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ADVOCATE EXPERIENCE


Advocate
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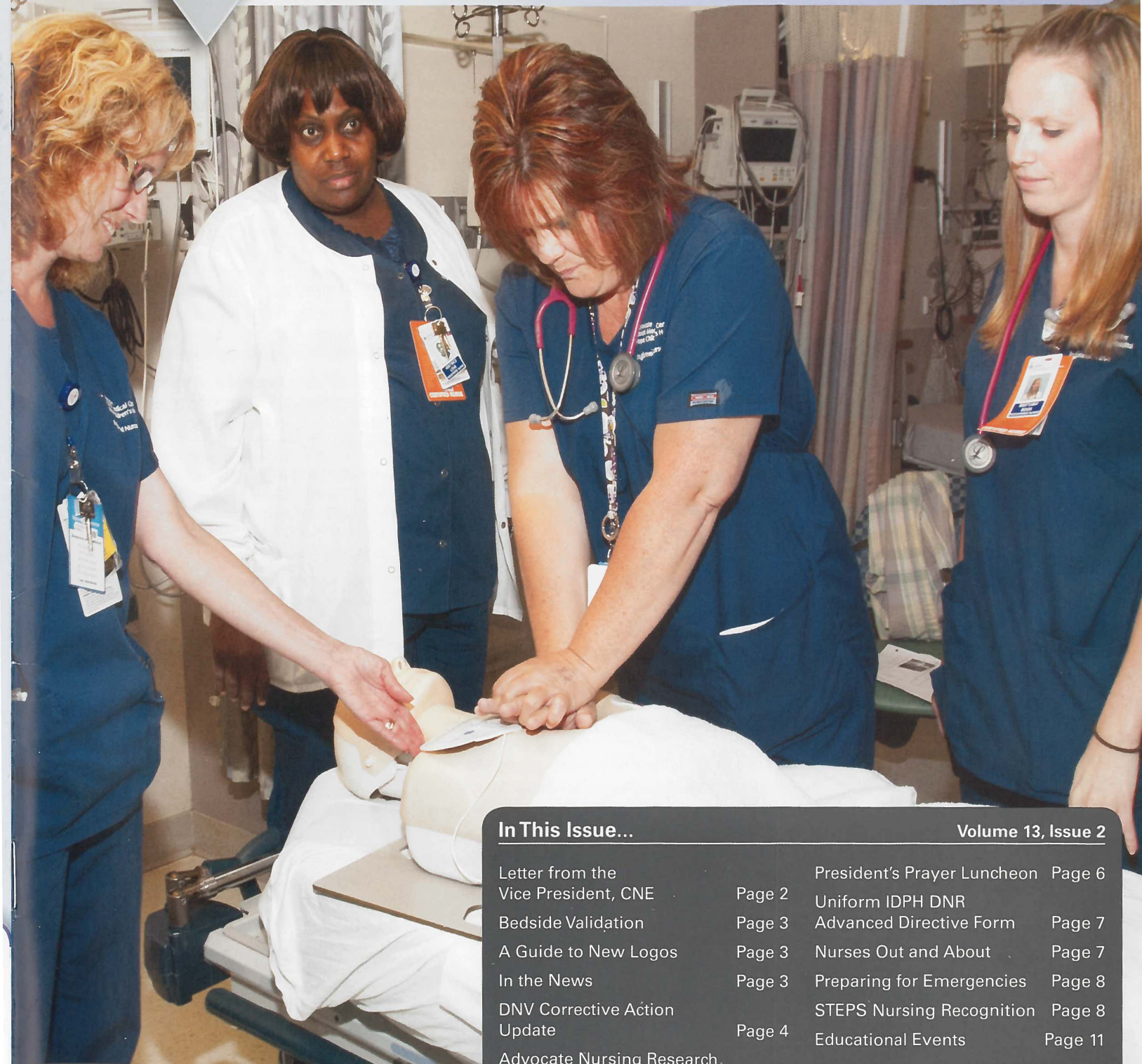
AdvocateCare

 Advocate
Christ Medical Center

 Advocate
Children's Hospital

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

Nurse's Notes



On the Cover

Pictured from Left to Right: Kathy Kamba, BSN, RN, CCRN, manager, central telemetry center; Ventrice Love, BSN, RN, nurse clinician II, procedure center; Gina Crowhurst BSN, RN, assistant clinical manager, procedure recovery; and Brittany Boggs, BSN, RN-BC, 5 west.

