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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

Advocate Christ Medical Center and Hope Children's Hospital is a good place to be. Two weekends ago, my family's life was turned upside down, and we could not have been in a better place.

Early Sunday morning, my husband, Pat woke me stating that he had some tingling in his fingers and his left arm did not feel "right." The nurse in me thought, "Is this a cardiac or neurological event?" while the wife in me thought "Quit complaining!" I got up, brushed my teeth, and by the time I came back into the bedroom, he was fast asleep. So, I attributed his symptoms to some radiculopathy from too much golf and went back to bed myself. Having no complaints when he awoke, we went to our nephew's graduation party that afternoon. When we got home, I immediately went for a bike ride to burn off a few of the tens of thousands of calories I had ingested over the past three days. I asked Pat to come with me but he declined. Upon my return, I asked him if he wanted to take a walk, knowing the bike ride did not make a dent in the calories. *This time he declined because his legs felt "funny." After much debate, I dragged him out for a long walk, thinking he would feel better if he got a little fresh air and exercise.* Shortly after we returned home, he once again complained of tingling in his fingers, so I took him to the Emergency Department (ED). I wanted him to have the best care available, so of course, we went to Christ Medical Center.

What transpired over the next several hours and days turned our world upside down. Pat immediately had an EKG when we arrived, which was not indicative of a myocardial infarction (MI). Good news, so we thought. Shortly thereafter, Pat's ED attending, Dr. Christian Badillo came in to assess Pat and to my chagrin, his initial impression was, yes, cervical radiculopathy! However, our thoughts of going home that evening shortly dissipated, when we were notified his first troponin level came back elevated; things went downhill from there. Over the next hour, Dr. Badillo began putting the puzzle together as results filtered in; at one point, we were discussing the possibility of brain metastasis. Pat was admitted for further testing and in less than 24 hours, we had our diagnosis; as a matter of fact, we got several. It was not what we wanted to hear, but we realized how fortunate we were, as it could have been much worse.



Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services/ chief nursing executive

This article however, is not about us — it is about you. You, the nurses, doctors, registration clerks, CIMS, PCAs, transporters, security guards, x-ray technicians, support associates, dieticians, social workers, care managers and nurse externs who provided my husband and family with **perfect care**. Each and every one of you made all the difference in the world to a patient, his wife and his children who were scared to death.

Pat's world-class care started in the ED with Dr. Christian Badillo, Paula, who registered Pat, Jamie, RN, Jennifer, RN, Valarie, and Mo ED tech. All were highly skilled, kind and attentive, checking up on us constantly.

The compassion and care continued throughout our entire stay. In cardiac cath and recovery we were in the competent hands of Dr. Avula, Mari Jo, RN, Kim, RN, Jenny, RN, Linda RN; and Maureen, Shannon, and Christine, cath techs. In radiology and the patient care center it was Dr. Grobelny, Kim, John, Leslie, RN, Anne, RN, and the entire interventional radiology/patient care center staff who cared for him.

Pat was admitted to 9 east/west, where he was worked up over the next four days, before his discharge on Thursday. All who came into his room exceeded our expectations, especially those directly involved in his care, his nurses Danielle, Rae, Sheila, his nurse extern, Meghan, who will make a fine nurse when she graduates in May, all his PCAs, Linda, Alishia, Lindsey, Deborah, Lynn and Erik.

I was equally overwhelmed with the support extended to me and my family from those who were not directly involved in Pat's case. Sherilyn, 9 east/west, CIMS, who sent me a beautiful email which I will cherish forever. Val, care manager, who touched me so deeply with her words of comfort and encouragement. Never underestimate how much the power of words impact healing for patients, strength for families.

There were so many of you who helped me and Pat, medically, emotionally and spiritually; we are forever grateful. Lastly I would like to acknowledge the neuro team: Dr. Wichter, Joey Eastman, Dee, Karen and the cardiac team, which included Dr. Trevedi and Maureen McCafferty. Simply put, you are my heroes. Words cannot adequately express my deep gratitude and appreciation.

What is even more inspirational is as I was writing this article I received a letter from another associate, Mary

Diamond, MSN, RN, infection prevention, whose brother passed away in July from cancer, at Christ Medical Center.

She wrote, "We cannot begin to express our gratitude to the wonderful nurses and patient care associates who were instrumental in getting him back home before he passed away on July 9. There were so many associates who were involved in his care that our family would like to express special thanks to Annie, Joan, Geri and Wendy from 3 south who were always there with encouragement and a kind word when things were difficult; Jessica from 9 east/west who always had a smile on her face and a kind word for us even when she was very busy hanging multiple units of blood. She was truly an "angel." We would also like to give a special thanks to a friend and nurse manager, Patti Wilson, who was there to support us when our brother required a second rapid response.

As a current and former ICU nurse at Christ Medical Center, I truly appreciate the dedication, expertise and compassion displayed by all the nurses in the medical intensive care unit, especially Paulina, Ewe, LeeAnn, Vickie, Sunshine and Jeff, who was so very kind to us during Kevin's third rapid response.

Kevin spent another 10 days in the surgical intensive neuro intensive care unit with a dedicated group of nurses who were kind, caring and considerate. I would like to thank Debbie, Ed O'Donnell, (no relation!), Chuck, Ismel and Elizabeth.

Though it was and continues to be a difficult period for our family, we can look back at our time at Christ Medical Center and know Kevin received excellent and compassionate care."

You have the power to make an everlasting impression on all the frightened and sick who walk through our doors. What impression will you leave? Will it look like the one etched in my mind? Will it look like the one etched in Mary's mind? Make the right choice; make a positive difference in the lives you are so privileged to care for. This is what world class care looks and feels like; it is no surprise to me that we are a Top 100 Hospital.

Thank you for what you do, thank you for making Christ Medical Center a good place to be; good because it is the best place for patients and families to receive care and an even better place to work.



Transformational Leadership

Magnet Force: Quality of Nursing Leadership

The 2012 Joyce Woytek Award

Colleen Leake, MSN, RN-BC, manager, clinical education



Diane Murphy, BSN, OCN, nurse clinician III, 3 south and infusion center, the 2012 Joyce Woytek Award Winner.

The 11th Annual Joyce Woytek Award for Nursing Excellence was held on May 7, 2012, at Silver Lake Country Club. More than 150 nurses attended the annual event to relax and celebrate with the nominees! This year's guest speaker was Donna Wright, MS, RN, from Creative Health Care Management. Donna's presentation, "Secrets Everyone Needs to Know in Health Care Today," had the attendees reflecting, laughing and learning. Using her own life experiences as well as humor, Donna spoke about relationship based care. One of her key points was the need for nurses

to take care of themselves in order to provide the best care to their patients.

Sixty nurses were nominated for the Joyce Woytek award this year. After each nominee was announced and had their nomination read by Nancy Burke, MSN, RN, ACNP, director, emergency services, as well as their picture taken with Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services, it was time for the suspense of the evening to come to an end. Diane Murphy, BSN, OCN, nurse clinician III from 3 south and the infusion center was the 2012 Joyce Woytek award winner! In her acceptance speech, Diane shared what a humbling experience it was to be nominated with so many outstanding colleagues. She also gave everyone goose bumps when she spoke about the privilege and honor to have taken care of Joyce when she was a patient on 3 south. This was a very touching moment for all.

As the evening drew to a close, many smiles, hugs, and pictures were taken to commemorate this wonderful evening!

Congratulations Diane!



Exemplary Professional Practice

Magnet Force: Interdisciplinary Relationships

Stepping up for Professional Practice

Maureen Craigmile, MSN, RN-BC, nurse clinician III, 5 south and Wendy Tuzik Micek, PhD, RN, NEA-BC, director, nursing science and Magnet

On Tuesday May 8, during National Nurses Week, a wonderful celebration took place at the Conference Center celebrating the Advocate Christ Medical Center's Magnet® status and honoring the excellence that is practiced here. The garden decorations, celebrating the theme "stepping up to excellent patient care and professional practice environment," provided the backdrop for what was to be an amazing celebration. The new uniforms that were selected for each division were creatively displayed on a clothes line for all to see.

- Nursing: navy blue
- PCA/Techs/Support Associates: teal blue
- Respiratory: pewter
- Medical Diagnostics: caribbean blue
- Rehabilitation Therapy: hunter green
- Phlebotomy: red
- Behavioral Health: wine
- Pharmacy: grey
- CIMS: Blue collared shirt, black sweater/vest, black pants

Individual nursing units together with their unit councils displayed their creativity and imagination in making stepping stones that will soon become part of a garden to be created in the new outpatient pavilion and/or new patient tower. The stepping stones exemplified the theme of "stepping up" for excellent patient care and professional practice and were enthusiastically embraced by over 48 units across Christ Medical Center and Hope Children's Hospital. They were on display during the Magnet celebration and staff voted for their favorites. The stepping stone voted #1 was adult respiratory, second place was pediatric respiratory, third place was 9 south, fourth place went to cardiac rehab and finally there was a tie for fifth place between the breast health center and the sleep disorder clinic. Please be sure to keep your unit's stepping stone in a safe place!

Daisy seeds were also distributed during the event as a reminder of the Daisy Award program. Christ Medical Center and Hope Children's Hospital is in its second year of honoring nurses with the Daisy Award. The Daisy Award was developed in November 1999 by the family of J. Patrick Barnes who died at the age of 33 of complications of Idiopathic Thrombocytopenia Purpura (ITP). In the family's grief they felt compelled to express their gratitude to nurses for the compassionate care Patrick received. As of May 2012, 1,257 health care facilities internationally participate and more than 30,000 awards have been given to date with 130,000 nominations written. During 2011, Christ Medical Center and Hope Children's Hospital presented 12 Daisy awards to outstanding nominees, three are given each quarter and 140 nominations total have been written.

Daisy nurse's clinical skill and especially her/his compassionate care exemplify the kind of nurse that our patients, their families and our staff recognize as an outstanding role model. Nomination forms are available online on the Christ Medical Center homepage under CELEBRATE!

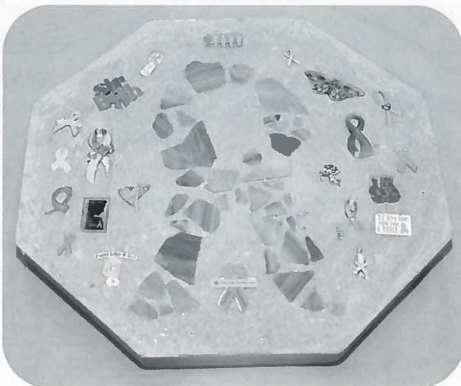
The highlight of the day was the 2012 Magnet® Clinical Division awards. These awards have been developed to recognize and reward the extraordinary contributions of our allied health clinicians, nurses, pharmacists and non-clinical associates that enhance the Magnet® work environment. Eight award categories with specific eligibility requirements were available for nominations. Congratulations to all of the nominators, nominees and winners! Rounding out the day was a wonderful meal provided to all associates on all three shifts. The hospital leadership and associates along with the Magnet Advisory Council members and Food and Nutrition helped serve the delicious food.

The day was an illustration of how far the medical center has come on our Magnet® journey and what great partnerships have been forged. However, the bar is always being raised. The medical center will be submitting its third Magnet® application in 2013 for re-designation, an accomplishment few hospitals have achieved. Thanks to the extraordinary associates and physicians who always lend a hand to help us achieve our goals and deliver excellent patient care!



Exemplary Professional Practice

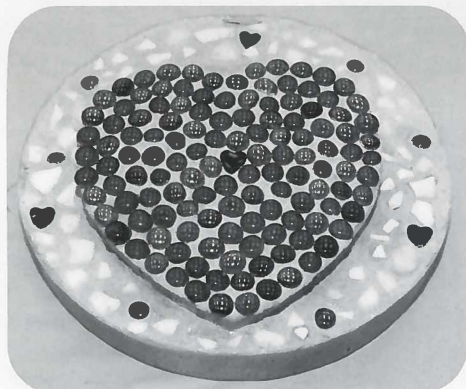
Magnet Force: Professional Models of Care; Interdisciplinary Relationships



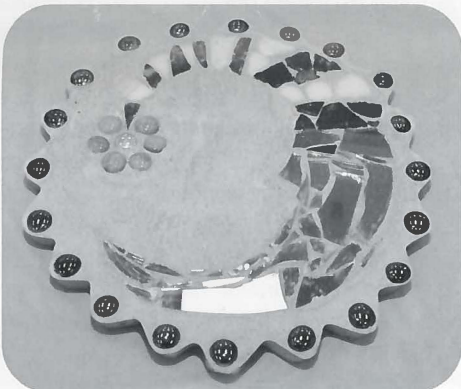
Breast health center



Pediatric respiratory



9 south



Sleep disorder clinic



Adult respiratory



Cardiac rehab

Congratulations to all of the 2012 Magnet Clinical Division Award Winners!

Physician Partnership

Christ Medical Center

- Pat Pappas, MD, cardiovascular surgery
- Brian Sayger, MD, emergency

Pediatrics

- Melissa Nater, MD, pediatric cardiology

Teaching

Christ Medical Center, RN

- Kimberly Butny, NICU

Allied Health

- Pamela Smith, pediatric respiratory care

Novice Practitioner

- Sarah Pruitt, 7 west

Advancing and Leading the Profession

Christ Medical Center

- Deb Stlaske, cancer institute

Pediatrics

- Kimberly Souder, PSNU

Management

Christ Medical Center

- Marie Andersen, MICCU

Pediatrics

- Michelle Tracey, 4 Hope

Preceptor of Distinction

Christ Medical Center

- Shelia Pepito, 9 east/west

Pediatrics

- Amanda Bryant, 2 Hope

Community Service

Local

- Kim Funk & Leigh Mangun-Shea, adult rehab services

Global

- Christina Kanke, SVTU

Clinical Team

Primary Care Nursing

- 7 west

Non-Clinical Team

- Stacey Julita, mission and spiritual care

Research

Pilot Study Evaluates Nutrition for ICU Mechanical Circulatory Support Device Patients

Michelle Nellett, APN, MSN, CCRN, CCNS, adult surgical heart unit

The following abstract highlights a research study that was conducted in the adult surgical heart unit at Advocate Christ Medical Center. This abstract and complete manuscript will be published in AACN ADVANCED CRITICAL CARE in the near future. The manuscript was co-authored by Mary Gregory, RD, LDN, and Cheryl A. Lefaiver, PhD, RN.

Establishing a nutritional protocol with accompanying algorithm allows a multidisciplinary team to make decisions to maintain or improve nutrition related outcomes during the intensive care unit (ICU) stay.

Methods

This descriptive pilot study, included subjects (n=11) recruited from a convenient sample of patients admitted for surgical implantation of a mechanical circulatory support (MCS) device. Nutritional and strength measures were compared across three time intervals: preoperatively, postoperative day 3, and within 48 hours of transfer from ICU.

Results

The mean age of the sample was 60 ± 8 years. Overall, subjects maintained preoperative nutritional status based on a non-significant change in the nutritional and strength measures from the preoperative period compared to transfer from ICU.

Conclusion

The nutrition protocol with algorithm provided a step-by step approach ensuring a consistent nutritional plan of care. It also standardized nutritional care while ensuring safe practice.

This research project was funded by the Advocate Christ Medical Center “Original Nursing Research Grant.” Monies were utilized to purchase a hand dynamometer to measure grip strength, and to cover the costs of various laboratory tests evaluated during the study. Travel grant monies were also awarded to cover travel and conference fees for a poster abstract to be presented at the 2010 American Association of Heart Failure Nurses (AAFHN)

national convention in Orlando, Fla.

Grant opportunities such as these are provided from the Nursing Research and Education fund. Contributions are generated via the Advocate Giving Campaign, Chip In for Nursing Research golf outing and individual contributions. Please visit the Nursing Research website via the Advocate intranet and go to Internal Funding for Nursing for more information. Opportunities await!



**New Knowledge,
Innovations and Improvements**
Magnet Force: Quality of Care,
Research and Evidence Based Practice

And the Survey Says ...

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

How do we know our patients and associates are satisfied? How do I know if my department is providing good customer service? Is my hospital a safe place to work and do we keep our patients safe? I need to collect data for a research project and I would like to do a survey. All these statements are reasons we participate as individuals and organizations in multiple surveys. This article provides definitions and rationale for completing surveys.

