Satisfaction  
c. Hospital acuity  
d. Number of assistive personnel
8. The findings from the Meade et al. (2006) study can be generalized to many hospital settings because the data were collected from hospitals of varying sizes from rural and urban environments?  
**a. True**  
b. False
9. The degree of dependability with which an instrument measures the attribute it is designed to measure is defined as:  
a. Randomization  
b. Statistical analysis  
**c. Reliability**  
d. Feasibility
10. In the Meade et al. study, which group was found to have a reduction in call light use, improved patient satisfaction and a reduction in the number of patient falls during the study intervention?  
a. Control (Routine Care)  
**b. One hour rounding**  
c. Two hour rounding



# Informed Consent in Clinical Research

## Volume 11, Issue 1 Contact Hour Quiz

- Research related informed consent is complete once the consent form is signed by the patient?
  - True
  - False
- Which of the following are the 3 basic characteristics of informed consent?
  - Information, benefits of the research protocol, liability statement
  - Information, documented cognitive assessment, ability to write
  - Information, voluntary participation, decisional capacity
  - Information, compensation for participation, voluntary participation
- There are 8 elements required by law to be included in the informed consent document.
  - True
  - False
- Who is responsible for ensuring that informed consent documents and processes adhere to required guidelines?
  - Federal and Drug Administration (FDA)
  - Institutional Review Board (IRB)
  - Principal Investigator
  - Department of Health and Human Services (DHHS)
- Who is responsible for ensuring that the informed consent process is adequate and provides potential subjects with sufficient opportunity to have questions answered?
  - Federal and Drug Administration (FDA)
  - Institutional Review Board (IRB)
  - Principal Investigator
  - Department of Health and Human Services (DHHS)
- What is required of those persons who will obtain informed consent from potential study subjects?
  - Provide evidence of research ethics training
  - Be listed on the study IRB application
  - Receive proper training about the study
  - All of the above
- A HIPAA authorization document is required to be signed independent of the informed consent document.
  - True
  - False
- Children assent is generally recommended for the following age group?
  - 5 years or older
  - 7 years or older
  - 9 years or older
  - 10 years or older
- What method should be used to verify the subject's understanding of the research study and its risks and benefits?
  - Document the interaction of informed consent
  - Answer the subject's questions
  - Ask the subject questions about the protocol
  - All of the above
- Special requirements are needed to enroll Non-English speaking subjects into the study?
  - True
  - False

## Your Answers

Please submit to Clinical Education

INA CE #:

### Informed Consent in Clinical Research

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(Please print clearly)

Time to read and answer questions: \_\_\_\_\_

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Unit/Department \_\_\_\_\_

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City \_\_\_\_\_

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Cost Center \_\_\_\_\_

## Evaluation:

At the end of this article the participant is able to:

- Identify 3 basic characteristics of informed consent yes ☐ no ☐
- Discuss the method used to verify the patients understanding of the research study. yes ☐ no ☐
- Were the objectives relevant to the goal of this program? yes ☐ no ☐
- Was the teaching method effective? yes ☐ no ☐
- Did this offering meet your objectives? yes ☐ no ☐
- Content was presented without bias of any commercial product or drug. yes ☐ no ☐
- Additional comments/suggested future topics:

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# Informed Consent in Clinical Research

Denise B. Angst, PhD, RN, director, Advocate Center for Pediatric Research, Advocate Health Care

*Frank is a 62-year old man recently diagnosed with non-Hodgkins (diffuse, large B-cell) lymphoma. After much testing and confirmation of his diagnosis, Dr. S, his oncologist, talks to him about possible treatment strategies and his prognosis.*

*Frank is well-educated, with a Master's degree in education. He is at this visit with his wife who became very emotional when the diagnosis was given. Both Frank and his wife feel overwhelmed with the information they have received and have difficulty understanding the medical terminology, even as it is simplified by Dr. S.*

*While discussing treatment strategies, Dr. S mentions that Frank is eligible to participate in a Phase III clinical trial. She begins to explain the trial but is interrupted:*

*Frank: I want you to do whatever you think will be best to get rid of my cancer. I don't care which one you choose. I don't want to be the one to decide.*

*Dr. S: I understand, but –*

*Frank: (Interrupts) I don't understand so much of this. I'm not a doctor and neither is my wife. We just trust that you will do what's best.*