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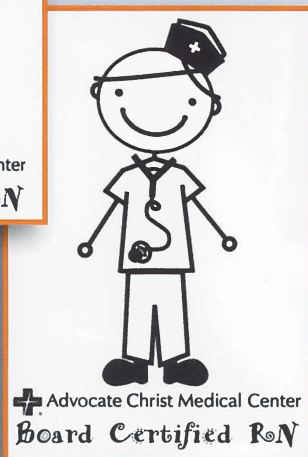
From the Desk of Lynn...

Lynn Hennessy, MS, MBA, RN, NEA-BC, vice president, chief nurse executive



So many exciting things have happened at ACMC and ACH-OL since we last distributed *Nurse's Notes* back in March: **Colleen Butler, RN, C-NPT**, won the regional GEM (Giving Excellence Meaning) award for Home, Community, and Ambulatory Care from Nurse.com and was recognized at the GEM Award Gala on May 10th; **Mike Wilkins** came on board as our new chief operating officer, proving a great partner to nursing; and **Susan Campbell, DNP, RN**, was named senior vice president and chief nursing officer of the system, the first ever in the history of Advocate and a huge win for nursing!

Also, our **board certification** deadline passed. Our 1st Quarter 2013 data shows over 60% of our nursing staff is board certified, up from 40% in the 4th Quarter of 2012! The numbers aren't solidified yet, but many more of you obtained certification in the 2nd Quarter of 2013. This is **tremendous!** All board certified nurses are welcome to stop by my office in administration, show your **orange** badge, and pick up a car decal as shown in the picture (AHC-OL version available too!) so you can toot your own horn!



As **construction** of our **Outpatient Pavilion** continues, demolition of the attached parking tower marks the start of construction for our **new and anxiously awaited and anticipated Patient Tower!** A patient tower that will house two 36 bed ICUs and a long-awaited home for Women and Infants which will hold 36 post-partum rooms, 8 high risk anti-partum rooms, 4 operating rooms, 4 PACU ante-partum beds and 15 Labor and Delivery suites.

Hopefully everyone took advantage of and enjoyed all the celebrations during **Nurse's Week** in early May.

Our **Magnet recertification** submission is in its final phase. All of your tremendous work is documented and soon will be on its way to our Magnet surveyors for our current recertification submission. Thanks to all of you for making it easy to find extraordinary skill, events, and outcomes to report!

Just this quarter, we have had so many accomplishments—too many to list—and we have much to look forward to in the future. I am thrilled to be part of such an amazing organization and to take this journey with all of you.

By now, your manager has shared your unit-level **spring associate satisfaction survey results** with you. Congratulations to those units and departments that are in high Tier Two territory and all of those who have made Tier One! I hope your satisfaction remains positive and that it spreads to other areas. If your unit was one of the units in Tier Three or a low Tier Two, please know that I am very committed to promoting a healthy

work environment, and I hope to work with you to improve your satisfaction.

Continued sources of frustration for many of you in the department of nursing revolve around job security, the increased scrutiny of staffing to need, hiatus of the ACE program, elimination of the weekend program, mandated certification, and the uniform require-

ment, to name a few. Today, healthcare is an extremely difficult and tumultuous environment to work in.