National Database of Nursing Quality Indicators (NDNQI) RN Satisfaction Survey 2012

Definition of the survey: The NDNQI RN Survey with job satisfaction scales measures job satisfaction at the unit level, similar to the measurement of all NDNQI indicators. Instead of focusing on the individual, the focus is on the nursing unit. This shift to a nursing unit focus supports the validity of the aggregated unit-level reports. In other words, asking RNs what the nurses with whom they work would say is generally accepted as an appropriate approach to reporting the level of RN job satisfaction on a nursing unit.

What is measured: Work context items relate to RN job plans, quality of care, ratings of the last shift worked, shift and shift rotation, breaks, floating and overtime. RN characteristic items include gender, race, age, tenure and education.

Eligibility criteria

- Include:
- RNs that provide 50 percent or greater direct patient care;
 - Assistant clinical managers and outcome specialists;
 - Full-time, part-time, PRN, or per-diem RNs employed by hospital; and
 - Employed in unit a minimum of three months by the first day of your survey.

- Exclude:
- RNs in management (MCO) or nurse education roles with less than 50 percent of job responsibilities in direct patient care (APN, nurse navigators);
 - Agency, traveler, or contract RNs;
 - New hires or internal transfers employed in current unit or workgroup less than three months; and
 - RNs on leave of absence.

Date/time of survey window: Determined each year

How results are communicated and used: Advocate Christ Medical Center and Hope Children’s Hospital nursing leadership team wants to fully understand the RN’s challenges and ongoing needs. The nursing leadership receives the survey results and is expected to share the results with their staff. Those units that demonstrate improvement opportunities are expected to use the survey data to develop action plans.

Being a Magnet nursing organization requires a commitment to an ongoing evaluation process. The nurses’ responses are used to continue to evolve as a Magnet-designated organization. Participation in the process leads to a level of empowerment which creates change and sustained development.

Physician Satisfaction Survey

Definition and eligibility criteria: Survey of all medical staff to determine the effect of changes occurring in the past year.

What is measured: Physician level of satisfaction as well as an assessment of the three units most visited

Date/time frame: Spot survey was completed in mid-May. The full survey usually occurs over Labor Day weekend for six to eight weeks with results available in December.

Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPSC)

Definition of survey: The HSOPSC assesses hospital staff’s opinions about issues related to patient safety, medical errors and error reporting.

Eligibility Criteria: The survey can be completed by all types of hospital associates (clinical and nonclinical) and physicians:

- Hospital staff who have direct contact or interaction with patients (clinical staff, such as nurses, respiratory care, phlebotomy, radiology, etc., or nonclinical staff, such as unit clerks, security, housekeeping, dietary, volunteers, pastoral care, etc.);
- Hospital staff who may not have direct contact or interaction with patients but whose work directly effects patient care (staff in departments such as pharmacy, laboratory/pathology);
- Hospital-employed physicians who spend most of their work hours in the hospital (emergency department physicians, hospitalists, pathologists, radiologists, anesthesiologists); and
- Hospital supervisors, managers and administrators.

The survey takes approximately 10 to15 minutes to complete. The survey responses are anonymous.

Date/time frame: The survey will take place August 6 through September 7.

How results are communicated and used: Safety culture dimensions strengths and potential areas for improvement will be reported at the hospital and unit level, as well as the system overall. Reports will include AHRQ’s HSOPSC 2009 Comparative Benchmark Database to assist hospitals to compare their site results with other hospitals. In addition, comparative analysis will be made

with 2008, 2009, 2010 and 2011 results. The survey reassesses the impact of our improvement efforts on the safety culture.

- Results are communicated at the unit level and at various hospital meetings.
- This has been added to the KRA list for 2012 with a target of at least the 75th percentile (in 2011 we achieved the 65th percentile)

Associate Satisfaction Survey

Definition of survey: Advocate Health Care uses Associate Satisfaction surveys to provide robust and reliable data on the level of engagement in our workforce that delivers the superior care to patients. The use of surveys reduces the uncertainty in managing human capital that helps leaders make better decisions, retain talent, and drive the performance of critical outcomes like quality, patient satisfaction and financial stability. The survey assesses associate commitment (synonymous with engagement) describing both the behavioral and attitudinal factors and their key drivers that impact commitment and lead to enhanced organizational performance. The survey uses valid, reliable items linked to robust national employee health care norms.

Eligibility criteria: All at-will associates, including registry staff are eligible to participate in the Associate Satisfaction survey on a volunteer basis

Date/time frame: Advocate Health Care is committed to continuously measuring associate satisfaction and surveys its system-wide population two times a year. The spring survey is the primary measure of engagement that fully assesses performance in the organization, manager and employee domains. The fall survey is a streamlined pulse check version assessing the same domains that reports associate commitment movement since the last survey.

How results are communicated: Survey results at a system- and site-level are heavily analyzed and compared to various benchmarks to give context to the overall and individual department/work unit performance. Top level summary and comparative results are shared across the system and with individual hospital sites. Respective department/work unit owners access their individual survey results via the vendor website to share their results with associates and create plans of action to constructively focus on any areas of improvement in associate commitment.

See “Surveys,” page 15

And the Winners are ... 1st 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.

Heidi Mesa, ADN, RN, nurse clinician II, 7 west

Heidi Mesa has been a nurse on 7 west for a little over a year. She meets all of the criteria of the Daisy award. She has such astute clinical skills, she often catches things that more experienced nurses have missed. Heidi has great attention to detail and not one little aspect of patient care gets missed under her watchful eye. She always acts in the best interest of her patients, and will challenge others in order to advocate for her patients. Heidi always takes time for compassionate communication, and goes to great lengths to make her patients happy and feel cared for. Although a new nurse herself, Heidi still mentors others and will take time to explain when things could be done better.



Heidi Mesa, ADN, RN, nurse clinician II, 7 west

Shally Philip, BSN, RN-BC, nurse clinician II, 8 south

Shally Philip role models professional behavior and leadership as she carries out her roles and responsibilities as nurse clinician II, charge nurse, clinical coach, preceptor, educator, and unit-based clinical resource. She is a highly skilled professional who leads by example. Shally is an extraordinary person and clinician who epitomizes nursing at its best. She is highly skilled, compassionate, a sound clinical thinker, collaborator and strives to do her best at all times. She serves as the ultimate patient advocate at the bedside, as a leader and as a coach for future generations.



Shally Philip, BSN, RN-BC, nurse clinician II, 8 south

Tamra Marco, RN, NIC-BC, nurse clinician II, neonatal intensive care unit (NICU)

Tamra Marco has been a staff nurse in the NICU and 2 east/west since 1980. Tamra is frequently recognized by families as someone who really makes a difference in theirs and their child's life. She helps make every family's stay in the NICU a positive experience. Tamra takes away the fears of the intensive care environment and treats families like she is inviting them into her home. She is even noticed by families she does not care for. A thank you note received recently stated, "It is odd I think you only had our daughter once in the 8.5 months we were there but you were always near us. I witnessed day in and day out what a remarkable person you are. Every patient I talked to whose baby you cared for we are thrilled to have you as a nurse. I think this is truly what you were meant to do with your life."



Tamra Marco, RN, NIC-BC, nurse clinician II, neonatal intensive care unit (NICU)



Exemplary Professional Practice
Magnet Force: Professional Models of Care

1st Quarter Daisy Award Nominees

Christ Medical Center

Sonia Agguire, SINI
Marie Andersen, MICCU
Dawn Bausone-Gazda, VAD
Nancy Brasic, 5 east
Maureen Canavan, 4 east/west
Lauren DeLaTorre, 9 south
Mildred Franco, SINI
Sue Huron, surgery
Marilyn Kline, outpatient infusion
Karrie Lepper, 7 east
Krystyne LeRose, SVTU

Nancy Marek, EEG, adult/pediatric neurology
Donna Mazulla, 7 west
Geraldine McGuire, 3 south/oncology
Sandra McIntyre, outpatient infusion
Terri Merriam, fetal diagnostics
Daniel Mefford, 5 east
Heidi Mesa, 7 west
Susan Naraya, 3 south
Joanne Nugent, 6 south
Sara Nessel, 6 south
Christina Niemiec, 7 east
Elaine Orzech, surgery
Shally Philip, 8 south/neurology

Elizabeth Rockwell, 3 east/west
Joanne Regan, ASHU
Colleen Sharp, emergency
Tamara Smith, Interventional radiology
Betsy Vanetten, labor and delivery

Hope Children's Hospital

Jenn Fortson, peds transport
Denise Kwansy, 2 Hope
Tamra Marco, NICU
Megan Posch, 2 Hope

Patient Safety

Measuring Our Safety Culture

Debra Kman-Malabanan, BSN, RN, manager, patient safety

As part of its goal to support a culture of patient safety and quality improvement in the nation's health care system, the Agency for Healthcare Research and Quality (AHRQ) has developed patient safety culture assessment tools. The Advocate system has participated in this survey, on an annual basis, since 2009. This survey is very different from the National Database on Nursing Quality Indicators (NDNQI) nursing satisfaction survey or the associate satisfaction survey. The AHRQ patient safety culture survey measures opinions about patient safety issues, medical error and event reporting within our medical center and on individual units. Patient safety is defined as the avoidance and prevention of patient injuries or adverse events resulting from processes of health care delivery. Events are defined as any type of error, mistake, accident, near miss or deviation, regardless of whether or not patient harm has occurred. At Advocate Christ Medical Center and Hope Children's Hospital, events are most frequently identified through the

reporting of incidents via the MIDAS Patient Safety Event reporting system, or commonly known as the remote data entry (RDE).

As an organization, Christ Medical Center and Hope Children's Hospital have actively been focusing efforts to improve patient safety. Leaders have analyzed 2011 survey results, shared them with staff and developed action plans to improve our culture. Some of the things we have put in place are "Safety Alerts," larger identification (ID) bands, Smart Pump Technology (Alaris IV pumps), medication bar-coding, glucometer scanning and a redesign of the portable oxygen tank black dust cover. All of the issues, which triggered development of the above noted interventions, have been identified through event reporting,

It is paramount for an organization to have the ability to identify near misses and errors in order to prevent errors. It is also important for staff to adhere to policies, procedures, guidelines and directions in order to maintain

patient safety and prevent errors. Performing a work-around such as scanning medication in other places than at the bedside is a deleterious behavior which places the patient at risk because one can be distracted and walk into the wrong room. Work arounds should not be encouraged because they can lead to error despite the use of the latest and greatest technology. If something does not seem to work efficiently discuss this with leadership for further evaluation. We value your input.

In conclusion, to enhance our safety culture, report errors and near misses so the organization has an opportunity to learn from events before they become harmful to patients and participate in the annual AHRQ Culture of Safety Survey which will begin August 6, 2012.



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

Recognition of Second Quarter 2012 for Outpatient Satisfaction

The outpatient advancing excellence committee would like to recognize the reward and recognition recipients, for outpatient satisfaction, in the second quarter of 2012!

We are happy to announce the reward and recognition recipients in the second quarter of 2012!

- | | |
|------------------------------|-----|
| 90% or above April-June 2012 | |
| 1. Sleep Disorders Center: | 99% |
| 2. Palos Physical Therapy: | 90% |

- | | |
|--------------------------|-----|
| 3. Cardio diagnostics: | 96% |
| 4. Mammography: | 98% |
| 5. Heart Failure Clinic: | 99% |
| 6. Lockport OP Rehab: | 99% |
| 7. Lockport Radiology: | 99% |
| 8. Tinley OP Therapy: | 96% |

Outpatient Satisfaction Star

Sleep Disorders Center went from 11% first quarter to 99% second quarter (88% difference)

Honorable Mention

EEG went from 25% first quarter to 68% second quarter (43% difference)



Exemplary Professional Practice

Magnet Force: Quality of Care: Patient Safety; Professional Models of Care

Dyad Profile

Leadership on 7 West

Debra Sheehan, ADN, RN-BC, interim manager, 7 west; Lori Short, BSN, RN-BC, clinical practice partner, 7 west; and Irene Tranowski, MSN, CRRN, clinical practice partner, 6 south

Debbie Sheehan, ADN, RN-BC is the interim manager of clinical operations on 7 west. She started her career at Advocate Christ Medical Center in 1999 as a staff nurse. She became an assistant clinical manager for night shift on 7 west in 2006. She has worked as a preceptor for 7 west, provided training for the nurses on the pulmonary step-down unit,



Debra Sheehan, ADN, RN-BC, interim manager, 7 west, and Lori Short, BSN, RN-BC, clinical practice partner, 7 west.

done scheduling and functioned as charge nurse. Debbie received her medical surgical certification in 2009, and is currently enrolled at Loyola University for her bachelor's degree in nursing.

Lori Short, BSN, RN-BC is the clinical practice partner (CPP) on 7 west. She also started at Christ Medical Center in 1999. Lori was a patient care associate (PCA) on 7 west until she graduated in 2001 and became an RN, and worked as a staff nurse on 7 west. Lori received her medical surgical certification in 2005. Among her roles on 7 west

Lori also was the outcomes specialist for two years before taking the CPP position. Lori is currently enrolled at Lewis University in the Family Nurse Practitioner track and looks forward to graduating in 2014.

7 west is a 24-bed medical surgical unit with six of those beds being for pulmonary step-down patients. It is a fast paced unit that cares for a variety of different patient disease processes. Debbie and Lori work as a dyad to provide the best possible care to their patients. They are committed to providing quality care to their patients as well as promoting a culture of safety. Due to staffing changes, they are in the process of training many new nurses, most of whom are new graduates. They find this process to be both challenging and rewarding. They are lucky to have a wonderful group of experienced nurses who are committed to mentoring the new graduates as they come in to work on 7 west. They work closely with the rest of the leadership team to strive for 100 percent compliance in the key result areas and are constantly developing action plans to help improve performance.



Transformational Leadership

Magnet Force: Quality of Nursing Leadership

Let Our Voices Be Heard

Joan Kelley, BSN, RN, TNS, nurse clinician III, clinical informatics

On the early morning hours of May 2, a contingent of more than 100 nurse members of the Advocate Nurse Advocacy Council (NAC) arrived to board buses with bright smiling faces. Those nurses leaving from the Advocate Oakbrook Support Center were greeted by NBC news media. Their mission was the annual trip to the state capitol in Springfield, Ill.

Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services at Advocate Christ Medical Center and the NAC director chair was on hand to support the efforts of NAC. According to Lynn, "This was my first trip to our capital with Advocate's Nurse Advocacy Council and what an exciting trip it was! I was so proud to see our nurses interacting with our legislators and communicating their views on issues that will impact our nursing profession and health care.

With over 9,000 nurses, Advocate is the largest voice for nursing in the state. It is vital we all get involved in shaping our future." The goal was to enlighten local legislatures about the plight of health care decisions that have the potential to devastate a business sector that has withstood failing economic times. The day began with an update of the key issues that are being discussed in state

chambers. Advocate's own government relations team was on hand to facilitate the day by connecting the nurses with local site legislators who govern the areas surrounding the many different Advocate Health Care sites.

Key issues for this years' trip included supporting tax exempt charity status for not-for-profit hospitals, opposition to proposed Medicaid cuts and a commitment to support nurse staffing ratios based upon an acuity model of care. The legislators are grateful for the expertise and invaluable input that they receive from nurses.

Nurses are leaders in the health care sector and are dedicated in providing the best outcomes for the patients they care for on a daily basis. Some of the key highlights of the day included being introduced and applauded for heroic nursing efforts during chamber sessions. The day concluded with a group meeting and picture with Governor Quinn.

It is imperative now more than ever to show solidarity of support and to work with lawmakers who are making health care decisions that impact the delivery of care. The



Stephanie Rossi, ADN, RN, nurse clinician II, MICCU; Kelly Keating, BSN, RN, nurse clinician II, MICCU; Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, nursing services; Kalina Dziadkowiec, BSN, RN, nurse clinician II, MICCU.



The Nurse Advocacy Council with Governor Quinn.

voices of nursing are very influential; we need to make them heard. This year's Fall Forum in October will prove to be particularly powerful, due in part to proposals of health care reform, but more importantly because it is an election year. Please help to show support for the forum by actively promoting and attending this commanding event. If you would like to learn more about how you can get involved, please contact NAC members, Joan Kelley, BSN, RN, TNS, nurse clinician III, clinical informatics at ext. 41-8066, or Stephanie Rossi, RN, staff nurse in MICCU.