*Dr. S: I know. But I do need you to make the decision.*

*Frank: (Interrupts) Please, Dr. S., just tell me what I should do ... what do you think would be best? I'll sign whatever you want me to sign. I just can't make this decision. I'm afraid that I'll choose the wrong treatment. You're the doctor; this is your specialty. Please just tell me what you think I should do.*

*Dr. S continues to try and explain the trial and treatment alternatives. Throughout this informed consent process, however, Frank and his wife frequently stop her and implore her advice regarding treatment. Despite their requests, Dr. S continues to explain the clinical trial protocol. She discusses randomization, investigational treatment versus alternative standard treatment, risks, benefits, voluntary participation and Frank's right to withdraw for any reason.*

*Frank and his wife are frustrated and confused about what to do. They are also concerned that this discussion is wasting time and delaying life-saving treatment. In the end, Frank signs the consent form to participate in the clinical trial because he believes that Dr. S knows what is best and*

*would not have suggested participation in the trial if it was not in Frank's best interest.*

*Was this process of informed consent adequate? What could Dr. S have done to have improved Frank's understanding and competency to make this decision on his own? Can informed consent ever be completely voluntary when it is couched in an illness context and in a doctor-patient relationship? These and other issues deserve careful consideration by investigators and others who are involved in the informed consent process.*

*Informed consent is both a legal and an ethical requirement in the conduct of research involving human subjects. It has also been one of the most frequently abused areas of clinical research in both past and more recent history. Although on the surface, informed consent appears to be a simple requirement, it is highly complicated by research subject characteristics, the nature and complexity of the research itself, and the context in which this process takes place, including the subject's health/illness status and the patient-clinician/investigator relationship. Informed consent is more than just a document that is signed to allow research participation. It is a process that begins with an initial explanation of the research and continues throughout a subject's participation, in an ongoing dialogue between the research subject and the investigator/research team.*

## General Requirements for Informed Consent

The U.S. federal regulations identify 8 pieces of information that must be included in the informed consent process and disclosed to potential research subjects or their legally authorized representatives. These are called the "elements" of informed consent in the Code of Federal Regulations (CFR), but in fact they are a means of implementing the three basic characteristics of informed consent: 1) information; 2) decisional capacity, and 3) voluntary participation. The categories of information required by law are:

- Statement that the study involves research, along with a description of the purpose(s) of the research, study procedures (including identification of those that are experimental), and the expected duration of subject participation
- Description of the foreseeable risks or discomforts (including physical, psychological, economic, legal, and social harms)
- Description of the foreseeable benefits to the subject or others



- Disclosure of reasonable alternatives or courses of treatment
- Statement about the implications of research participation for the subject's confidentiality
- Statement about compensation in the event of injury
- Contact information for obtaining answers to questions that subjects may have about the research
- Statement about the voluntary nature of participation and the subject's right to withdraw at any time

The regulations also identify "optional" elements of informed consent that should be described when appropriate. These include:

- The possibility of unforeseeable risks
- Circumstances under which the subject's participation may be terminated by the investigator
- Additional costs that research subjects may incur
- Possible consequences of withdrawal and procedures for early termination
- Statement assuring that the subject will be given any new information during the course of the study that may affect a subject's willingness to continue participation
- The approximate number of subjects to be studied

The informed consent document must not only contain the information required by law, it must also convey this information in a way that research subjects can understand. The difficulties inherent in creating a document that contains all of the required elements and communicates them using terminology subjects can understand is formidable. Review of the consent document and process, therefore, is a key responsibility of institutional review boards (IRBs). Under Federal regulations, the IRB is charged with the responsibility of ensuring that informed consent documents and processes adhere to the required guidelines.

To assist investigators and research teams, the Advocate Health Care IRB, like many others, has developed written guidelines and a consent form template with standard language and formatted sections that guide researchers in developing consent forms that are consistent with the Federal requirements. When developing a consent form, investigators should write with potential subjects in mind and avoid technical language and complicated terminology whenever possible. Medical terms and procedures should be adequately explained in layman's language.