We have put many strategies in place to improve our work environment regarding the issues you have identified and **will** continue to develop plans with your input. However, we cannot go into the future blindly: cost management is and will continue to be a key strategy for every healthcare organization in order to remain viable. With these efforts comes a need for effective management of

our resources and we must work together to understand and effectively manage changes to our organization for the future.

We are in the business of caring for people. As your chief nurse executive, I am in the business of caring for you. I am committed to working with you to improve your satisfaction, and I need your help to get there.

In the last edition of *Nurses Notes*, I spoke of "respect," one of our Behaviors of Excellence (BOEs). This edition, I am committing to being "responsive," another of Advocate's BOEs—responsive to your needs. I believe communication is the key. To improve communications and keep my finger on the pulse of what matters to you, I am scheduling regular meetings for staff, managers and directors.

I will conduct **forums** every other month and rotate times between mornings, mid-day and late evening so associates from all shifts have the opportunity to attend.

I hope to see you there. I have also committed to meeting with the clinical managers bi-monthly, the assistant managers quarterly, and the PCPC Council, and I will continue to regularly round.

When you see me in these coming months, whether at a forum or in the halls, I hope you feel that you can approach me with ideas for improvement and concerns you may have. You can always call me at 41-4079, make an appointment to come and see me, or email me at lynn.hennessy@advocatehealth.com. And don't forget, when you see me, show me your **orange** "certified nurse" hang tag, and I will give you your car decal!

We will work together to improve our work environment. We've achieved so many positive things together, and I truly look forward to achieving much more with you in the years to come.

Be Responsive -

Listen and respect needs with kindness, patience and respect.

Bedside Validation for Central Line Associated Blood Stream Infection (CLABSI)

Sue Heslop, BSN, RN, CCRN, TNS

manager, surgical vascular thoracic intensive care unit

LEARN Model:
Environment



New Knowledge,
Innovations & Improvements

Nurses' ability to practice is constantly challenged by changes in research, policy, patient acuity, time constraints, and requirements of regulatory agencies. Confronted with these increasing demands on nursing to validate competency on high-priority issues, as well as in areas of high risk, the CLABSI team developed a plan to verify competency by using an observed performance format or bedside validation. The CLABSI team leadership collaborated with their in house experts – the vascular access device (VAD) team, and created a tool to examine bedside practice. The purpose of the tool is to allow the nurse a written resource summarizing the most current evidence-based best practice and

policy updates regarding the care and maintenance of central access devices, and to serve as a checklist to validate competency. This will be a culture change, but it will provide another layer of safety for the patients, ensuring consistency of their practice. As there is movement away from traditional classroom education to evaluation of actual skills, the CLABSI team leadership hopes to see an improvement in outcomes.

The first phase of training included the front line leaders and APNs/educators on all the in-patient units. They are prepared to begin the individualized coaching/mentoring, at the bedside, as they validate the nurse's skill and competency

for all aspects of central line care and maintenance. Returning the nurse validation process back to the bedside will allow for an interactive method of learning while hard wiring best practices. This prototype has been successfully used to ensure consistency in practice and to validate skills for other high profile competencies. The team is excited to embark on this format of education as we move towards a zero CLABSI rate!

Please be apprised that this method of validation is currently active. See your APN/educator when you have your next patient with a central line in order to complete the bedside validation process.



A Guide to New Logos

The Editorial Board of Nurse's Notes will link the articles in the newsletter to the Advocate Experience, Magnet recognition and the Professional Practice Model. We are using logos to make this connection.

Features will be denoted with one of the three colored triangles (Advocate Experience, Access and Affordability, AdvocateCare) to the left of the feature title to note the link to the Advocate Experience. To the right of the feature title will be the new Magnet logo with designation of the applicable Magnet component (Transformational Leadership; Structural Empowerment; Exemplary Professional Practice; New Knowledge, Innovations, and Improvements; Empirical Quality Outcomes). Additionally, there will be reference to the Professional Practice Model or LEARN Model.