Structural Empowerment

Magnet Force: Community and the Healthcare

Beta Cell Bikers Rock the Tour de Cure

Joan Kelley, BSN, RN, TNS, nurse clinician III, clinical informatics

The Tour de Cure is a fundraising cycling event that is held in 44 states nationwide to benefit the American Diabetes Association (ADA). In 2011, more than 55,000 cyclists in 80 nationwide events raised more than \$18 million to support the mission of the ADA which is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. Not only was Advocate Health Care on hand as a corporate sponsor for this great event but Christ Medical Center's very own Beta Cell Bikers contributed by raising over \$3,000 for the event. Remarkable enough, emergency department nurse Nancy Kelly and her husband raised a combined amount of nearly \$2,000. This year's event was held on June 10, 2012. Team captain Jim Jensen, Christ Medical Center pharmacist, enlisted a commanding crew of 13 associates to ride on this hot sunny June morning. Along with Jensen, additional Christ Medical Center associates who participated in this event included Joan Kelley, Nancy Kelly, Branka Milicev, Rolla Sweis and Adrian Tovar.

According to Jim, "This is for a great cause, we were able to raise a large sum of money to help the ADA with diabetes programs and fund research to combat this disease."

Riders were able to take on their own personal challenge to get ready to experience the ride of their life! The event began and ended at Wheaton-Warrenville South high school. There was a route for every age and ability at the Chicagoland Tour de Cure. Riders had the option of choosing from a 10 or 15 mile ride on the Illinois Prairie Path, or to push further for a 35 mile trek or tackle the open road with the 62 and 100 mile routes. It was a unique day of fun, fitness and a chance to gain the satisfaction of achieving a personal challenge. Riders were asked to raise a minimum of \$150 per rider and Advocate Health Care generously contributed by donating the \$25 fee required to join the event.

The people the riders met along the way were what made the Chicagoland Tour de Cure a special ride.

Support teams were on hand to take special care of the riders. There were great rest stops hosted by both businesses and volunteers. Snacks and beverages were in abundance thanks to their generous donations. The community came out in droves to help cheer on the riders as they pedaled through the town.

The sense of accomplishment that was felt as they crossed the finish line was only matched by the difference that will be made in the lives of the nearly 26 million Americans who live with diabetes.



Structural Empowerment

Magnet Force: Community and the Healthcare Organization

Out and About

Nursing Symposium: Exemplary Professional Practice, Education and Innovation in Action

Nicholas Zahara-Such, BSN, RN, nurse clinician I, 2 Hope; and Lynn Curran, BSN, RN, professional nurse educator, clinical education

The 8th Annual Nursing Symposium: Exemplary Professional Practice, Education and Innovation in Action, was held on April 17, 2012. Due to the nearly 200 attendees, the atmosphere buzzed with excitement for learning and networking. There were three nationally recognized keynote speakers and afternoon breakout sessions for attendees which provided educational opportunities related to research, evidence-based practice, diversity in nursing, academic partnering and improvements in practice. In addition, this year more than 40 scientific posters displayed excellent projects from 15 organizations throughout the Chicagoland area. Our own nurses from Advocate Christ Medical Center and Hope Children's Hospital presented 16 of the posters and work from throughout Advocate Health Care was well represented with an additional 14 posters. Evaluations from the event were overwhelmingly positive. For example, one attendee stated that the conference provided fantastic examples covering nursing rounds, shared governance, research and stamping out unhealthy work environments. Comments also showed how attendees will use the information gained at the conference: "The meta-analysis and publication sessions were essential to improving my practice and communication," said one attendee. And another mentioned that a panel on diversity will be presented at the next regional conference ... and that they will celebrate men in nursing for National Nurses Week in 2013."

The commentaries below represent perspectives from two of our staff who attended the event. Plans are already underway for the symposium for next year, so please save the date for April 9, 2013.

Nicholas Zahara-Such, BSN, RN, nurse clinician I, 2 Hope

I had the pleasure of going to the Nursing Research Symposium on April 17, 2012. As a relatively new nurse, trying to decide which direction to go with my career, I am grateful for experiences in different settings to practice nursing. During the lunch break there was a diversity lunch which celebrated differences in nurses. Being a male nurse who is interested in nursing research, this was a perfect conference for me to attend.

The first guest speaker was Kathleen Vollman, MSN, RN, CCNS, FCCM, FAAN, who spoke about the key role

and impact nurses should make in health care. William Lecher, MS, MBA, RN, NE-BC, spoke about the topic of diversity in nursing with an emphasis on gender, and he also led the diversity lunch. The third keynote speaker was Lisa Hopp, PhD, RN, who spoke on evidence-based quality improvement. All of the speakers were informative and kept the attention of the audience. Kathleen even ended her presentation by inviting everyone to stand up and dance.

The diversity luncheon was small and informal. It was attended by a diverse population of nurses. Everyone introduced themselves and shared how they got into nursing. It was interesting how many of the people in attendance were influenced by nurses who were diverse themselves. William expanded more on his diversity lecture from earlier and talked about the American Assembly for Men in Nursing, of which he is the president. It was somewhat shocking to learn that there was not an Illinois chapter.

Diversity in nursing is something that I have not personally thought about much before this presentation, even though I myself am a minority in nursing and considered diverse. Be it race, gender, or something else that makes you stand out, minorities play an important role in who we are as nurses. Nursing research is easily overlooked and forgotten in the hectic world of floor nursing, but it can be a vehicle to find evidence that positively impacts practice, thus it is an integral aspect of advancing nursing practice.

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

It was difficult for William Lecher to work side-by-side with his carpenter father, and tell him that he was going to pursue nursing as his career path. His announcement to his father and his construction peers may not have been accepted as well as it would have been if he had chosen something more "suitable" for a male such as a doctor or a pipefitter.

William Lecher, MS, MBA, RN, NE-BC, was one of the keynote speakers at the 8th Annual Nursing Symposium and presented "Diversity with a Gender Emphasis." William is a senior clinical director for the Cincinnati Children's Hospital and Medical Center and the president of the American Assembly for Men in Nursing. William

spoke strongly of the need to recruit and retain male nurses and that the shortage of nurses will not be solved until we consider gender.

The American Assembly for Men in Nursing (AAMN) is a driving force in a recruitment initiative to encourage men to enter the profession. The aim of the AAMN is to create a vehicle for discussion of issues affecting male nurses. The AAMN's key objectives include recruitment of male nurses, professional growth and development of male nurses, promotion of research about men's health and male nurses and support of its members' full participation in the profession of nursing. William spoke of the need to transform the image of nursing as a gender neutral profession by using gender inclusive nursing images and gender neutral nursing language.

He also spoke about the Institute of Medicine's Future of Nursing report which recommendations include increasing the percentage of nurses with a baccalaureate degree to 80 percent by 2020 as well as doubling the number of nurses holding a doctorate degree. Within these recommendations, gender diversity and the AAMN are discussed for their vital role in offsetting the nursing shortage as well as expanding nursing roles. William quoted Luther Christman, PhD, RN, a dedicated nursing advocate who constantly pursued the improvement of nursing practice and educational standards for nurses. "No one race, gender, or ethnic group has a monopoly on the quality of intelligence, scientific competence, imagination, empathy, tenderness, concern for others, or motor skill ability. To state otherwise is to deny reality."

At the conclusion of his presentation, a participative luncheon was held with William Lecher along with site leadership, other keynote speakers, and a representative group of male nurses from sites throughout the system. They discussed the importance of improving the message of nursing as gender neutral and encouraged the development of a south side Chicago chapter of AAMN.



New Knowledge, Innovations and Improvements

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

Cultural Diversity

Celebrating Nursing Diversity: Age

Linda Sobanski, RN, nurse clinician III, CHF clinic

The nursing profession is a very culturally diverse population. Look around and you will see people from all over the world caring for our patients. One aspect of diversity not often thought about is age. There are two groups to be considered, namely, the experienced, older nurses and the younger, new graduate nurses. Approximately 40 percent of the workforce will be over 50 years of age by 2020 (Barclay, 2006).

Experienced nurses have more life experiences, perseverance and determination which are why they have lasted so long in this stressful work environment. Through their years they have been able to perform complex tasks, recognize early warning signs, and deliver high quality health care. There is a high level of clinical performance that emerges because of their formal education and experiences. They also have developed great interpersonal skills dealing with patients, families and other health professionals over their years of practice.

The relationship between experienced nurses and new graduate nurses should be a give and take, a sharing of information between each other. Having a good mix between these two groups will assure positive outcomes for all. The experienced nurse brings lifelong experiences, intuitions and interpersonal skills. They share their knowledge and experiences with the new graduate. In return, they get recharged and excited all over again with the energy from the new graduate. The new graduate brings enthusiasm, energy and excitement, along with technological savvy to share new ways to provide and enhance patient care. The new graduate should feel safe and supported through each new experience. This relationship develops into a mentor/mentee relationship. Hence the dynamics between the two groups promote lifelong learning.

Our nurses represent different backgrounds, ethnicities, genders and age groups. There is uniqueness in everyone. This is evident in the different insights, perspectives and views that nurses bring to work every day. They all want to feel valued. By creating a supportive and respectful environment where experienced nurses feel they are able to work and contribute, and where new graduates are able to apply their new knowledge in a safe and supportive place, a culture of diversity will be created. Teamwork and equality can be fostered in our profession by creating an environment where our nursing staff is culturally diverse with both experienced nurses and new graduate nurses. This will help us to retain the best of our profession and deliver quality nursing care beyond 2020.

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Exemplary Professional Practice

Magnet Force: Quality of Care

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
FAX: 41-5640

Risky Business

In Illinois, Who Decides?

Martha Winter, RNC, MJ, director, risk management

Consider these scenarios: A 76-year-old woman had always thought her nephew would be her decision maker. Although she had a son, she thought he would not be her best representative in medical decision making because he had personal challenges of his own. Another 65-year-old woman specified one of her five adult children to be her surrogate because the others had viewpoints incompatible with hers. Meanwhile, a 59-year-old man chose a close friend to be his surrogate, even though he had a daughter that would be his surrogate under Illinois law. The link between all of these scenarios is: although all the individuals had specific desires regarding who they would prefer for decision makers, they arrived at the hospital unresponsive, without the ability to express their desires and without advance directives. As a result, the health care providers must look to the Illinois Health Care Surrogate Act (755 ILCS 40/1) for direction.

Approximately two thirds of the states have health care surrogate laws. We are fortunate in Illinois to have such legislation. The Health Care Surrogate Act enables medical decision making to be provided for individuals who lack the ability to make their own decisions and do not have a Living Will, Health Care Power of Attorney or Declaration for Mental Health Treatment. Before the surrogate decision-making process can be followed, two requirements must be satisfied: 1) A physician must

determine and document in the medical record the lack of "decisional capacity" (the ability to understand and appreciate the nature and consequences of a decision regarding medical care); and 2) Confirm (to the best of our knowledge) that no Advance Directive documents exist.

The law defines a priority list of individuals capable of being surrogates. They are as follows: 1) The patient's court appointed "guardian of the person;" 2) A legal spouse; 3) An adult son or daughter; 4) Either parent (except in cases of sole custody); 5) An adult sibling (18 or older); 6) A grandchild; 7) A close friend; or 8) court appointed "guardian of the estate."

A common conflict involves surrogates of the same level thinking they have a greater authority (i.e. the oldest child believes he/she is entitled to be the decision maker because of age) over another surrogate. Not so! When there is more than one person at the same priority level (including parents), they are required to try to reach an agreement. If they cannot agree, the physician will honor the decision made by the majority, unless one surrogate in the level goes to court to seek guardianship over another.

Advance directive documents should be available for review. A patient who has had a previous admission may have a valid power of attorney document in a past medical record. Family members may need to obtain a

document copy from the patient's home, or from the attorney who prepared the documents. Each situation can be very different and risk management can assist you in resolving these types of issues. In the absence of advance directives, trusted surrogates may come forward without documentation (birth certificates, marriage license, etc.). Unless there is reason to challenge the surrogate's word, due to suspicious information or a family is in disagreement, it is appropriate to proceed under the assumption that information provided is valid and legal. There are additional aspects of health care surrogacy that are not addressed in this article. Please read and become familiar with the Advocate Christ Medical Center Health Care Surrogate Policies (01.007.024 and 01.007.010).

Risk Management is a resource department available to staff 24/7 by calling extension 41-RISK or through the page operator.



Exemplary Professional Practice

Magnet Force: Quality of Care:
Ethics; Consultation and Resources

Book Review

The Fault in Our Stars by John Green

Debbie O'Connell, MSN, RN-BC, NEA-BC, director, clinical education

It seems to be a time for young adult (YA) fiction. With the publishing and film success of the "Twilight" and "The Hunger Games" series, more adults are reading this genre. "It provides for the pleasures and consolations they used to get from conventional literary fiction." – TIME. THE

FAULT IN OUR STARS, YA fiction, tells the story of two adolescents who meet in a cancer support group in Indiana.

Hazel Grace is terminal. She describes herself as a grenade; there is nothing she can do about hurting her parents. Her survival is dependent upon experimental chemotherapy from the Republic of Cancervania that is holding her thyroid tumor and chest

metastases at bay. Her life, at 16 years of age, consists of watching America's Next Top Model and attending the Cancer Kid Support Group.

One day a new member, Augustus, attends the support group. Gus has "with a touch of osteosarcoma" and is a terrible driver because of his artificial leg, known as Prosty. Their relationship grows based upon a common obsession with a reclusive author and the book that ends in the middle.

Hazel Grace and Gus are determined to find out the end of the story and THE FAULT IN OUR STARS is an irreverent quest to find the author while dealing with living with cancer. The universal "Will I be loved?" and "Will I be remembered?" take on a new meaning when your odds of five-year survival are 20 percent. "The math kicks in and you figure that's one in five ... so you look around and think, as any healthy person would, I gotta outlast four of these bastards."

I read this book because my 26-year-old son called me to tell me he "just read the best book of his life." John Green's novel is melancholy, sweet, funny and beautiful. Readers describe this book as heart breaking and life changing. I think so too.

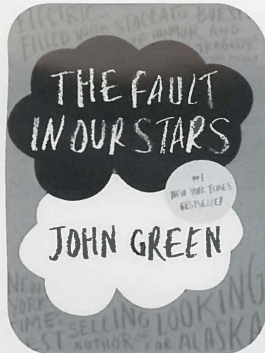
"When you go into the ER, one of the first things they ask you to do is rate your pain on a scale of one to ten,

and from there they decide which drugs to use and how quickly to use them. I'd been asked this question hundreds of times over the years, and I remember once early on when I couldn't get my breath and it felt like my chest was on fire, flames licking the inside of my ribs fighting for a way to burn out of my body, my parents took me to the ER. The nurse asked me about the pain, and I couldn't even speak, so I held up nine fingers.

Later, after they'd given me something, the nurse came in and she was kind of stroking my head while she took my blood pressure and said, "You know how I know you're a fighter? You called a ten a nine."

But that wasn't quite right. I called it a nine because I was saving my ten."

John Green, THE FAULT IN OUR STARS



Structural Empowerment

Magnet Force: Image of Nursing

A Tale of Two Nurses ... Can You Guess Who is Who?

Bonnie Blevins, MS, RN, APN, Heart and Vascular Institute and Cindy Spicka, BSN, RN, ONC, nurse clinician, Midwest Orthopaedic Consultants

Chances are you have spotted the two of us in the hospital rounding with our respective surgeons. We are frequently mistaken for one another, maybe because we look a lot alike. Or could it be possibly because we both have worked for cardiology groups in the past and have recently transitioned to work with surgeons within the past five years?

Bonnie Blevins, MS, RN, APN, began working at Advocate Christ Medical Center in 1995 in cardiology after obtaining her MS from Governors State University. She then joined Consultants in Electrophysiology working for over 12 years as their NP. Currently, Bonnie is an

advanced practice nurse (APN) working for the Heart and Vascular Institute at Christ Medical Center. She assists Drs. Ellenby, Govostis, Kang and Pradhan in caring for the vascular patients on their service.

Cindy Spicka, BSN, RN, ONC, nurse clinician, began her career at Christ Medical Center in 1988 in the neuro ICU, having graduated from the Evangelical School of Nursing in 1985. She was employed by MidAmerica Cardiovascular for eight years before joining Midwest Orthopaedic Consultants as a nurse clinician. Cindy currently works with Drs. Branovacki, Lim, Perez-Sanz, Redondo and Troy, and is responsible for the care of the orthopaedic clients on their service. She is

currently attending Governors State University (just like Bonnie) and will graduate in 2013 as an APN.