Investigators must also keep in mind the low health literacy levels of many Americans. A recent national survey found that 14 percent of adults in the United States have a "below basic" level of "prose literacy" defined as the ability to use printed and written information. The study also concluded that the prevalence of poor health literacy is highest in those who are 65 years and older, Hispanic, or did not graduate

from high school.<sup>1</sup> It is important to remember that among all groups other than health care professionals, health literacy will be lower than prose literacy because of the specialized language that is characteristic of health care environments.

### **Who May Conduct the Informed Consent Process?**

The principal investigator (PI) is responsible for ensuring that the informed consent process is adequate and provides potential subjects with sufficient opportunity to both have their questions answered *and* consider whether or not to participate. Therefore, individuals who obtain consent must be knowledgeable about the research. They must be able to describe the purpose, procedures, benefits, risks and alternatives to participate in the research and must be able to answer research subjects' questions. For the Advocate Health Care IRB, like many other institutions, all individuals who will participate in the informed consent process must be listed on the IRB application and must have evidence of research ethics training. Ultimately, the PI is responsible for ensuring that these individuals are properly trained and are knowledgeable to assure that ethically and legally valid consent is obtained from all research subjects.

### **Documenting Informed Consent**

For most research involving greater than minimal risk, the CFR requires that informed consent be documented by the use of a written consent form approved by the IRB, and signed by the research subject or the subject's legally authorized representative. A witness's signature is also required on the consent form when the research involves greater than minimal risk or when a translator is used to assist a subject in understanding the research. The informed consent document that is signed must be an exact copy of the document most recently approved by the IRB. It must also bear the appropriate IRB date stamp. A copy of the consent form is given to the research subject, the original is kept in the subject's research record, and a copy is put in the subject's medical chart if the subject is a patient. The consent form must be signed prior to *any* research activity, including data collection, and serves as written evidence that the informed consent process occurred.

It is important to note that verbal or telephone consents are not appropriate unless the IRB has waived the requirement for a signed consent form. Deferred consent, obtained after any study procedures have taken place, is also unacceptable.

### **Waiver of Signed Informed Consent**

The IRB may approve a consent process that alters or omits some or all of the elements of informed consent. For example, the IRB may waive the requirement of informed consent but also require that the investigator provide subjects with a written summary of the research (e.g., a



summary at the top of an opinion-response survey). The IRB may waive the requirement to obtain informed consent altogether when research cannot be practicably carried out otherwise.

Generally, the IRB will grant a waiver for obtaining signed consent when: a) the only record linking the subject and the research would be the consent document, and the primary risk would be potential harm resulting from a breach of confidentiality; or b) the research presents no more than minimal risk to subjects and involves no procedures for which written consent is normally required outside of a research context. Examples of studies for which informed consent may be waived include retrospective chart reviews or studies of existing pathology specimens already collected at the time of the IRB application. If the study can be classified as minimal risk and adequate procedures are in place for protecting subjects' confidentiality, the IRB Chair will generally approve a waiver of consent.

For all research that involves a waiver of signed informed consent, the principal investigator must provide a detailed description of the reason(s) for the waiver. To do so, the Advocate Health Care IRB requires that an additional form be completed along with the IRB application. This simple form ensures that the waiver complies with federal regulations.

#### **HIPAA Authorization Addendum**

For all research involving protected health information, a Health Insurance Portability and Accountability Act (HIPAA) authorization must be included and signed by all research subjects. In most cases, this is a template form that is attached to the informed consent document. In other cases, the IRB may approve embedding HIPAA language in the consent form, thus a separate HIPAA authorization is not required. When it is not possible or practical to obtain a HIPAA authorization from research subjects, the IRB may grant a HIPAA waiver. The form for obtaining such a waiver is available on the Advocate Health Care IRB website. Criteria for obtaining such a waiver are similar to those used when considering requests to alter or waive informed consent.

#### **Informed Consent and Vulnerable Populations**

Meaningful informed consent requires satisfying each of the three elements previously identified: information, decisional capacity, and voluntariness. If a consent form does not fully disclose or adequately explain the purpose of research, possible side effects, etc., we cannot say that a subject's consent is *informed* even though it may be freely given. If a consent form is well written and fully explained but the subject enters the study only because she thinks it is what her doctor or family wants her to do, we cannot say that her consent is truly *voluntary*. Meaningful informed consent is

also undermined when decisional capacity is lacking or impaired such that a prospective subject cannot make a decision to opt for or against participation. Some may be cognitively impaired and thus unable to understand what is clearly conveyed in the consent form. Other subjects may have cognitive understanding, but be unable to make a decision due to mental disease or emotional stress.