- LEARN is based on the nursing theory "Novice to Expert" by Patricia Benner which has stayed consistent since 2000.
- LEARN stands for:
 - **L**eadership
 - **E**nvironment
 - **A**utonomy
 - **R**esearch
 - **N**ovice to Expert
- Whichever letter of the LEARN Model that is the feature emphasis will be in bold with what it stands for underneath in bold, for example: **LEARN** Model Environment.

Thank you from the Editorial Board

In the News

Non-STEP Promotions:

- Kimberly Duback, BSN, RN, CPN, clinical practice partner, keyser center
- Tammy Klapp, BSN, RN, CPN, manager of clinical operations, keyser center
- Edythe Pettenger, BSN, RN, IBCLE, neonatal intensive care unit was promoted to lactation consultant
- Elise Madeck, APN, MS, CPNP, pediatric intensive care unit was promoted to advanced practice nurse

Presentations:

- American Society of Peri Anesthesia Nurses 32nd National Conference was held in Chicago, Illinois at the Chicago Hilton on April 14th – 18th. Team Leader, Bonnie McGreal, RN and Jackie Murauski, MSN, RN, APN, CNS, CCRN, CPAN did a poster presentation on The Journey of Improving Patient Satisfaction. Team Leader Maggie Colabunono, BSN, RN, CPAN, CAPA and Jackie Murauski, MSN, RN, ANP, CNS, CCRN, CPAN did a poster presentation entitled the CPAN CAPA Certification Journey.
- Members of the pediatric/neonatal transport team presented "Pediatric Case Studies" to EMS Region VII first responders. The presentation was offered at Bedford Park, Burbank, Chicago Ridge, Oak Lawn Fire Department and at Advocate Christ Medical Center

External Awards/Recognition:

- Colleen Butler, BSN, RN, C-NPT, nurse clinician III, neonatal-pediatric transport team, ACH-OL, was selected as a regional finalist and then was selected as a national finalist for the GEM - Giving Excellence Meaning award in the category of Home, Community and Ambulatory Care
- Neonatal intensive care unit's unit council coordinated a team for the March of Dimes - Walk America on April 28th, 2013 with approximately 50 walkers raising \$10,000.

MVP Nominations:

- Mary C. Clark, MA, BSN, RN-BC Manager of Care Management for Partnership
- Maureen Sheehy, BSN, RN-BC Coordinator of Care Management for Stewardship
- Katherine Erk RN, BSN, nurse clinician II, 9 east/west for Partnership
- Vicki Regnier RN, ADN, nurse clinician II, 9 east/west for Compassion

DNV Corrective Action Update

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

LEARN Model:
Environment



New Knowledge,
Innovations & Improvements

Our initial Det Norske Veritas (DNV) survey based on the National Integrated Accreditation for Healthcare Organizations (NIAHO) standards was an extremely positive and rewarding experience. The surveyors that participated in the five day survey were consultative and found many "best practices" that were considered noteworthy. A thorough approach to evaluate our patient care processes identified several non-conformities. A total of 18 non-conformities (NC 1 and NC2) were identified during the survey process. Leaders throughout the hospital were assigned the responsibility for developing a corrective action plan, associate education and quality metrics that will be used to determine the efficacy of the corrective action plan. These plans were developed with the major tenets of DNV in mind, continual improvement, consistency, customer (patient) satisfaction. Below you will find additional information regarding some of the NC1 findings and the corrective action plans that have been developed, specifically, advance directives, restraints, and temperature monitoring.

The DNV findings uncovered a lack of staff knowledge in the following areas related to advance directives: The process for notifying the patient of this right at their first encounter and the process for documenting the most current information in the medical record. An advance directive is a written documented statement made while a patient, over 18 years old, has decision-making capacity regarding who should make health care decisions if the patient loses that capacity, and/or treatment(s) the patient wishes to receive or forgo in the future if it becomes impossible to make those wishes known. An advance directive is necessary when undergoing testing or procedures that could have an adverse outcome, it is not necessary for simple procedures such as routine blood draws or a chest x-ray. Federal law requires that patients are told of their right to make an advance directive when receiving care at a health care facility. The policy for Advance Directives, #01.007.001, has recently been revised to provide direction and clarification on the process for providing a patient with additional information pertaining to advance directives or helping to create an advance directive. Clinical staff should be familiar with the locations where advance directive information can be documented.