Throughout the years, doctors and nurses alike have approached us almost on a weekly basis asking Bonnie how she likes ortho and asking Cindy how to contact the vascular surgeons. As comical as it might sound, it happens all the time. Whenever we would get together we would laugh about it, and have even thought about having t-shirts made saying "I am not vascular" and "I am not ortho." All kidding aside, we will not be offended if you continue to mistake us for one another. Just do not ask Bonnie to look at your sore ankle or broken finger.



Bonnie Blevins, MS, RN, APN, and and Cindy Spicka, BSN, RN, ONC.



Exemplary Professional Practice

Magnet Force: Professional Models of Care

National Nurses Week 2012 Celebration

Nurses Week 2012 was celebrated with a variety of activities and events. These included the Magnet Celebration and Awards, the historical uniform fashion show as well as introduction of the new uniforms, the annual Joyce Woytek dinner and award presentation and the certification luncheon. Please enjoy this Nurses Week collage of pictures commemorating a remarkable week.





Performance Improvement

Alcohol Withdrawal in the Hospitalized Patient

Margaret Steinmetz, MS, RN, nurse clinician III, medical intensive cardiac care unit

If you are a nurse working at a bedside, it is probably no surprise to you that we are seeing an increase in patients who while admitted for other reasons, go through alcohol withdrawal during their inpatient stay. Without proper treatment, alcohol withdrawal can spiral into a dangerous situation for both the patient and the staff caring for the patient. The problem is already huge and is getting worse. There are many social issues that contribute to the increase such as a poor economy, and a high unemployment rate but alcoholism crosses all economic and social lines. Approximately 8 million people in the United States are alcohol dependent (defined as 7 to 14 drinks per week). The incidence of patients with alcohol withdrawal syndrome is projected to be nearly 2 million per year, with an estimated annual cost of over \$100 billion for medical treatment.

With over 8 million alcoholics in the United States, excessive alcohol consumption is the third leading preventable cause of death in the United States. There are approximately 500,000 episodes of alcohol withdrawal requiring medication to treat per year. Alcohol withdrawal carries a mortality rate of 15 percent but decreases to five percent with early recognition and appropriate treatment. Some reports suggest that at least 25 percent of general medical inpatients have alcohol use disorders. The incidence of patients admitted with alcohol withdrawal syndrome is projected to be 2 million per year.

Alcohol withdrawal symptoms can be minor usually presenting within six hours of the last drink and resolving within 24 to 48 hours. Symptoms of minor alcohol

withdrawal include but are not limited to insomnia, tremors, mild anxiety, gastrointestinal upset, headache, diaphoresis, palpitations and/or anorexia. Severe symptoms, requiring more aggressive pharmacologic therapy, include seizures, alcoholic hallucinosis and delirium tremens. Severe withdrawal symptoms usually occur 48 to 96 hours after the last drink but can occur as soon as two hours after the last drink and last an average of one to five days (although we are seeing more extended time frames for some patients). Delirium tremens can include hallucinations, disorientation, tachycardia, hypertension, low-grade fever, agitation and diaphoresis.

Recognizing the need for better, more consistent treatment for these patients, a group of nurses from the medical intensive cardiac care unit (MICCU) developed an evidence-based set of standing orders to treat patients suffering from alcohol withdrawal. Because the degree of withdrawal severity can vary from mild to severe, two sets of orders were developed and implemented throughout the hospital.

The Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) was identified as the best tool available to determine severity of alcohol withdrawal and to guide therapeutic interventions. Using CIWA, the nurse assesses for alcohol withdrawal symptoms such as nausea and vomiting, tremors, paroxysmal sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, and orientation or clouding of sensorium. Each category is

given a numerical score and then added together for a total CIWA score. Treatment interventions are then based on this score. Evidence-based order sets provide clear guidance when a patient is escalating and include first the use of intravenous (IV) Ativan and then (for severe withdrawal) the use of IV Phenobarbital, continuous Ativan drips and intubation where indicated. In the intensive care unit (ICU), technology such as Bispectral Index (BIS) and End-Tidal CO₂ aide in providing safe and effective treatment for these patients. This aggressive approach to treatment is aimed at early, appropriate intervention to prevent escalation.

During the period a patient is actively withdrawing from alcohol, it is impossible to provide interventions aimed at rehabilitation. To be sure these patients do not "slip through the cracks," the standing orders automatically trigger a consult for the substance abuse liaison that provides resources, at an appropriate time, for when the patient is discharged.

Since the implementation of these standing orders, we have had fewer instances of patient escalation. This is a great example of nurse's identifying a problem and working together to find a solution.

**Exemplary Professional Practice**

Magnet Force: Quality Improvement

Portraits of Excellence

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

**Dorothy Mieczko, RN, pediatric emergency department**

Considered a cheerleader for the pediatric emergency department, Dori is known for her upbeat attitude and positive outlook. She establishes close rapport with her patients and their families and handles crises with professionalism. Community is important to Dori. She visits area nursing homes on a monthly basis and sends packages overseas in a show of support for members of the military.

Angeliza Montgomery, RN, 9 east/west

Considered to be passionate in coaching new nurses and sharing her "best practices, Dixie is porta catheter-certified, certified in the care of left ventricular assist device (LVAD) patients, an LVAD liaison and a tuberculosis liaison. As LVAD liaison, she educates patients and their families about the heart device. Dixie also acts as a health outcomes specialist, tracking incidence of influenza, pneumonia and venous thromboembolism to ensure that these disease are accurately documented and that the appropriate treatments are administered properly. She assists with the discharge and transfer of patients to help lower length of stay and facilitates communication among physicians, nurses, patients and families.

**Lynne Murphy, BSN, RN, emergency department**

Lynne is an example of superior patient care. She takes the time to listen to and interact with patients and their families, provides impassioned care, treats patients' emotional and spiritual needs in addition to their physical problems, and develops the kind of bond that makes patients feel as if they are the only ones there. Both newly hired nurses and experienced staff in the department look to Lynne as an important resource. She supports the team by adjusting her own busy schedule to accommodate others' needs. She is an active member of the unit council and regularly volunteers at her church and her children's school.

Kathy Niemczura, BSN, RN, adult surgical heart unit

Highly respected by co-workers and physicians, Kathy is a preceptor who helped develop the education for progressive mobility in the adult surgical heart unit. She also teaches newer nurses on continuous renal replacement therapy and ventricular assist devices. Kathy has designed numerous tools and posters to highlight key areas of learning and even was invited to take a short trip to educate other professionals about wounds and the untoward impact of immobility on a patient. She is frequently recognized by patients and their families for her compassion and kindness.

**Nana D. Owusu Nyarko, BSN, RN, CCRN, adult surgical heart unit**

A mentor, preceptor and team player, Nana is respected by physicians and colleagues alike. She is recognized for her critical thinking skills and her ability to guide others. She is a member of the educational enrichment team, helping others to train in the use of the unit's high-tech equipment, such as LVADS, intra-aortic balloon pumps and continuous renal therapy devices. Having already completed her certification in critical care, Nana is currently enrolled in a master's degree program to advance her professional skills.

Sarah Pandolfi, BSN, RN, CPN, 4 Hope

Sought out by her peers as a resource for clinical care issues, Sarah functions as a charge nurse, preceptor and mentor to new and current staff on the unit. Her many competencies include work as a diabetic liaison, providing education to families of diabetic patients as well as to nursing staff on the complex care required for diabetic patients; her service as a tuberculosis liaison, tracking all 4-Hope staff members for compliance with year TB tests; and her skills in PAC and PVAT. Additionally, she continues to be a performance improvement collector of data for the unit and is playing an important role in promoting nursing certification and professional practice. She is a member of Advocate's Nurse Advocacy Council and is an Illinois Poison Control educator for 4-Hope.

**Mary Beth Partyka, MSN-C, RN, ANP, pain center**

A nurse for some 20 years at Christ Medical Center, Mary Beth started her career in the PACU before transferring to the pain service where her passion for treating patients in pain flourished. Not satisfied with just the pain service nurses providing safe and effective pain management, she committed herself to providing pain management education to nurses, physicians, pharmacists and resident physicians house wide. To that end, she offers such education at new nurse orientation, gives a four-hour lecture to nursing interns and serves as a preceptor to physician residents, pharmacy residents, attending physicians and nurses as she rounds throughout the hospital.

Colleen Plude, BSN, RNC, neonatal intensive care unit

Charge nurse, preceptor and mentor, Colleen educates the staff on the care of neonatal tracheotomies and partners with an attending physician to teach the use of the neonatal abstinence scale for infants exposed to, or being withdrawn from, narcotics and/or sedation. Certified in neonatal care, Colleen treats some of the most acutely ill infants. Her ability to assess the needs of the infant and the communication needs of the parents helps prevent family frustrations. Colleen also serves as a core S.T.A.B.L.E. instructor.

**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

- Emergency department: Kathy Bowen, ADN, RN, NCIII
- MICCU: Kristin Leshinske: RN, NCIII

Daisy Award

- Tamra Marco, RNC, NCII - NICU
- Heidi Mesa, RN, NCII - 7 West
- Shally Philip, RN, NCII - 8 South

Newly Certified Nurses*Critical Care*

- Central telemetry center: Therese Tew, BSN, RN, CCRN
- MICCU: Ryan Yamat, BSN, RN, CCRN
- SINI: Claudia Craig, BSN, RN, CCRN; and Courtney Pritchard, BSN, RN, CCRN
- 8 east/west: Linda Tidei, ADN, RN, PCCN
- 9 south: Kelly Albertsen, BSN, RN, PCCN; and Ashley Morrison, ADN, RN, PCCN

Emergency Department

- Emergency room: Melissa Didomenico, BSN, RN, CEN; Bridget McNicholas, BSN, RN, CEN; Laura Pratt, RN, CEN; and Kim Ryback, BSN, RN, CEN

Heart and Vascular Institute

- ASHU: Lunette Castillo, BSN, RN, CCRN; and Jamie Natale, BSN, RN, CCRN
- Cardiodiagnostics: Lisa Collins, BSN, RN, CCRN; Deborah Gentile, RN-BC; and Bridget Martin, BSN, RN, CCRN

- Cardiac cath/invasive cardiology: Robert Broderick, ADN, RN, RCES; Lynn Burke, BSN, RN, CVRN; Julie Connolly, BSN, RN, CCRN; Kimberly Foley, BSN, RN, CVRN; Anne Gryczewski, BSN, RN, CVRN; Deborah Rhodes-Mitkas, ADN, RN, CVRN; and Mary Jo Vail, BSN, RN, CVRN

- Heart and vascular quality: Michelle Kristof, BSN, RN, CVRN; and Catherine McAvoy, BSN, RN, CVRN

- SVTU: Krystyne LeRose, BSN, RN, CCRN, NCII; and Allan Magtoto, BSN, RN, CCRN, NCII

Medical/Surgical

- Procedure recovery: Kim Kent, BSN, RN-BC; Kellie Loerop, BSN, RN, PCCN; Elizabeth Neibert, RN, PCCN; and Marilyn Remoto, BSN, RN, PCCN
- 7 west: Brittany Bogs, BSN, RN-BC, ANCC; and Melissa Sartori, BSN, RN-BC, ANCC

Neurosciences Institute

- 8 south: Agata Czubiak, BSN, RN-BC; DeeAnn Foster, BSN, RN-BC; Eileen Ipema, BSN, RN-BC; Kathleen Mast, BSN, RN-BC; Gina Sedlak, BSN, RN-BC; Angela Taylor-Norman, BSN, RN-BC; Toni Tobias, BSN, RN-BC; and April Vinci, BSN, RN-BC

Pediatrics/Hope

- Sandra Clark, MSN, RN, NEA-BC
- 2 Hope: Jennifer Koss, BSN, CPN
- 4 Hope: Deborah Bezler, RN, CPN; Dawn Clesson, BSN, RN, CPN; and Lisa Tejack, BSN, RN, CPN
- NICU: Michaelyn Benedict, BSN, RN, NIC-BC; Angelice Clayton, ADN, RN, NIC-BC; Amy Daly, BSN, RN, NIC-BC; Cherolyn Goodman, ADN, RN, NIC-BC; Virginia Kullerstrand, BSN, RN, NIC-BC; Holly Michaelowski, BSN, RN, NIC-BC; Gertrude Miller, RN, NIC-BC; Mary Murphy, BSN, RN, NIC-BC; Beverly

- Saylor, BSN, RN, NIC-BC; Christine Sterling, ADN, RN, NIC-BC; Nicole Turner, BSN, RN, NIC-BC; Susan Vella, ADN, RN, NIC-BC; and Tracy Vroegh, BSN, RN, NIC-BC

- PICU: Colleen Butler, BSN, RN, CNPT, NCIII

- PSHU: Megan Matlin, RN, CCRN; Joan Musso, RN, MA, CCRN, MCO; and Cindy Yarger, RN, CCRN

Women and Infants Health Services

- 3 east/west: Kristen Fetchko, BSN, RN-BC

Cancer Institute

- Sandy McIntyre, ADN, OCN

Care Management

- Laura Benedict, BSN, RN-BC
- Anita Friel, BSN, RN-BC
- Valerie Grellner, BSN, RN-BC
- Ginny Keaveny, BSN, RN-BC
- Cheryl Mister, BSN, RN-BC
- Debra Romano-Barnes, BSN, RN-BC
- Lori Rovnyak, BSN, RN-BC

Compliant Documentation

- Michelle Gonzalez, BSN, CCDS
- Kathy Johnson, BSN, CCDS

Palliative Care

- Lynn Sevik, RN, CHPN

Degree Completion*Critical Care*

- MICCU: Ryan Yamat, BSN, CCRN

Heart and Vascular

- Cardiology surgery: Lisa Lenzen, MSN, RN
- Heart and vascular Quality: Lisa Wieland, MSN, RN, ANP

Neurosciences Institute

- 6 south rehab: Ralu Mogbo, MSN

Pediatrics/Hope

- NICU: Lauren Graefen, BSN, RN

Cancer Institute

- 3 south: Laura Atton, MA

Clinical Informatics

- Mary Fedor, MSN, RN

Nursing Research - IRB Submission

- *Effects of Music Intervention on Patients Undergoing Colonoscopy*
Principal Investigator: Margaret Ryan, RN, CGRN
Sub Investigators: Sonia George, MSN, RN, ACNS-BC; Mary Lynn Schultz, MSN, RN, ACNS-BC CGRN; Heather Doorhy, BSN, RN, CGRN; Michelle Shaban, BSN, RN, CGRN; Pat Steffek, RN; Debbie McMahon, RN; Elaine White, MS, RN; Sue Delmonte, RN; and Joy Velasco, BSN, PCCN

- *Retrospective Analysis of Efficacy, Survival and Complications in Early Stages of NSCLC Treated with SBRT/Cyberknife*
Principal Investigator: Paul Gordon, MD
Sub Investigators: Basharith Kahn, MD; and Patty Mullenhoff, MS, APN

**Structural Empowerment**

Magnet Force: Image of Nursing



STEPS Case Study

Respiratory Syncytial Virus and a Baby Girl's Will to Live

Kristin J. Coleman, RN, nurse clinician III, pediatric intensive care unit

Patient demographics

FN is a 6-month-old caucasian female twin born prematurely at 26 weeks gestation. FN was positive at birth for intrauterine drug exposure to heroin and cocaine. Biological mother is also bipolar and admits to smoking, using IV drugs, and using cocaine throughout her pregnancy. FN is in Department of Children and Family Services (DCFS) custody living with a foster family who is also caring for the twin, two adopted children, and two children of their own. They also run an in-home day care.

FN spent four months in the neonatal intensive care unit at Lutheran General Hospital (LGH) where she underwent a patent ductus arteriosus ligation. She was discharged from LGH to foster care. She has no known drug allergies and her only home medications were caffeine, poly-vi-sol with iron, and ergocalciferol.