In the case of Frank and his wife, for example, it is not so much lack of information or organic cognitive impairment that compromises informed consent. Certainly Dr. S, the physician/PI, is making an honest effort to engage them in a meaningful consent conversation. Frank and his wife are not being coerced by any person, but rather by the illness itself. They feel overwhelmed by the diagnosis of a serious disease, and this understandable emotional burden makes it difficult for them to comprehend certain concepts and use those concepts to make a decision.

Evaluating the quality of informed consent (information, decisional capacity, and voluntariness) is always important, but special scrutiny should be applied to particular groups of subjects who may be vulnerable because of limitations in their decisional capacity (e.g., children) or voluntariness (e.g., prisoners). Federal law includes regulatory guidelines pertaining to vulnerable populations, and this will be discussed in greater detail in future FORESight newsletters. However, since Advocate Health Care is actively engaged in pediatric research, the requirements for informed consent related to children deserve some mention here.

#### **Parent Permission and Child Assent**

Research involving children requires the child's assent (affirmative agreement) to be enrolled and one or both parents' (or a guardian's) permission. Because one cannot give "consent" for another person, many institutions rightly call these documents "Parent Permission Forms" rather than consent forms. Investigators must secure permission from parents or guardians prior to enrolling children in research. In addition, children who have adequate capacity must also be given the opportunity to learn about the research and provide their assent or "affirmative agreement" to participate. Assent is generally recommended for children who are aged 7 years or older and must be documented in writing. Assent documents should also be crafted to suit the age group of children who are being invited to participate. As children grow older, they are more able to understand and convey their reasons for assent and dissent. Including them in the consent process and paying attention to their experiences as patients and research subjects recognizes their developing autonomy while acknowledging the need to protect their vulnerability as children. This balance of protection and freedom is grounded on the fundamental principle of respect for persons discussed in the first FORESight newsletter.



### **New Information and Other Developments**

Investigators have a responsibility to keep subjects informed throughout the research about any new developments or information that would affect their willingness to continue to participate. This is especially important when information comes to light regarding potential risks. When new information becomes available (e.g., new risks or benefits) or there are changes to a research study (e.g., study design or procedures), the consent form must be modified and submitted to the IRB as an amendment. The revised consent form, once approved, should be used in the informed consent process with all subsequent potential participants. However, the investigator must also address how this new information will be communicated to research subjects who have already been enrolled. If their involvement in the research has ended, it may be sufficient to notify these research subjects with a letter. For subjects who are still actively participating in the research, reconsent may be required. Research sponsors may suggest or require a particular course of action that the IRB must review and approve. The IRB will make its own recommendations about when and how to reconsent subjects.

### **Non-English Speaking Subjects**

When it is anticipated that non-English speaking subjects will be recruited, a translated version of the IRB-approved informed consent form should be developed and submitted to the IRB for review. The investigator will also need to address the methods that will be used to ensure understanding of the research by non-English speaking subjects. This must involve more than just a translated consent form, and should include research personnel listed on the IRB application who can speak the language of potential participants and answer any questions that they may have throughout their research participation.

When the inclusion of non-English speaking subjects is not anticipated, but a non-English speaking person is eligible to participate, a short form written in the subject's language can be used in addition to the IRB-approved English consent form. The short form is read by the potential subject; the English consent form is orally translated into the subject's native language by a translator.<sup>2</sup>

Generally, the short form is a simple 1-page document that describes the elements of research participation in general. Before using the short form, the Advocate Health Care IRB must be contacted to ensure appropriate usage and compliance with required guidelines. The short form is available in Arabic, Polish, Russian, and Spanish by request from the IRB office (847-384-3527). In January 2008, these will be available via the IRB website:  
<http://www.advocatehealth.com/system/jobsedu/edu/irb/forms.html>. (Advocate Health Care's HIPAA Authorization is also available in Arabic, Polish, Russian, and Spanish via the IRB website.)