Patient Access/Registration completes an advance directive inquiry form on any patient registered for services in either, the emergency department, interventional

radiology, ECT or the GI Lab.

Cardiac Catheterization Lab inquires about advance directives in a pre-procedure call to the patient, and documents the information on the paper procedure record.

Day Surgery inquires and documents in CareConnection ad hoc on the advance directives power form.

Inpatient nursing units should document in CareConnection on the advance directives power form.

Spiritual Care follows up with patients/families if either "copy exists, not on chart" or "patient wants to complete advance directive or receive information" is checked in Care Connection. These tasks are automatically generated and sent to spiritual care via CareConnection. If more immediate assistance is required staff should call 41-5175 or page the on-call chaplain. Spiritual care will document their interactions with a patient under the advance directive power form. If and/or when a patient or their family member provides an advance directive it should be documented in Care Connection with a new advance directive power form. A copy of the advanced directive should be placed under the red tab in the medical record and the appropriate box should be checked.

Restraints were cited as NC 1 due to inconsistent documentation of assessment/reassessment, physician orders for restraint and renewal not within appropriate timeframes, reason for restraint lacked patient specific behavior and lack of data aggregation and analysis for required elements. Corrective action plans have been developed by key stakeholders from the restraint committee which has been expanded to include a restraint champion from each clinical inpatient unit. These individuals will be responsible for calculating, reviewing and reporting the quality metrics for restraints to their monthly division meetings. The Advocate system CareConnection team is exploring the possibility of expanding the drop down menu to include the most common behaviors that would necessitate the use of restraints. Also, all clinical directors will be responsible for reporting trends to the quality management oversight committee of restraint utilization along with an action plan when a clinical area does not meet National Database of Nursing Quality Indicators (NDNQI) benchmark data.

Temperature monitoring was identified by the surveyors to be a process that was in

place but extremely inconsistent and fragmented. During the course of the DNV survey incomplete records were identified for medication refrigerators, nourishment refrigerators, and fluid warmers. In clinical areas no records for nourishment freezers existed. For those areas responsible for monitoring the temperature of a device previously listed, it was found that the corrective action documented was also incomplete.

A new temperature log was created for refrigerators, freezers and warmers that provide additional clarity and when completed appropriately would be in compliance with DNV NIAHO standards. Some other key changes included:

- Assigning responsibility to an appropriate person to monitor and record the temperature
- Revising the Advocate Christ Medical Center policies providing guidance on temperature monitoring to include the newly designed temperature logs and a process flow map
- Forwarding to each division administrative assistant on a monthly basis, the temperature logs for fluid warmers, contrast warmers, medication refrigerators, nourishment freezers and nourishment refrigerators
- Investigating the use of technology to allow for an electronic monitoring system to continuously record temperatures for patient medications, refrigerated patient food and frozen patient food outside of the dietary department. This technology will promptly notify our telecommunications department that is staffed 24 hours /day, 7 days/week, if one of these devices is out of range and the location of the device.