The foster mother took FN to an outside hospital for an increased work of breathing. She was found to have respiratory syncytial virus (RSV) bronchiolitis and transferred by the transport team to 2 Hope. The foster mother later brought the twin sister in who was also admitted to 2 Hope with RSV. FN was on the floor for two days when she was noted to have an increased work of breathing and a decrease in oxygen saturations, resulting in an increase in required oxygen. A chest x-ray was done which revealed a spontaneous pneumothorax. FN was then transferred to the pediatric intensive care unit (PICU) where she was placed on a high flow nasal cannula. A chest tube insertion was performed. FN dropped her heart rate and saturations during insertion, which required intubation and mechanical ventilation. A right subclavian double lumen was inserted for central venous access.

Over the next four days, FN's respiratory condition worsened. Her status had progressed to acute respiratory distress syndrome (ARDS) with progression to respiratory failure. Her oxygen saturations were low and her mechanical ventilation settings were high. She was put in prone positioning and paralyzed to optimize her oxygenation. FN suffered a bradycardic episode as a result of hypoxia, which required manual bagging, chest compressions, epinephrine, and atropine. She was then placed on high frequency oscillating ventilation (HFOV) to maintain her oxygen saturations over 85 percent. Her perfusion was noted to be poor which resulted in a continuous milrinone drip administration.

Nurse-patient relationship

I first cared for FN the day she was admitted to the PICU. I met the foster father first who seemed concerned but distant. I updated him on her condition and offered explanations to the care I was giving to which he appeared overwhelmed. He made a few comments about how he told the foster mother that these twins would be more than she could handle. That first night was the last we saw of the foster father.

FN's twin sister was on 2 Hope still requiring feedings and attention, so the foster mother spent most of her time on the floor that night, however, she did visit FN's room briefly. I introduced myself and updated her of FN's condition and plan of care. She was tearful and concerned, but seemed very overwhelmed by the sight of the tubes. She asked questions that revealed the lack of understanding of the depth of FN's condition. I then took the time to offer her emotional support and explain to her in layman's terms the seriousness of FN's condition and the equipment in use. By educating parents and caregivers about equipment and technology in use, nurses may reduce the stress of caregivers while caring for a child in the PICU (Dunn & Board, 2011).

For the remainder of FN's hospitalization, foster mom

would visit occasionally during the day and I would update her over the phone at night. Consents were obtained through DCFS. Biological mother did come to visit with DCFS once during her hospitalization. Social services was involved with this case as well. After a few nights of taking care of FN, I became more attached to her. I felt a deep empathy for FN, for she had been through a tremendous amount of struggle and instability in her short six months of life. I would often talk to her in a soothing voice, stroke her head, play soothing sounding music for her, and I was able to hold her when all the tubes were removed.

Overview of patient's disease

Pathophysiology

RSV is the most common cause of bronchiolitis and pneumonia among infants and children under one year of age (Villareal, 2008). It is the leading viral cause of death in children less than five years of age. Epidemics usually occur yearly from November to March. FN's admission was in December, so this fell within "RSV season." Eighty percent of RSV bronchiolitis occurs within the first year of life, peaking between two to six months. By two years of age, virtually all children have been infected with RSV at least once (Leung, Kellner, & Davies, 2005). Although all children develop RSV infection, the risk of acquiring this infection is increased by attendance at daycare centers, exposure to environmental pollutants (second hand smoke), having school-aged siblings, living in crowded conditions, multiple birth, having minimal breast feeding, prematurity, male gender and lower socioeconomic status (Todd, Roberg, & Welliver, 2010). Risk factors for developing severe RSV include preterm birth, congenital heart disease, or chronic lung disease. FN has many of the above listed risk factors putting her at high risk for a severe form of RSV and an increased risk of complications. She was born prematurely at 26 weeks gestation, she was not breast fed, her foster mother ran an in-home day care, her foster father smoked, she had school age foster siblings, she lived in a crowded condition, and she was of lower socioeconomic status.

RSV is a medium-sized, membrane-bound RNA virus that infects host cells developing in the cytoplasm of the infected cells and matures by budding from the plasma membrane (Villareal, 2008). RSV belongs to the Paramyxoviridae family within the pneumovirus genus (Leung et al., 2005). The incubation period varies from two to eight days. The illness generally lasts ten to 14 days (Selby, 2008). The virus is spread from respiratory secretions through close contact with infected persons, or contact with contaminated surfaces or objects (Villareal, 2008). The virus is unstable in the environment and is readily inactivated with soap and water and disinfectants.

RSV infection causes inflammation and necrosis of the bronchiolar epithelial cells (Leung et al., 2005). The lumina of the bronchioles become obstructed from edema of the airway wall, increased mucus secretion, sloughed epithelium and cellular debris. Infants are particularly vulnerable to obstruction because their airways are small in diameter (Kelley & Allen, 2007). The bronchiolar obstruction leads to air trapping and hyperinflation. In FN's case, the severe air trapping coupled with her increased work of breathing led to the development of a spontaneous pneumothorax. A pneumothorax is a collection of air in the pleural cavity of the chest between the chest wall and the lung (Roman, 2010).

The first signs of RSV infection are rhinorrhea, pharyngitis, coughing, sneezing and a low-grade fever (Villareal, 2008). After a few days, these manifestations

develop into respiratory distress, particularly tachypnea and dyspnea. Hypoxemia results from ventilation-perfusion mismatch which can lead to respiratory failure and ARDS (Leung et al., 2005). FN suffered from fevers, coughing, and runny nose at home and was brought to the hospital when her work of breathing increased. Two days later, she developed hypoxia, which progressed to ARDS and respiratory failure.

ARDS is a complication to lung injury which produces respiratory failure associated with diffuse alveolar injury and permeability pulmonary edema (Hazinski, 1992). The fluid and collapse of the alveoli impedes the exchange of oxygen and carbon dioxide, which leads to hypoxemia. Progressive pulmonary edema ultimately results in the development of intrapulmonary shunting and hypoxemia that is often unresponsive to oxygen administration. Lung compliance is also reduced. Progressive hypoxemia leads to a decrease in cardiac output. This was the case with FN, which resulted in her being placed on HFOV.

Overview of treatment plan

There is no cure for RSV, so treatment is based on observation and supportive care (Todd et al., 2010). This treatment includes hydration, careful respiratory assessment, monitoring oxygen saturations and administering supplemental oxygen as needed. In addition, suctioning the upper airway and intubation with mechanical ventilation may be needed.

FN's treatment began on the general pediatric floor with oxygen therapy and the administration of bronchodilators. She was made NPO and IV fluids were initiated. Her treatment was focused on treating the symptoms and supportive respiratory care. FN was placed on contact and droplet precautions per infectious disease protocol. RSV is highly contagious and careful isolation protocols should be followed (Leung et al., 2005).

Upon arrival to the PICU, FN was placed on a high flow nasal cannula to maintain her oxygen saturation above 93 percent. The pediatric surgery team was called to the bedside for chest tube insertion. During insertion, FN dropped her saturations and she was bradycardic. She required emergent intubation and mechanical ventilation at that time. Her heart rate returned to normal limits; however, she continued to remain hypoxic with her oxygen saturations in the low 80s. She was rapidly progressing to ARDS. A central venous catheter was inserted into her right subclavian vein for central access. Sterile technique was utilized under the blood stream infection protocol.

To minimize oxygen demands, FN was placed on pharmacological paralysis. Adequate sedation was ensured during paralysis. Paralysis reduces the oxygen consumption by respiratory muscles, which allows for better ventilatory control of the patient (Hazinski, 1992). Prone positioning was attempted to improve the impaired gas exchange caused by ARDS. Prone position improves the matching of ventilation and perfusion which improves oxygenation (Pelosi et al., 1998 as cited by Morrell, 2010). When patients are supine, the alveoli in the back parts of the lungs fill with fluid and collapse. When patients are turned prone, the effect of gravity is reversed and lung tissue is recruited (Burns, 2005).

Upon assessment of peripheral perfusion, FN was noted to have an increased capillary refill time of eight seconds on her lower extremities. Her pulses were weak, her extremities mottled and cool. A continuous Milrinone infusion was started to increase perfusion. Milrinone is an afterload reducer, which has positive inotropic effects and vasodilation effects (Sethuraman, 2008).

See "Respiratory Syncytial Virus," page 14

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Nursing Now

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.



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CareConnection

Emergency Department Welcomes First Net: ED CareConnection

Jeff Redican, RN, CEN, clinical informatics

Hello First Net, good-bye PICIS. Mark your calendars for the official October 3 go-live date, when the emergency department (ED) at Advocate Christ Medical Center will switch over to the Cerner First Net ED CareConnection software system. Presently the ED at Christ Medical Center is the eighth Advocate Health Care site and the fourth Advocate Health Care level I trauma center to operate using the system.

The planning stages for implementation of this system have been ongoing for several years. It has entailed countless hours, and staff members from both Christ Medical Center and Kensington support center. As reported by Anne St. John, RN, senior clinical analyst and ED nurse, "Advocate Health Care's vision includes completion of the electronic medical record from admission to discharge. CareConnection ED extends the existing CareConnection medical record to the emergency department." Some of the key benefits of First Net ED CareConnection include:

- Increased continuity of patient care resulting from having communicating software systems;
- Improved patient waiting times by the identification of activities required in the ED encounter and the ability to highlight potential delays in the ED;
- Ability to support workflow through diagnosis-specific documentation tools; and
- Better accountability of revenue through the generation of more accurate and complete billing.

The system offers important ED tools such as triage and tracking boards that enables staff to rapidly identify the highest acuity patients. The ability to prioritize patient acuity levels enables the ED staff to provide care that is needed immediately, resulting in the best outcomes for the nearly 100,000 patients that are cared for annually in the ED at Christ Medical Center.

According to Joan Kelley, BSN, RN, clinical informatics analyst, nursing staff on the units will no longer have to decipher through lengthy ED documentation to determine if pain medication was administered or the exact time that an antibiotic was given. "The documentation in the First Net system will be able to be readily found in the Care Connection system," says Joan. Technically they are the same with the main difference being the tracking board which is unique to the ED setting. This is a huge win not only for the ED, but for the patients that have come to depend on the ED for the great care that is consistently provided 24-hours-a-day, 7-days-a-week.



New Knowledge, Innovations, and Improvements

Magnet Force: Quality of Care; Quality Improvement

Educational Events

ACLS

EMS Academy 5220 W. 105th St., Oak Lawn
Sept. 6, 8:15 a.m. to 5 p.m., EMS Academy
Oct. 25, 8:15 a.m. to 5 p.m., EMS Academy

ACLS Renewal Course

Sept. 14, 7:30 to 11:30 a.m., 0614
Sept. 14, 12 to 4 p.m., 0614
Nov. 9, 7:30 to 11:30 a.m., 0614
Nov. 9, 12 p.m. to 4 p.m., 0614
Dec. 14, 7:30 to 11:30 a.m., 0614
Dec. 14, 12 to 4 p.m., 0614

ACMC Nursing Research Council Meeting

Sept. 25, 11 a.m. to 12 p.m., 0629A/B
Oct. 23, 11 a.m. to 12 p.m., 0629A/B
Nov. 27, 11 a.m. to 12 p.m., 0629A/B

APN/CPP Council Meeting

Oct. 17, 1 to 2:30 p.m., 0629 A/B
Nov. 21, 1 to 2:30 p.m., 0629 A/B

Basics of LEAN

Sept. 4, 9 to 11 a.m., 0614
Oct. 2, 9 to 11 a.m., 0614
Nov. 6, 9 to 11 a.m., 0614
Dec. 4, 9 to 11 a.m., 0614

Care Management Education

Sept. 20, 1 to 3 p.m., 0636A/B
Oct. 18, 1 to 3 p.m., 0636A/B
Nov. 15, 1 to 3 p.m., 0636A/B
Dec. 20, 1 to 3 p.m., 0636A/B

Clinical Coach Course

Sept. 5, 8 a.m. to 12:30 p.m., CE classroom
Sept. 19, 2 to 6:30 p.m., CE classroom
Oct. 6, 8 a.m. to 12:30 p.m., CE classroom
Oct. 17, 2 to 6:30 p.m., CE classroom
Nov. 14, 8 a.m. to 12:30 p.m., CE classroom
Nov. 28, 2 to 6:30 p.m., CE classroom
Dec. 12, 8 a.m. to 12:30 p.m., CE classroom

Ethics for Lunch

Sept. 28, 12 to 1 p.m., 0629 A/B
Oct. 26, 12 to 1 p.m., 0629 A/B

Magnet Advisory Council

Sept. 25, 9 to 10:00 a.m., 0614
Oct. 23, 9 to 10 a.m., 0614
Nov. 27, 9 to 10 a.m., 0637

Neurovascular Conference

TBA

Nurse Forums

Dec. 20, 7 to 8:30 a.m., 0629 A/B
Dec. 20, 12 to 1:30 p.m., 0629 A/B
Dec. 20, 6 to 7:30 p.m., 0629 A/B

Nursing Grand Rounds - Adult

Sept. 13, 12 to 1 p.m., 0629 A/B
Oct. 16, 12 to 1 p.m., 0629 A/B
Nov. 06, 12 to 1 p.m., 0629 A/B

Nursing Grand Rounds - Pediatrics

Nov. 6, Ped Nursing Conf (all day), Tinley Park Convention Center
Dec. 11, 11 a.m. to 12 p.m., 0629 A/B

Nursing Residency

October 2011 Cohort

- Sept. 28, 7:30 a.m. to 3:30 p.m., 0636

January 2012 Cohort

- Sept. 6, 7 to 11:30 a.m., Clinical Education Dept.
- Oct. 2, 7 to 11:30 a.m., Clinical Education Dept.
- Nov. 1, 7 to 3:30 p.m., Clinical Education Dept.
- Dec. 11, 7 to 3:30 p.m., Clinical Education Dept.

March 2012 Cohort

- Sept. 20, 7 to 11:30 a.m., Clinical Education Dept.
- Oct. 18, 7 to 11:30 a.m., Clinical Education Dept.
- Nov. 13, 7 a.m. to 3:30 p.m., Clinical Education Dept.
- Dec. 19, 7 a.m. to 3:30 p.m., Clinical Education Dept.

June 2012 Cohort

- Sept. 21, 7 to 11:30 a.m., 0629A/B
- Oct. 31, 7 to 11:30 a.m., 0636A/B
- Nov. 29, 7 to 11:30 a.m., 0629A/B

September 2012 Cohort

- Sept. 7, 7 a.m. to 3:30 p.m., Clinical Education Dept.
- Sept. 26, 7 a.m. to 3:30 p.m., Clinical Education Dept.
- Oct. 24, 7 a.m. to 11:30 a.m., Clinical Education Dept.
- Nov. 16, 7 a.m. to 3:30 p.m., Clinical Education Dept.
- Dec. 17, 7 a.m. to 3:30 p.m., Clinical Education Dept.

November/December 2012 Cohort

- Oct. 26, 7 a.m. to 3:30 p.m., 0636
- Nov. 27, 7 a.m. to 3:30 p.m., Clinical Education Dept.

Pediatric Advanced Life Support (PALS)

EMS Academy, 5220 W. 105th St., Oak Lawn
Sept. 21, 8 a.m. to 5:00 p.m., EMS Academy
Oct. 12, 8 a.m. to 5:00 p.m., EMS Academy
Nov. 16, 8 a.m. to 5:00 p.m., EMS Academy

Psychiatric Grand Rounds

Sept. 12, 11 a.m. to 12 p.m., 0613
Oct. 10, TBD, 0613
Nov. 14, TBD, 0613

Professional Clinical Practice Council

Sept. 20, 7:30 a.m. to 4 p.m., 0629 A/B
Nov. 8, 7:30 a.m. to 4 p.m., Hilton Oak Lawn

Preceptor Allied Health

Oct. 22, 8 a.m. to 12:00 p.m., Clinical Education Dept.

Save the Date!