The short form consent must be signed by the subject or the subject's legally authorized representative and witnessed by the translator. The English version of the informed consent form (that has been orally translated) must also be signed by the person obtaining the consent and by the translator (as witness). Copies of the non-English short form and the IRB approved English informed consent document should be given to the subject or representative (and if the subject is a patient, copies should also be filed in the medical record).

### **Evaluating the Adequacy of Informed Consent**

Much research has shown that research participants often do not understand the information that is presented during the consent process and problems with readability of research consent forms have been widely documented.<sup>3</sup> Areas that are commonly misunderstood include randomization, the use of placebos and potential benefits for research participants.<sup>4</sup> Moreover, one of every seven volunteers report that they did not read the informed consent form prior to giving their consent.<sup>5</sup>

One reason why individuals may gloss over or not even read these consent forms can be related to the "therapeutic misconception."<sup>6</sup> Many clinical research studies enroll patients who already have a trusting relationship the physician-investigator or other members of the research team. As with the case of Frank and his wife, these subjects may not fully understand how participating in research is different from being a patient. For example, in many clinical trials, the investigator must follow a protocol with strict dosing requirements and schedules; subjects may be assigned a particular drug or device based on chance; and the research team may not know which treatment the subject is receiving. The therapeutic misconception occurs when the research subject mistakenly thinks that his treatment in a research study will be "therapeutic" just as though he were receiving medical care outside of a research study. This misconception may well be complicated by the fact that many times the investigator talking to the potential research subject about the research is also the same person who is managing his clinical care. This makes it difficult to differentiate the intentions that exist in clinical research (generalizable knowledge) versus those in clinical practice (individualized care). For example, research subjects may believe that their treatment in the research is based on their individual needs, when in fact a protocol has been written for the subject group. In the clinic, Dr. S might be able to titrate or schedule dosing based on individual metabolism and convenience; but as PI, Dr. S must adhere to the study protocol. If the subject's physiology or personal schedule is not compatible with the protocol, the subject is not eligible to participate in research or, having been enrolled, should be withdrawn.



Therapeutic misconceptions impair the validity of the informed consent process. In order to minimize these and other misunderstandings, the investigator should adequately describe how research participation will be different from standard clinical care. This discussion should include how the procedures, risks and benefits differ, and should address any uncertainty associated with the trial, and how study participation contributes to advancing understanding but may not benefit individual subjects.<sup>78</sup>

An investigator is responsible for ensuring that potential research subjects understand the research and its risks and benefits. To do so, an investigator should not only answer questions, but also ask questions that help to further the discussion and consideration of the research, prompt subjects to ask additional questions, and allow the investigator to assess subjects' understanding. Useful questions are open-ended, such as "How would you describe, in your own words, the purpose of this research?" or "What are the possible risks to you if you participate in this study?" The investigator should then document this conversation and the subject's apparent understanding or uncertainty about the research.

## Conclusions

Informed consent is an essential ethical and legal requirement when conducting human subject research. It is an ongoing process designed to give individuals the information they need to decide whether or not to participate, or to continue participation, in a research study. More than just a signature on a form, the informed consent process is a meaningful dialogue between investigators and potential subjects that begins when a potential subject is initially contacted and continues until the completion of the research.

**"Respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. This opportunity is provided when adequate standards for informed consent are satisfied."**

—The Belmont Report<sup>9</sup>

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## Internet Resources

OHRP, "Tips on Informed Consent,"  
<http://www.hhs.gov/ohrp/humansubjects/guidance/ictips.htm>

Declaration of Helsinki  
<http://www.wma.net/e/ethicsunit/helsinki.htm>

FDA Guidance for Institutional Review Boards and Clinical Investigators (1998), "A Guide to Informed Consent"  
<http://www.fda.gov/oc/ohrt/irbs/default.htm>

The Belmont Report  
<http://ohsr.od.nih.gov/mpa/belmont.php3>

## Applicable Laws and Regulations

45 CFR 46.116 [DHHS: General Requirements for Informed Consent]  
45 CFR 46.117 [DHHS: Documentation of Informed Consent]  
21 CFR Subpart B (50.20, 50.23, 50.24, 50.25, 50.27) [Informed Consent of Human Subjects]

## Abbreviations

AHC	Advocate Health Care
CFR	Code of Federal Regulations
HIPAA	Health Insurance Portability and Accountability Act
IRB	Institutional Review Board
PI	Principal Investigator