Education was assigned to appropriate clinicians throughout Advocate Christ Medical Center and Advocate Children's Hospital -Oak Lawn regarding the corrective actions previously described. The education has been assigned through the Advocate Learning Exchange (ALEX) and provides a comprehensive PowerPoint presentation that was presented to leadership at the Patient Care Leadership held in May 2013. Upon completion of the house-wide education, the department of regulatory compliance will be performing validation audits to verify that staff have a working knowledge of the corrective actions and that the processes have been instituted. ▼

Advocate Nursing Research Symposium: Collaborating to Advance the Profession

Cheryl Lefaiver, PhD, RN, CCRP

LEARN Model:
Research

New Knowledge,
Innovations & Improvements



The Advocate Health Care Nursing Research Council successfully collaborated to advance the profession during the First Annual Advocate Nursing Research Symposium on April 9, 2013. With over 200 attendees, the atmosphere buzzed with excitement for learning and networking. The morning sessions included presentations by two nationally recognized keynote speakers: Carol Boston Fleischhauer, MSN, RN, JD and Sheila Hass, PhD, RN, FAAN who provided tangible actions to translate evidence into practice at the bedside. The afternoon breakout session provided educational opportunities related to interdisciplinary collaboration, effective mentoring, using an evidence-based practice model and using technology for translational research. The scientific interactive poster session provided an excellent opportunity for networking and learning. This year 39 scientific posters displayed excellent projects from 22 organizations throughout the Chicago land area. Our own nurses from Advocate Christ Medical Center and Advocate Children's Hospital-Oak Lawn presented 10 of the posters or presentations and work from throughout Advocate Health Care was well represented with an additional 14 posters. Evaluations from the event were overwhelming positive, 97 percent of respondents felt they would take away at least one thing from this session that will change your approach to evidence-based practice or nursing research. When asked what attendees would change in their practice one respondent stated "That we have to "do" research to implement EBP and not Hope." ▼

4th Quarter Daisy Award Winners

Donna Marzullo, BSN, RN, nurse clinician II – 5 west

Donna provides exemplary care to each and every one of her patients, while maintaining her ever present smile. Donna always goes above and beyond to meet her patients' needs. During the Christmas holidays, Donna and her daughter made each patient in the unit a fleece blanket. There were a few left over from the day that she passed them out, so she saved those to give to the patients on Christmas night. Donna delivered each blanket herself to the patients. The patients were very grateful that Donna took time out of her busy schedule and thought of them while they were in the hospital during the holidays. She is seen as a mentor by other staff nurses and is also always willing to precept nurses new to the organization.

Lisa Thomas-Craft, BSN/RRT, nurse clinician II, adult surgical heart unit

Daisy nomination submitted by a family member of a patient. Lisa is a jewel! She is one of the most precious gems that Advocate Christ Hospital is privileged to have. My sister is was a patient in the ASHU. She had a VAD implanted and Lisa was her nurse the afternoon she was brought up from surgery. From the first meeting, Lisa's professional, caring manner gave my family immediate ease that she would be in good hands. Lisa meticulously charted a plan for my sister, monitoring and caring for her healing. Lisa gave my sister what she needed...inspiration! She encouraged, coached, and supported my sister ALL day! Lisa made my sister believe that she could and would be better! My sister told me, "She believes in me like you do!"

Without a doubt, Lisa is a competent and thorough professional and has the craft and mechanics of nursing completely handled. But what makes her extraordinary is the personal care and extra mile she goes with her patients. This hospital is very fortunate to have such a caring professional on its staff, but not as blessed as we were to have her as our nurse!

Cheryl Hill, RN, ADN, nurse clinician II, pediatric intensive care unit

Cheryl is the type of nurse that exemplifies compassion and excellence in her field. She is often called upon to care for patients and families with extremely delicate situations, because her caring nature offers comfort in times of despair. Most recently, Cheryl accepted a special challenge- to care for the child of a co-worker. During this time, Cheryl was a true advocate for the patient and family. Cheryl was always up to date on this child's plan of care and made sure that all of her caregivers were too. She started a cookbook fundraiser for the patient's family to help with their medical expenses.

The family requested her day after day and thanked her constantly for being such an angel. When this child passed away, Cheryl comforted the family and helped them to grieve. The patient's dad referred to her as "a second mom", and said that they would never forget how she cared for them all. Cheryl offers an admirable style of nursing that makes it an honor and a pleasure to work with her.