- Sept. 7, Julie Schaffner Research Fellowship
- Sept. 14, In the Midst of Chaos (all day), Tinley Park Convention Center
- Sept. 25, Wound Care Conf (all day), Auditorium
- Sept. 28, Achieving Excellence thru Dept of Ped Conf, Hamburger U
- Oct. 11, Big Issues for Little Patients (all day), Tinley Park Convention Center
- Oct. 12, Joanna Briggs Institute 6th Annual ICEBP Conference, Purdue University Calumet Campus (2 tracts: Basic & Advanced)
- Oct. 18, School Nurse Half Day Conference, 0629 A/B
- Oct. 23, Caring for Survivors of Violence (all day), Auditorium
- Nov. 7, 4th Annual Kidney Transplant Symposium (all day), Auditorium
- Nov. 14, Perinatal Conference-OB day (all day), Oak Lawn Hilton
- Nov. 15, Perinatal Conference-Neonatal day (all day), Oak Lawn Hilton
- Nov. 14-15, Advocate Injury Institute Trauma Conference (2 days), Wyndham, Lisle

Steps Application Deadlines

Sept. 1

Trauma Nurse Specialist Course

Sept. 11 to Nov. 7, Tuesdays and Wednesdays, 8 a.m. to 4 p.m., EMS Academy



Structural Empowerment

Magnet Force: Professional Development

Rehab Programs Receive Certification

The Cardiac Rehab program at High Tech and the Pulmonary Rehabilitation program at Advocate Christ Medical Center met the criteria for American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) program certification. They join the Christ Medical Center Cardiac Rehab department in becoming certified by AACVPR. Becoming certified was a long process of data collection and submitting information on staff competencies, patient health outcomes and satisfaction, cardiac and pulmonary risk reduction, emergency management, individualized plan of care, continuing education for staff development and other required information.

When a cardiac or pulmonary rehab program becomes certified it is an affirmation that cardiac and pulmonary patients in that program receive the highest quality of rehabilitative care. To become certified the programs demonstrated their performance of clinical care according to the most current national guidelines and

evidence based research. This included a review of the physician communication process, improved patient health outcomes and satisfaction, cardiac risk reduction, optimizing pulmonary function, optimal patient education, medical emergency management, individualized plan of care, and continuing education for staff development.

Additional certification benefits include:

- Patients and family members seek programs that are considered the best and the classification of certified helps them decide between programs.
- The essential standards required in certification are becoming recognized by insurance companies as part of performance measurements in patient care.
- AACVPR is the only organization that certifies cardiac and pulmonary rehab programs.

Professional Clinical Practice Council (PCPC) July Meeting Update

Nancy Hernandez, BSN, RN-BC, nurse clinician II, 5 west

On July 19, 2012, the Professional Clinical Practice Council (PCPC)

convened for its quarterly meeting. The PCPC meeting consists of unit council chairs from all clinical units in the hospital, and they strive to enhance decision making, use of evidence-based practice, and collaboration with other disciplines.

At the meeting the certification mandate was discussed. Eligible nurses have until December 31, 2012, to take a certification exam. Frequently asked questions regarding the certification



Deb Desmond promoting PCP Leadership development.

mandate were reviewed. Also, at the meeting it was explained to the members how closely budgets are looked at to keep costs in line. Strategies implemented to help decrease cost include elimination of the weekend program and changes to the 12 hour shift benefits to align what we are doing at Advocate Christ Medical Center with what is happening at other hospitals across Chicagoland.

Additionally, the huge focus on nosocomial infections was discussed. Units are really focusing on clostridium difficile and central line infections. To help tackle these, a new position/opportunity is being created, namely, the infection prevention liaison. This role

is similar to the performance improvement liaison. Basically the nurse in this position will have the responsibility for staff education on the units regarding infection control and prevention and personal protective equipment (PPE) as well as acting as resource person for the unit.

Finally, because patient satisfaction is such a priority, unit chairs reviewed their unit strategies for the key result areas (KRAs) related to noise, physician satisfaction and bedside shift report. The sharing of best practices remains one of the PCPC's highlights enhancing professional growth and development.



Exemplary Professional Practice
Magnet Force: Interdisciplinary Relationships

Respiratory Syncytial Virus

Continued from page 12

The next day, FN suffered from a progressive hypoxia, her oxygen saturations dropped and she went bradycardic. A pediatric code blue was initiated, chest compressions done, and two doses of epinephrine were given. Her heart rate returned to baseline within four minutes. After this episode, her blood gases were poor and her saturations were in the low 80s. The decision was made by the PICU team to place her on high frequency oscillatory ventilation (HFOV) to improve her gas exchange and oxygenation.

HFOV delivers small tidal volumes at fast frequencies to the patient (Morrell, 2010). This reduces the air trapping which is a problem with conventional ventilation in ARDS. The alveoli are stented open and the lung tissue is recruited. A mean airway pressure causes the chest to vibrate or "wiggle" (Burns, 2005).

FN was also started on inhaled nitric oxide (INO) through the oscillator. INO improves oxygenation in patients with ARDS by selective pulmonary vasodilating (Morrell, 2010). It increases oxygen transportation across the walls of the alveoli. She also continued to receive albuterol for bronchodilation every two hours through the HFOV circuit.

Patients on HFOV require heavy sedation and paralytic agents to ensure compliance with the ventilator (Morrell, 2010). FN was on continuous drip infusions of fentanyl (narcotic for pain relief), versed (benzodiazepine for sedation), ketamine (anesthetic for sedation), and vecuronium (for paralyzation). Since FN was paralyzed, she had a bispectral index sedation (BIS) monitor in place to closely assess her sedation level. This is a sensor placed on FN's forehead that transmits electroencephalograph signals to the BIS module where they are processed to provide a direct measure of level of consciousness (Olson, 2004). Our goal for FN was to maintain the BIS monitor in a 40 to 60 range, which was indicative of a moderate hypnotic state. The lower the number the more sedated the patient is. We also assessed train of four (peripheral nerve stimulator) every four hours while she was on the paralytic. The muscle twitch response to the small electrical stimulus delivered by the stimulator corresponds to the degree of nerve receptors blocked by the paralyzing drug, which assists in assessment and titration of medication dosage (Ruggles, 1998).

Patient/family response to disease and treatment

FN remained on HFOV for six days. She was switched back to conventional ventilation when her chest x-rays showed improvement and when she tolerated weaning of the HFOV. She was extubated 13 days later to a nasal cannula and on room air two days after that. She was then transferred back to the general pediatric floor where she continued to recover.

FN received a swallow study while she was on the general pediatric floor which showed she was a risk for

aspiration and she was not ready for oral (PO) feeding yet. The foster mother had to be trained to administer nasogastric feedings to FN. There were questions about whether or not this foster home was the best placement for FN and her sister. They were medically fragile and already at a high risk due to their prematurity. This foster home ran an in-house day care, which exposed FN to multiple viruses. The foster father was uninvolved during the hospitalization, and the foster mother was minimally involved. Social work was involved, her DCFS caseworker was contacted and staffings were done. Despite efforts, FN was returned to the same foster home. She has since been re-hospitalized with viral infections; however, she has not been back to the PICU.

While on the general pediatric floor, FN received physical, occupational and speech therapies. She would make eye contact, smile, and coo when I would visit her on the floor. She liked to be held and she liked her crib mobile. I would always make sure I started her music before I left her room.

FN is at risk for reactive airway disease and asthma in her years to come. The relationship of early childhood respiratory infections such as RSV to the occurrence of asthma has been studied (Sterling & El-Dahr, 2006). It has been suggested that RSV may enhance the development of allergic inflammatory responses when the host is exposed to allergens after an episode of bronchiolitis. Several studies support the association between early life RSV illness and recurrent episodes of wheezing and the development of asthma during the first decade of life (Piedimonte & Perez, 2008).

Personal critique

I was able to take care of FN one-on-one for several night shifts in the PICU. I fell for her from the start. She was such a beautiful baby with blonde hair, blue eyes and round cheeks. She had been through so much in her short six months of life. She was born too early with drugs in her system, she fought for her life in the neonatal intensive care unit for four months, sent out into the foster system for two months, then contracted RSV and was fighting for her life again. FN was alone in the hospital most of the time, so I would make a point to stay in the room with her. I talked to her, touched her and played music for her, even when she was sedated and paralyzed. After she left the PICU, I would visit her often and hold her when she was on the general pediatric floor. I like to think she recognized my voice because she would look at me and smile when I was holding her.

I chose FN for my case study because I was interested in learning more about RSV and ARDS. Although I have taken care of many patients with RSV in the PICU, I have never seen a patient with RSV become as sick as FN was. It was interesting to me that FN was a textbook case of an at-risk infant. It made me sad to know that if FN would have received the Synagis vaccine, she could have avoided this hospitalization. Prevention is the key strategy for controlling RSV. Administration of the immunization is costly and monthly consecutive shots throughout RSV season are required (Mosby, 2004). Not

only is the vaccine important for babies in the at-risk categories, but also good environmental hygiene practices are key to preventing the spread of this virus (Todd et al., 2010). I learned that it is important for me to educate families of these high-risk groups about the dangers of RSV and prevention strategies.

In caring for FN, I learned the importance of caring for the whole person, even when the patient is sedated, paralyzed, and no family members are around. In addition to careful physical assessments and interventions, it is important to talk to, touch, and play music for our sedated patients. In spending time with FN, I learned about an infant's innate will to live. Through great struggle, FN came so far and made such progress, despite being just six months old.

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Clinical Feature

New in the Adult Surgical Heart Unit: The Total Artificial Heart

Christine Sanders, RN, nurse clinician II, adult surgical heart unit

In the adult surgical heart unit (ASHU) at Advocate Christ Medical Center the doctors and nurses work consistently to provide our patients with up-to-date cutting edge treatment to improve patient outcomes and quality of life. Our patient population consists of men and women ages 18-80, who are diagnosed with coronary artery disease, valvular disease, congestive heart failure and cardiomyopathy. Treatments for these patients include medical management and surgical management such as coronary artery bypass, valve repair/replacement, mechanical circulatory support devices and heart transplantation. Recently our institution incorporated a new device, to treat patients who present with severe biventricular failure that are awaiting heart transplantation. This new device is the Syn Cardia's Total Artificial Heart (TAH-t).

The TAH-t is an air driven pulsatile device that is composed of two outflow grafts, two atrial inflow cuffs, one left ventricle, one right ventricle, four prosthetic valves and two air cannulas. The TAH-t is approved by the Food and Drug

Administration (FDA) as a bridge to transplant for patients with biventricular failure and a body surface area (BSA) greater than 1.7. The advantages of TAH-t are absence of dysrhythmias, as the patient has no electrical conductivity post implantation, higher cardiac output, up to 9.5 liters per minute, organ recovery, prevention of right heart complications and generation of pressures high enough to overcome elevated pulmonary artery pressures.

Currently there are two patients on the unit with TAH-t.

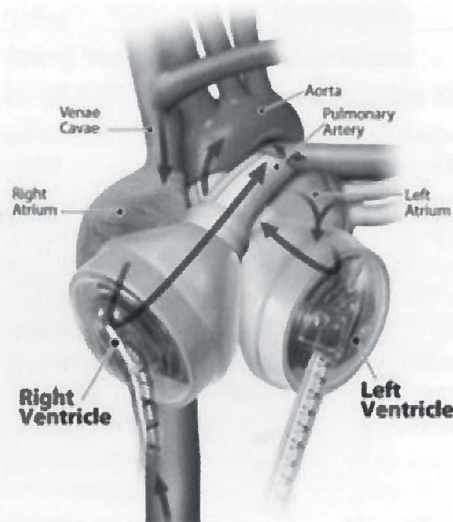
The first patient is a 64-year-old male with heart failure initially on left ventricular assist device (LVAD) therapy who developed post traumatic stress disorder (PTSD) after experiencing multiple defibrillations from his implantable cardiac defibrillator (ICD) for ventricular tachycardia (VT) Storm. His TAH-t was implanted on May 9, 2012. He was off of ventilator support in less than 24 hours and is steadily progressing. His psychological issues have resolved as a result of the TAH-t because there is no electrical conductivity involved in the function of this device. The second patient is a 31-year-old male who's right heart disease was worsening despite medical management and LVAD therapy

he had been on for more than a year. The LVAD was unable to deliver the cardiac output that would support

him based on his BSA and the degree of heart failure he had developed. His TAH-t was implanted May 10, 2012. His course of recovery, while more complicated than our other patient, is progressing as a result of higher cardiac output delivery. Lab results provide evidence that with the TAH-t both his liver and kidney function are improving. Both patients are currently awake and alert in the ASHU, participating in progressive mobility awaiting heart transplantation.

The final phase of treatment will begin once both patients are stable enough to transition home on the freedom driver, the portable controller for the TAH-t. Both patients along with their families will be educated by Ventricular Assist Device (VAD) coordinators and unit nurses' on the care and function of the TAH-t and the freedom driver. They will perform return demonstration at the conclusion of training to ensure safe transition for the patient from the hospital to home to await a donor heart.

The team work that has gone into successfully implementing the TAH-t has illuminated how Christ Medical Center's Heart and Vascular Institute is making a difference one heart at a time.



Exemplary Professional Practice

Magnet Force: Quality of Care

Partnership in Education and Practice

Leadership Students Impacting Care

Kaleigh R. Nolan, senior nursing student, Lewis University

As our nursing matriarch Florence Nightingale once said, "I think one's feelings waste themselves in words; they ought all to be dispelled into actions which bring results." For my final role transition assignment, I was allowed to become part of the nursing team on the adult surgical heart unit (ASHU) at Advocate Christ Medical. As a twice recognized Magnet institution, the unit staff is well-known for offering the highest excellence, quality care, evidenced-based practices and patient safety. The wealth of knowledge and nursing care demonstrated on the unit enhanced my passion for the nursing field. The opportunity to assist in the care of highly acute and complex cardiac patients generated my respect for the environment in which the nurses proudly work. These nurses embraced a holistic care outlook and considered the mind and emotional feelings of their patients, not only the physical body.

During my rotation in ASHU, I was privileged to witness and participate in the holistic care provided by this team of dedicated professionals working with and caring for a patient with an implanted left ventricular assist device (LVAD) and CentriMag who had been waiting for a heart transplant since December 2011. In the majority of similar cases, physicians aim to gradually wean patients from the CentriMag and transition them back into their homes. Unfortunately in my patient's case, he was unable to be successfully weaned and needed to remain hospitalized until a heart became available. In trying to maintain the patient's positive outlook, physical therapists, physicians and nurses alike made it their goal to help the patient travel outside the hospital for fresh air and a change of scenery whenever possible, acting in line with their holistic care approach. With a passion for the outdoors and hobbies which included hunting, motorcycle riding and being an active fisherman, any time outside to be reminded of his life prior to his current health issues was greatly appreciated and treasured by the patient. I was lucky enough to be able to join the patient, his wife, my preceptor Michele, and Krystyna, a fellow ASHU nurse, on one of their walks outside. In order to make the journey outside, a complex process ensued and

each step was explained to me by the patient himself. Each component of his care required attention as the CentriMag machine was watched by one of the nurses, battery packs checked, then connected to the LVAD by the patient, intravenous (IV) poles moved in to coincide with the patient, and a walker and wheelchair were available on standby.

Having to remain in a hospital room with such an active personality took a toll emotionally on my patient. As Florence Nightingale advocated and through lessons I have learned during clinical experiences, positive demeanor help drive positive outcomes. In my patient's case, he had done everything to prepare himself to receive a healthy heart; the hard part was in the wait. Each day came and went as the patient tried to maintain positive thoughts and outlook during this difficult time. As the nurses on the unit noticed his mood decline, efforts to distract him and encourage trips outside for some fresh air during the day offered a quick turn around and generated a clearly visible change in my patient. He voiced how during these trips he felt that there was hope and that things would change for the better.

As my rotation on the ASHU was nearing a close, I came in on a Monday morning and learned the news that on his 100th day on the unit, a heart became available. My patient underwent heart transplant surgery, and in the hours leading up to the procedure, pure excitement radiated from the patient and staff alike. Currently working towards a full recovery and with no signs of rejection, the patient voiced that for the first time since his admission in January, he felt well enough to go home and acknowledged that it was through the attentive and holistic care offered by the staff and physicians alike in ASHU that brought him to this point. The staff in ASHU truly demonstrated the work of Florence Nightingale showing how taking the time to care for a patient extends past medications and charting. Nursing encompasses understanding and learning our patients and helping them believe in recovery.



Structural Empowerment

Magnet Force: Image of Nursing

Surveys

Continued from page 3

Other surveys

Often support departments send surveys to associates in order to evaluate their customer service satisfaction. Many departments including clinical education, Ricoh (print shop), performance improvement and risk management send these annually. Managers are asked to evaluate the student nurse experience.

Soon nursing staff will be asked to participate in the GIAP survey.

Geriatric Institutional Assessment Profile (GIAP)

Definition of survey: It is a self-completed survey for hospital staff (only RNs and ACMs) designed to assess

four institutional parameters:

- Attitudes regarding the institution's care of the older adult patient;
- Knowledge of institutional guidelines for care of the older adult patient;
- Knowledge of best practices for four common geriatric syndromes — sleep disturbances, pressure ulcers, incontinence and use of physical restraints; and
- Perceived institutional strengths and barriers to "best practice" for care of older adults.

Eligibility criteria: RNs and ACMs of inpatient adult units excluding the units on the 2 east/west, labor and delivery and 5 south. The emergency department is also included in the survey.

Date/time frame: July 23 through August 6, 2012, and recommend repeating every two to three years.

How results are communicated: The results will be communicated via presentations at the NICHE (Nurses Improving Care for Healthsystem Elders) Steering Committee meeting, Patient Care Leadership and divisional- or unit-specific if requested. The results will be used as a guide to our journey and to detect improvements/changes post-implementation of the program.



Exemplary Professional Practice

Magnet Force: Quality of Care, Interdisciplinary Relationships

Regulatory

Transition to Least Restrictive Restraints

Ernesto Flores, MT (ASCP), CIC, manager, regulatory compliance

Advocate Christ Medical Center and Hope Children's Hospital will be taking steps to reduce restraint usage and when necessary, utilize the least restrictive restraint. This measure follows guidelines set by the Centers for Medicare and Medicaid Services (CMS) which require that when restraints are utilized that an institution use the least restrictive and effective restraint available. Christ Medical Center and Hope Children's Hospital are increasing the usage of less restrictive types of restraints, such as the roll

belt. Posey vests which are considered a more restrictive type of restraint will have limited availability. The reduction of restraint usage combined with the transition to least restrictive restraints marks just some of the many initiatives currently underway at Christ Medical Center and Hope Children's Hospital to provide a safer environment for our patients.

As always, please feel free to contact Ernesto Flores, regulatory compliance manager at extension 41-5239 or

Irene Tranowski, clinical practice partner, 6 south at extension 41-3374 with questions regarding restraint usage.



Exemplary Professional Practice

Magnet Force: Quality of Care, Patient Safety

National Time Out Day

Charlene McCabe, BS, RN, CNOR, nurse clinician III, clinical practice partner, surgery

This year, National Time Out Day was June 13. This annual awareness campaign began in 2004 by the Association of Perioperative Registered Nurses (AORN) to remind surgical team members to conduct a time out for every patient, every time.

If you have ever spent time in the operating room, you are already familiar with the words the circulating nurse



Pictured from left to right (back row) are David Perout, BSN, RN, nurse clinician II; and Charlene McCabe, BS, RN, CNOR, nurse clinician III; clinical practice partner. In the front are Shannon Laughlin, BSN, RN, nurse clinician II; and Kerri Skora, RN, nurse clinician I

uses to signal the time out. This occurs a few minutes before a procedure begins when the surgical and anesthesia teams review a patient's chart. Creating a standard pre-surgical safety process is part of the National Patient Safety Goals.

- Universal Protocol (UP) requires that hospitals:
 - Verify that all relevant documents, x-rays, lab tests, antibiotic prophylaxis, implants, etc., are available prior to surgery, and that they have been reviewed and are consistent with each other. Surgical teams are required to verify that each member of the team, as well as the patient, is in agreement on the procedure to be conducted and the exact site of that surgery.
 - Clearly mark the incision site in a way that will be visible even once the patient is prepped and draped.
 - Take a "time out" immediately before starting the procedure to perform a final check to make sure that the correct patient is about to undergo the correct procedure, on the correct site, and that the antibiotic prophylaxis, in accordance with Surgical Care Improvement Project (SCIP) protocol, was given within one hour of incision time.

National Time Out Day is a powerful way to support surgical nurses' ability to speak up for safe practices in the

operating room. This annual awareness campaign is consistently supported by The Joint Commission, the World Health Organization, and the Council on Surgical and Perioperative Safety (CSPS) for its ability to increase awareness of safe practices that lead to optimal outcomes for patients undergoing surgery and other invasive procedures.

This year the Operating Room at Christ Medical Center entered a "Time-Out Day" photo contest and received the following response:

Thank you for your photo submission! There were so many great photos and it was a really tough decision. Our winners were already chosen, but your photo was a close runner up! It was such a great photo; we would like to send you a Time Out Day package anyway! We would love to use your photo in our Time Out Day announcement.



Exemplary Professional Practice

Magnet Force: Quality of Care: Patient Safety; Professional Models of Care

Will You Be the Match?

Margaret Steinmetz, MS, RN, nurse clinician III, medical intensive cardiac care unit

Every year thousands of people are diagnosed with leukemia and other blood disorders. Some of these people will require stem cell transplants to save their life. Seven out of 10 patients do not have a match from a relative. Therefore they rely on an unrelated donor. Can you imagine being in this position?

Donating stem cells is a relatively easy process. First, you must get on the donor registry. This involves a simple swab of your mouth and takes less than 10 minutes. Once on the registry, if you come up as a match for someone, you are contacted and consent is obtained to go further. You are given a complete physical to be sure you are in optimal health and it is safe to donate. Once it is determined that you are a healthy match, stem cells can be donated in one of two ways. Most donations involve

peripheral blood cell donation. This involves donating blood through a sterile needle stick in your arm. The blood is then circulated through a machine that separates the needed cells and then returns the rest of the blood through your opposite arm. The other less common way is through bone marrow donation where the liquid marrow is withdrawn from the back of the donor's pelvic bone.

There are more than 9 million potential donors on the donor registry but a shortage of suitable donors still exists, especially among some ethnic groups. Currently, there is a growing need for racially and ethnically diverse donors.

With this very special need in mind, the critical care division is sponsoring a Registry Donor Drive on Friday,

September 7. Representatives from Be the Match, a national marrow donor program, will be located in the lobby next to the gift shop (formerly known as the Discharge Lounge) to help sign you up. They will be there from 7 a.m. to 4 p.m. and will be available to answer questions and obtain buccal swabs. There is no charge to be on the registry or to donate. Potential donors must be in generally good health and be between the ages of 18 and 60. Please join us to see if you can Be the Match for someone.



Structural Empowerment

Magnet Force: Nursing and the Community

In the News

Non-Step Promotions:

- Laura Jester, MSN, RN-BC, ACNS was promoted to advanced practice nurse for surgical OB on 3 east/west.
- Elizabeth Rockwell, BSN, RN-C, nurse clinician II was promoted to assistant clinical manager for surgical OB on 3 east/west.
- Jennifer Cavett, BSN, RN, nurse clinician II was promoted to assistant clinical manager for the medical intensive cardiac care unit.
- Beth Klag, RN, CRRN was promoted to assistant clinical manager of 6 south.

External Awards/Recognition:

- Geanette Barry, BSN, RN-C, nurse clinician III, Kristen Fetchko, BSN, RN-BC, nurse clinician II, Jillian Hellman, BSN, RN-BC, assistant clinical manager and Deb Izzo, BSN, RN-C, nurse clinician II, Surgical OB 3 east/west were nominated for the Joyce Woytek Award.
- Julie Evanish, BSN, RN, PCCN, nurse clinician II, 9 south, was awarded the Christ Medical Center and Hope Children's Hospital Annual Patient Safety Award, March 2012.
- Lorri Arroyo, ADN, RN, 9 south, was nominated for the Joyce Woytek Award, May, 2012.
- Sheila Pepito, BSN, RN, PCCN, nurse clinician II, 9 east/west was the recipient of the Magnet Award for preceptor of the year.
- 9 east/west Falls Committee was nominated for the Magnet Clinical Division Awards.
- Danielle Markham, ADN, RN, nurse clinician II, 9 east/west was nominated for new practitioner at the Magnet Clinical Division Awards.

- Jessica Maier, ADN, RN, nurse clinician II, 9 east/west was nominated for educator at the Magnet Clinical Division Awards.
- Kimberly Shells, BSN, RN, nurse clinician II, and Alison Moran, BSN, RN, nurse clinician II, 9 east/west were nominated for the Joyce Woytek award.
- Lauren De LaTorre, BSN, RN, nurse clinician I, 9 south was nominated for the Daisy Award.

MVP nominations:

- Diane Ward, BSN, RN, registry nurse, pediatric emergency department
- Nancy Dell, ADN, RN, nurse clinician II, 9 east/west
- Alison Moran, BSN, RN, nurse clinician II, 9 east/west.



Structural Empowerment

Magnet Force: Professional Development

CONTACT HOUR EDUCATION

Traumatic Brain Injuries: Not Just Nails in the Head

Lorri McCourt-O'Donnell, MSN, ACNP-BC, CNRN, advance practice nurse, neuroscience institute

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 December 1, 2012.
2. Return the answer forms through in-house mail or fax
MAIL: Clinical Education, Room 1030
FAX: ext. 41-5640

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. 41-4409 or e-mail her at: Sue.Barry@advocatehealth.com

Answers to the 2012 Volume 11, Issue 2 Contact Hour Quiz: "Polypharmacy and the Elderly"

1. Polypharmacy has no official definition, but can be considered as:
 - a. Any number of drugs over seven
 - b. Any number of drugs over three
 - c. Involving only prescription drugs and not OTCs
 - d. **Any combination or number of drugs that can be unnecessary or redundant and defeats the attempt to render the best patient care**
2. The nurse must be cognizant of a patient's potential polypharmacy because:
 - a. **It may be the reason for the patient's admission to the unit or can potentially lead to future adverse events**
 - b. It is difficult to give so many medications
 - c. Polypharmacy prevents the RN from spending more time with the patients
 - d. The RN is worried about the cost of so many drugs
3. Polypharmacy can result in the following:
 - a. One drug (or more) increasing the effect of another drug(s)
 - b. One drug (or more) decreasing the effect of another drug(s)
 - c. Decreased compliance due to increased number of medications
 - d. Toxicity and adverse events leading to hospital admissions and increased length of stay
 - e. **All of the above**
4. As patients age, which of the following is false?
 - a. Increase in number of chronic health conditions
 - b. **Decrease in medication consumption**
 - c. Increase in medication consumption
 - d. Increased incidence of polypharmacy
5. When a physician, RPh, or RN perform a review of medications, which of the following must be considered?
 - a. All prescription drugs
 - b. All OTCs
 - c. All vitamins and alternative medications
 - d. **All of the above**
6. An RN is preparing a patient newly started on amiodarone for discharge. The RN should:
 - a. Only talk about side effects of amiodarone
 - b. Only talk about the drug interactions
 - c. **Discuss the side-effects and potential for drug interactions associated with amiodarone and remind patient to inform his/her other health care professionals about the addition**
 - d. Do not discuss amiodarone at all since it is a benign drug
7. An RN must suspect a medication-related problem in a patient if one of the following develops:
 - a. The patient begins to ask too many drug-related questions
 - b. The patient refuses his meds
 - c. **The patient's current complaint started with an addition or change in prior therapy**
 - d. The patient complains about a change in bowel status
8. Nurse Myrna Byrd looks at the new admit's drug list and notices that the patient is on acid suppression therapy, ferrous sulfate, calcium carbonate, and vitamin B12 tabs. She knows stomach acid is necessary for iron, calcium, and B12 oral absorption. When Dr. Healum Quick arrives on the unit, Nurse Byrd should
 - a. **Ask Dr. Quick about the acid suppression therapy**
 - b. Say nothing unless the pharmacist says ok
 - c. Suggest a dose increase on the iron, calcium, and B12
 - d. Break into song
9. Nurse Helda Hare admits a patient with a lower gastrointestinal bleed. Patient is on clopidogrel (Plavix), and aspirin for a recent cardiac stent placement. Patient is also on escitalopram (Lexapro), and Warfarin (Coumadin). He is also on some alternative medicine drugs — superman tabs for strong bones, lead-the-charge tabs for increased visibility, and Siberian eel tabs to increase his charm. Nurse Hare should:
 - a. Only tell the physician about the aspirin and the clopidogrel (Plavix™)
 - b. Include only the prescription medications when she calls the physician
 - c. Ask the physician if she should hold all of the prescription drugs, but not the alternative medications, since they are not considered "real medications"
 - d. **Call the pharmacy and see if the ingredients in the alternative medications can be identified, since they may interact with the patient's warfarin (Coumadin)**
10. Nurse Great-one on 3 South calls a meeting to discuss the implications of polypharmacy on the patients. They all decide which of the following?
 - a. Polypharmacy makes cost-control difficult
 - b. Polypharmacy is especially dangerous on their unit because of the possible interactions with chemo drugs
 - c. When a sudden problem develops in a chemo patient, polypharmacy makes identifying the cause more difficult
 - d. **All of the above.**

Traumatic Brain Injuries: Not Just Nails in the Head

Volume 11, Issue 3 Contact Hour Quiz

Mary is a 75 year old woman who is normally in good health. She sees her primary care practitioner regularly. Mary presents to the clinic with a chief complaint of "not feeling right" upon further investigation you find Mary is more lethargic than usual and is complaining of headache. She is accompanied by her daughter.

1. What is the most important information you would want to ask Mary or her daughter based upon her presentation?
 - a. When was the last time you ate?
 - b. Have you hit your head lately, i.e. been in a car accident or fallen lately?
 - c. Are you sleeping well at night?
 - d. Are you taking any new medication?

Mary and her daughter reveal to you that she was in a minor motor vehicle accident about three weeks ago and hit her head on the side support of the car. They did not seek treatment as Mary had no complaints at that time.

2. Based upon this information what is the most likely diagnosis?
 - a. Acute Epidural Hematoma
 - b. Hypoglycemia
 - c. Sub Acute Subdural Hematoma
 - d. Alzheimer's Disease
3. As the clinic nurse what test would you anticipate being ordered for Mary?
 - a. CT scan of the head
 - b. Neuropsychiatry consult and testing
 - c. Fasting Blood Sugar
 - d. Physical Therapy

Mary is transferred to the Emergency Department (ED) where she underwent a CT of her head. The CT of her head shows a subdural hematoma. While in the ED Mary becomes even more lethargic, is nauseous and begins vomiting and has pupil changes.

4. As her primary nurse you are aware that this is a sign of?
 - a. Alcohol withdrawals
 - b. Benzodiazepine Overdose
 - c. Increased Intracranial Pressure
 - d. Hypotension

5. As the primary nurse you should anticipate all the following interventions except?
 - a. Intubation for airway protection
 - b. Starting vasopressors for systolic blood pressure of 110
 - c. Neurosurgical consultation
 - d. Preoperative lab work
 - e. Administration of mannitol

Mary further deteriorates and required intubation for airway protection.

6. After her airway and ventilation are secured, as the primary nurse your next intervention should be?
 - a. Allowing her family to see her as she is dying
 - b. Ensuring her systolic blood pressure remains greater than 90 mm Hg
 - c. Placing a nasogastric tube to initiate feeding
 - d. Calling the neurosurgeon for consult
7. Secondary brain injuries are due to the excessive imaging required to treat the primary injuries and avoid litigation.
 - a. True
 - b. False
8. Hyperventilation is the most effective treatment of increased intracranial pressure.
 - a. True
 - b. False
9. Adults over 75-years-old are more likely to survive a head injury since they have more intracranial space secondary to brain atrophy.
 - a. True
 - b. False
10. Once a patient has sustained a TBI they must be prescribed Dilantin and continue to take it for 21 days.
 - a. True
 - b. False

Your Answers

Please submit to Clinical Education

INA CE #:

Traumatic Brain Injuries

1. a. ☐ b. ☐ c. ☐ d. ☐
2. a. ☐ b. ☐ c. ☐ d. ☐
3. a. ☐ b. ☐ c. ☐ d. ☐
4. a. ☐ b. ☐ c. ☐ d. ☐
5. a. ☐ b. ☐ c. ☐ d. ☐ e. ☐
6. a. ☐ b. ☐ c. ☐ d. ☐
7. a. ☐ b. ☐
8. a. ☐ b. ☐
9. a. ☐ b. ☐
10. a. ☐ b. ☐

(Please print clearly)

Time to read and answer questions: _____

Name _____ Credentials _____

Unit/Department _____

Address _____

City _____

State _____ Zip _____

Phone # _____

E-mail _____

Cost Center _____

Evaluation:

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

1. Define the 3 types of TBI. yes ☐ no ☐
2. Describe the initial management of a TBI. yes ☐ no ☐
3. Were the objectives relevant to the goal of this program? yes ☐ no ☐
4. Was the teaching method effective? yes ☐ no ☐
5. Did this offering meet your objectives? yes ☐ no ☐
6. Content was presented without bias of any commercial product or drug. yes ☐ no ☐
7. Additional comments/suggested future topics: _____

Traumatic Brain Injuries: Not Just Nails in the Head

Lorri McCourt-O'Donnell, MSN, ACNP-BC, CNRN, advance practice nurse, neuroscience institute

Background

Traumatic brain injury (TBI) is a leading cause of death and disability in the United States. The numbers are staggering, according to the Centers for Disease Control and Prevention (CDC):

- 1.7 million Americans will sustain a TBI
- 1.365 million seek care in our nation's Emergency Departments (ED)
 - 80 percent being released from the ED
- 275,000 hospitalizations
- 52,000 deaths

TBIs are a contributing factor in 30.5 percent of all injury related deaths. The cost of TBI weighs heavily on our health care system. The direct and indirect cost of TBI in 2000 was estimated at \$60 billion dollars (www.cdc.gov).