3rd Quarter, 2012 Daisy Nominees

Geneva Schaffer, Radiology PCC; Lea Good, 6EW; Kathy O'Kane, Clinical Bed Management; Kari Sullivan, 7 West; Kathleen Browne, Imaging Center PCC; Jenny Henke, 3EW; Anastasia Pytlewski, SINI; Veronica Gonzales, 7 East; Nancy Brasic, 5 East; Annette Zaborski, 9 South; Stefanie Powers, 6 South; Heidi Cramer, 6 South; Karyn, Oncology; Nursing Staff, Oncology



Advocate Implements Leadership Daily Safety Huddles

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

LEARN Model:
Environment



Exemplary Professional Practice

Advocate Health Care is committed to making the organization a safe place for patients to heal and for staff and physicians to practice. The next step in our safety journey is the implementation of leadership daily safety huddles. The daily huddles (also called "daily check-ins") are designed to promote a culture of safety putting safety at the core of everything we do. The huddle is intended to share situational awareness (*what is going on and how we can plan our day*), heightened risk awareness; provide early identification and resolution of problems, and increase transparency and accountability for safety. The Advocate Christ Medical Center and Advocate Children's Hospital-Oak Lawn daily huddles are attended by directors, physicians, and senior leadership in a face to face forum and led by presidents Ken Lukhard and Mike Farrell respectively. Managers are also in attendance by phone. Huddles are brief, lasting no longer than 15 minutes, start on time, always end on time and focus on ensuring exceptional patient care and error prevention.

Huddles make talking about safety easier and dialogue about how we are at risk, how we can reduce our risk, and how we can support each other and increase transparency.

Huddles:

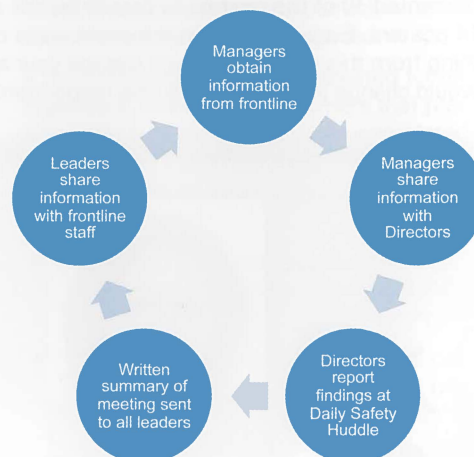
1. LOOK BACK – Significant safety or quality issues from the last 24 hours/last shift
2. LOOK AHEAD – Anticipated safety or quality issues in next 24 hours/next shift
3. Follow up on Start-the-Clock Safety Critical issues

Examples of items which are included in the huddle are:

- Days since last serious safety event
- Good Catches
- Injuries to patients or staff
- Very critical patients, especially one moving between departments
- Same name patients
- Assessment or treatment delays or deficiencies
- Incidents of VAP, CLABSI, or Falls
- Medication errors/shortages
- Exposures to infectious disease
- Social safety issue – involving patients, family members, employees and others

- Maintenance – equipment incidents (CT scan outages)
- Computer issues
- New products or processes
- Environmental or Food Services

Daily Huddle process:



We encourage frontline staff to be aware of issues that may impact patient or staff safety and report these issues to your leadership team. Safety concerns and good catches should always be reported in the Midas Patient Safety Database. ▼

President's Prayer Luncheon

Joanne Mazurski, education data management coordinator, clinical education

On Thursday, May 2, 2013, Pat Williams was the guest speaker at the annual President's Prayer luncheon. Pat Williams is the Senior Vice President of the NBA's Orlando Magic and a motivational and inspirational speaker. Pat and his wife, Ruth, have 19 children – fourteen were adopted from four foreign countries.

In January of 2011, Pat was diagnosed with multiple myeloma. He shared with us his thoughts on living with a terminal illness and what strategies made all the difference.