Additionally, with the military conflict in the Middle East, TBI has become the hallmark injury of many military veterans. Over 28 percent of Iraqi war veterans were found to have at least a mild TBI while another 12 percent sustained penetrating TBI.

Demographics

The age group with the highest number of TBI-related ED visits, hospitalizations and deaths occur in children less than five, followed by older adolescents 15 to 19, and adults older than 75. Adults 75 and older are more likely to be hospitalized for TBI and die from their injuries. Males sustain a higher incidence of TBI versus females in every age group. Males account for 59 percent of reported TBIs. In the United States, as well as other industrialized countries, TBI is a leading cause of death in children and young adults (www.cdc.gov).

Classification/mechanism of injury

TBI can be classified into three categories; blunt, penetrating and blast injuries.

- Blunt injuries occur with motor vehicle crashes, pedestrian versus automobiles, falls, sports injuries, and assaults.
- Penetrating injuries include gunshot wounds (GSW), stab wounds, and impalement injuries, as well as the occasional nail gun accident.
- Blast injuries are rare in the general population but are seen as the result of warfare.

Falls contributed to 35.2 percent of TBI followed by:

- 17.3 percent motor vehicle accidents
- 16.5 percent being struck by or against (i.e. workplace or sports related)

- 10 percent assaults
- 21 percent other/unknown causes.

Death from TBI occurs mostly from firearms 34.8 percent, followed by motor vehicle related events 31.4 percent, and lastly falls 16.7 percent (www.cdc.gov).

TBI pathophysiology

To better understand the damage that occurs to the brain during an injury, we need to look at the brain and how it is protected. The brain is a very delicate organ weighing about three to four pounds and cushioned by cerebral spinal fluid (CSF). Additionally, there are three layers of protective membranes that encase the brain; the dura, arachnoid and pia mater. The dura is the thick inelastic outer covering, the arachnoid is the thin web like covering, and the pia is the delicate innermost covering of the brain and nerves. The skull is the bony structure that houses and protects the brain and its supportive structures. The intracranial contents are divided in the following manner, 80 percent brain, 10 percent CSF and 10 percent blood products.

Defining TBI

Several organizations from the CDC to the Americans with Disabilities Act have sought to define TBI. Many definitions exist with no universally accepted definition. The prevailing theme in all definitions is an insult to the brain caused by an external force that may or may not result in neurological impairment. Furthermore, TBI's can be then categorized as mild, moderate and severe. The Glasgow Coma Scale (GCS) is one tool clinicians use to determine the severity of the TBI.

A mild TBI can be defined as a patient with a GCS of 13 to 15 in addition to the patient being awake and oriented 30 minutes after the injury. A moderate TBI also holds no generally accepted definition. However, The National Traumatic Coma Data Bank classifies a moderate TBI as a GCS of 9 to 12. Periods of unconsciousness and post traumatic amnesia are additional factors used to differentiate a moderate head injury from a mild or severe head injury.

A severe TBI is classified by a GCS of 3 to 8. Airway, breathing and circulation (ABC's) are often affected with a severe TBI. The airway is affected secondary to a decrease in level of consciousness (LOC) which can lead to impaired breathing patterns and the inability to control secretions. Circulation can be compromised with tachycardia or bradycardia, hypertension or hypotension, widening pulse pressures and respiratory irregularities. The neurological exam is impaired, LOC is altered, pupillary changes may be

seen, motor abilities may be affected and cranial nerves can be compromised all depending on the location of the head injury.

Primary versus secondary injury

The initial impact to the brain results in the primary injury. Initial treatment of the injury is dependent on the type of injury. Injuries can be managed both medically and surgically. The primary injury manifests itself in some of the following injuries:

- Skull Fractures
 - Linear:
 - Associated with mild TBI
 - Depressed:
 - Associated with contusions
 - Greatest incidence of posttraumatic seizures
 - Increase risk of infection secondary to dural disruption
 - Basilar:
 - At the base of the skull
 - Rhinorrhea, otorrhea, hemotympanum
 - Hearing loss
 - Battle sign
- Epidural Hematoma – blood between the dura and the skull
 - Arterial Bleed – middle meningeal artery
 - No underlying parenchymal injury
 - “Talk and die” syndrome
- Subdural Hematoma
 - Acute:
 - Up to 72 hours following injury
 - Subacute:
 - Several days to two to three weeks after injury
 - Chronic:
 - Weeks to months after injury
- Contusion
 - Bruising of the cortex:
 - Temporal, frontal
 - Associated Edema
- GSW or penetrating
- Diffuse
 - Concussion
- Axonal shearing/diffuse axonal injury
 - Angular acceleration/deceleration
 - Axonal shearing, diffuse edema

Secondary injuries are systemic and/or neurological complications that impair the delivery of oxygen and nutrients to undamaged brain cells. While the initial trauma results in damage to the brain tissue that is irreparable, secondary injuries are what health care practitioners aim to prevent. Secondary injuries can occur within minutes or days of the primary injury. Secondary injuries involve metabolic changes that lead to impaired blood flow and oxygenation to neurons, causing anaerobic metabolism and cellular acidosis leading to cytotoxic edema and breakdown of the blood brain barrier. These injuries cause an

inflammatory response that eventually leads to cellular excitotoxicity and neuronal death.

This cerebral death march can be manifested by an increase in intracranial pressure (ICP) and a decrease in cerebral perfusion pressure (CPP). Intracranial pressure is the continual balance of brain, blood and CSF. Normal ICP is between 0 and 15 mm Hg. Intracranial hypertension is defined as an ICP reading of greater than 20 mm Hg lasting longer than five minutes. CPP is the pressure gradient required to drive blood flow to the brain and is used to determine adequacy of cerebral blood flow (CBF). CPP is measured by subtracting mean arterial pressure (MAP) from ICP ($MAP - ICP = CPP$). Normal CPP is around 80 mm Hg. Global ischemia can occur with a CPP less than 60 mm Hg.

ICP is measured by the placement of a cerebral pressure monitoring device. There are many different devices used to measure ICP. However, the gold standard is the placement of an external ventriculostomy catheter or drain (EVD) this allows for monitoring of ICP as well as draining of CSF. The EVD is placed aseptically at the bedside or in the operating room (OR) by a neurosurgeon. The catheter is placed in the anterior horn of the lateral ventricle of the non-dominant hemisphere. The catheter is then leveled at foramen of Monro, and transduced to the appropriate device for a wave form and ICP measurement.

Initial nursing management of a patient with a severe TBI

Initial assessment of the patient who sustained a severe head injury should be completed in a stepwise approach. The ABCD acronym is one systematic approach.

- Airway
 - Patent airway management and proper oxygenation should be secured.
- Breathing
 - Effective breathing patterns should be maintained via mechanical ventilation or supplemental oxygen
 - Keep SPO2 greater than 90 percent
- Circulation
 - Hypotension should be avoided, keep systolic blood pressure (BP) greater than 90 mmHg
 - Isotonic intravenous solutions should be used
- Disability or Neuro Exam
 - LOC
 - GCS
 - Pupils

The mechanism of action can be a useful in determining the potential severity of a head injury as well as other potential injuries that could impair cerebral function. Neuroimaging is ordered once the patient is stabilized to determine the nature and extent of an injury. Additional imaging is

generally at the discretion of the practitioner managing the patient. Often repeat imaging is performed 12 to 24 hours after the initial image.

Ongoing neurological assessments of the patient who sustained a TBI are critical. Worsening secondary injury can often be seen by a rise in ICP and a subsequent fall in CPP. Preserving CPP and managing elevated ICP is the foundation of TBI treatment. Since the skull is a rigid container that houses the brain, blood and CSF any increase in intracranial contents can result in elevated ICP and compromised CPP. The Monroe-Kelly doctrine implies if there is an increase in one component of intracranial contents then there must be a reduction in the other. The Brain Trauma Foundation has established guidelines based on extensive research to guide care for the patient who has sustained a TBI.

In most head injuries the initial neurological assessment is repeated hourly until the patient returns to baseline or until the patient's condition stabilizes and the practitioner orders a change in exam frequency. The neuro exam should be repeated more frequently if there is any deviation from the initial exam. Nurses should be alerted to 'red flags' such as a worsening headache, confusion, nausea and vomiting. Additionally, nurses should be aware of changes in the neuro exam including decreased LOC, pupillary changes, motor weakness, slurred speech and seizure activity. Any of these 'red flags' warrants an immediate call to the practitioner managing the patient.

Managing the severe TBI patient occurs most often in a critical care setting. These patients may require mechanical ventilation and continual monitoring of vital signs to deal with any physiological changes than may impair cerebral perfusion. Managing oxygenation levels at greater than 90 percent, keeping systolic BP at greater than 90 mmHg, and serial neurological exams are basic primary components of caring for the TBI patient. Placement of an EVD to control ICP requires specialized nursing care often found in the critical care setting.

Managing ICP, according to the Brain Trauma Foundation, improves outcomes of the TBI patient. ICP treatment should begin when the ICP reaches 20 mm Hg. Therapies to manage ICP are aimed at restoring the equilibrium of the intracranial contents. Surgical decompression is one option used to restore the balance. A craniotomy is a surgical procedure where the neurosurgeon removes the skull and subsequently removes the blood, tumor or foreign body causing pressure on the brain. The skull is then replaced, skin closed and the patient is transferred to the intensive care unit (ICU) for postoperative care. A craniectomy is another surgical procedure in which the skull is removed. A craniectomy allows the brain to swell without causing additional pressure on the brain that leads to herniation. A cranioplasty is the surgical procedure that allows for the replacement of the skull. A cranioplasty is performed once

the patient has recovered from the initial injury. Prior to the cranioplasty a helmet should be used to protect the brain while the patient is out of bed.

Level II recommendations

Level II recommendations for the medical management of increased ICP include simple interventions like keeping the head midline in a neutral position with the head of bed at 30 degrees. Draining CSF with an EVD has also been found to decrease ICP. Drainage of CSF can vary depending on institute protocols, and can range from continuous drainage to a set amount per hour. ICP was reduced 10 percent from baseline for around 10 minutes with as little as three ml of CSF drained (Kerr, Weber, et al, 2001).

In the past hyperventilation was routinely used to manage ICP. However, hyperventilation can result in cerebral vasospasm and reduced cerebral blood flow. Maintaining PaCO₂ at 25 mm Hg is the goal in the first 24 hours following a TBI. Hyperventilation can be considered as a tempering measure to reduce ICP prior to any surgical interventions, allowing the PaCO₂ to climb between 30 to 35 percent for a brief period while surgery is being arranged.

Sedation plays an important role in preventing increases in ICP during routine nursing interventions like endotracheal suctioning, repositioning, and other bedside procedures. Agitation and coughing additionally raise ICP. Ensuring proper sedation will prevent increases in ICP during required nursing interventions. Short acting agents like propofol are preferred as they allow the practitioner to complete needed neuro exams.

Mannitol is an osmotic diuretic that can be used to decrease ICP. Effective dose ranges for mannitol are 0.25 to 1 gram per kilogram. Mannitol can be infused as a one time bolus dose, a targeted dose during periods of increased ICP, and scheduled around the clock. Mannitol can cause an increase in serum sodium and serum osmolarity and labs must be closely monitored. Laboratory measures of electrolytes are usually drawn every six hours with the mannitol being held for serum osmolarity greater than 320 mOsm/L (Brain Trauma Foundation, 2007).

Seizures are a secondary injury that can be prevented and are a Level II recommendation. Seizures cause an increase in metabolic demand and neurotransmitter release. Seizures are most likely to occur within seven days of injury but can occur later. Anticonvulsants are used to prevent seizure in the acute phase when the brain is most vulnerable. Dilantin is often given as a loading dose then as a scheduled dose. Anticonvulsants are given for seven days as prolonged use has shown no long term benefits (Brain Trauma Foundation, et al., 2007).

Level III recommendations

Hyperglycemia is a potential complication for the TBI patient. Treating glucose levels at 110 mg/dl has lead to lower

mean and maximum ICP when compared to patients whose glucose levels were allowed to rise and were only treated at levels greater than 220 mg/dl (Van Beek, Schoonheydt et al, 2005). Caution should be used to avoid hypoglycemia as glucose is the primary source of energy for the brain. Further research is needed to determine the appropriate blood glucose levels for TBI patients.

Hyperthermia is detrimental to the patient with a TBI. Approximately 68 percent of patients with a TBI will experience a fever within 72 hours. In the stroke population hyperthermia in the first 24 hours carries a 78 percent mortality rate compared to two percent in the normothermic patient (Castillo, et al, 1994). Several studies have looked at the relationship between increased ICP and hyperthermia and found a correlation. However, there are several limitations in the studies mostly being small sample size. While this is a Level II recommendation, further research is needed.

Refractory Intracranial Hypertension

A small percentage, about 10 percent, of patients with TBI will be refractory to any interventions to reduce ICP. Ongoing research is being aimed at new ways of managing ICP in this population. Moderate hypothermia, core temp range 33 to 36 degrees Celsius, is one method. In 2008, the Brain Trauma Foundation issued cautions in inducing hypothermia. Hypothermia carries significant complications, including, pneumonia, electrolyte abnormalities, shivering and cardiac arrhythmias. The ICU nurse needs to be diligent in monitoring the patient for such potential complications.

Hypertonic saline is another modality used to decrease ICP. The exact mechanism of action is unknown; however hypertonic saline reduces brain water through dehydration in undamaged tissue. Several studies have looked at differing concentration of hypertonic saline from two percent up to 23.4 percent and have reported favorable outcomes (Qureshi & Suarez, 2000). However caution is needed as the majority of these studies were plagued by small sample sizes. The Brain Trauma Foundation cautions the use of hypertonic saline.

Maintain adequate CPP. The optimal CPP for the TBI patient remains unanswered. A CPP greater than 70 mm Hg and less than 50 mm Hg should be avoided. Extremes of greater than 10 percent from baseline should also be avoided. In general a CPP of 60 is thought to be adequate to maintain perfusion. Using vasopressors and fluid boluses to manage CPP should be done with caution. There are many pulmonary and systemic complications with the use of both.

Further research is needed to determine which vasopressors and at what amounts are considered safe and effective at managing CPP (Brain Trauma Foundation, 2007).

Conclusion

Like most disease processes, prevention is the key in TBI. Encouraging seatbelt use, proper driving speeds, not driving distracted can have the potential to reduce serious head injuries in motor vehicle collisions by 50 percent. Wearing helmets while riding a motorcycle can reduce your risk of dying from a head injury by 50 percent. Wearing helmets while riding a bicycle can reduce your risk of a head injury by 85 percent. Every dollar spent on bicycle helmets saves two dollars in health care costs (Brain Trauma Foundation, 2007). Educating the elderly regarding falls and home safety, like removing throw rugs and using proper lighting can reduce their risks of falling. Proper helmets for athletes of all ages and proper recognition of concussion symptoms can prevent re-injury and worsening or recurring symptoms.

Caring for the patient who has sustained a TBI is a delicate balancing act. Nurses can see a BP change through an arterial line or cuff pressure, a potential heart arrhythmia through an EKG tracing, but there is no device used to monitor neurological function. A good neurological exam and good nursing care is the foundation for caring for any patient with any neurological diagnosis, including TBI. Nurses are key players in the prevention, recognition and treatment of TBI.

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