- He has an optimistic spirit and positive approach. Being hopeful and enthusiastic about life comes in handy when facing difficulties.
- He is a man of faith. When a crisis hits, we can either say, Lord, you let me down or you can do a swan dive into the Lord's lap and put your arms around his neck and hang on for dear life.

- The love and support of family is very important. Cling tightly to your family now. Make sure your marriage is strong – work hard at it. Build solid relationships with your children. When the tough times hit, there is nothing like family rallying around you.
- At your place of work, build strong relationships. You spend more time with the people at work than you do with any other area in your life. They will be there to support you.
- Volunteer your time in the areas that you have a passion for, areas that can make a difference in another person's life. These are areas outside work and beyond your family.

Above all, Pat reminds us that in the middle of a crisis, the anchor of the Lord will hold during the storm. Where are you at right now? There are 3 positions to be in:

1. You just came out of a storm,
2. You are in a storm, or
3. A storm is in your future.

How will you deal with the storm?
Be prepared.



LEARN Model:
Environment



Exemplary Professional Practice

What You Need to Know About the New Uniform IDPH DNR Advanced Directive Form

Fran Flynn, MS, APRN, BC-CNS, advanced practice nurse, palliative care

LEARN Model:
Environment



New Knowledge,
Innovations & Improvements

The new Illinois form for DNR has been revised to meet national standards for **physician orders for life sustaining treatment (POLST)**. The new form is referred to as the POLST form and replaces the previous Illinois Department of Public Health (IDPH) DNR form. The structure of the POLST form helps to communicate patient's wishes more specifically and does a better job guiding and documenting informed conversations about patient wishes based on their goals for care in their current health state. A significant difference between the POLST form and the previous IDPH DNR form is that the POLST form can be used to communicate patient wishes for patient who DO want cardiopulmonary resuscitation (CPR) as well as those who DO NOT want CPR. In addition to documenting whether or not the patient wishes to receive CPR, it is structured to address three broad levels of medical care based on aggressiveness of medical interventions:

1. Comfort care only
2. Basic medical treatment [generally not including life sustaining technology and avoiding intensive care unit (ICU) admission]
3. Life support measures (including intubation, mechanical ventilation and ICU management).

In addition, the POLST form addresses patients' wishes regarding artificial nutrition (tube feedings).

As with the old form, the POLST form is a signed medical order for documenting a seriously ill patient's wishes for a variety of life-sustaining treatments. It should travel with the patient to assure that the patient's treatment preferences are honored across all health care settings including the home. The form is signed by 1) the patient or their representative, 2) a witness and 3) the attending physician. The witness should be over 18 years of age and should NOT be a direct care provider, power of attorney (POA) or surrogate decision-maker. If based on the physician's judgment, the patient lacks decisional capacity; the form can be signed by the patient's POA for health care or surrogate decision-maker (usually next of kin). Health care providers are required by law to honor treatment choices documented on the POLST form and are protected from liability if they follow the directives in good faith. Below are a few tips for nurses about the POLST form:

- When patients enter the hospital with a completed POLST form, it is important to read it CAREFULLY to understand the patient's specific wishes that may range from do everything to comfort care only.
- If a limitation of emergency treatment (LET) order is being initiated during the

patient's hospital stay and the patient or their representative wants these orders to be continued OUTSIDE the hospital setting REGARDLESS of the patient's disposition (e.g. home, extended care facility, etc.), the POLST form should be completed along with the LET form and a copy placed in the medical record under the *Advanced Directive* tab

A new POLST form should be completed whenever a patient's wishes for advanced directives change and the old form should be voided by placing a strike through the document and writing the word void on it and placing it back into the medical record. For questions about the POLST form, you may contact Fran Flynn, MS, APRN, BC-CNS, palliative care (41-4299), Lynn Sevik, BSN, RN, CHPN, palliative care nurse (41-8117), Dr. Kozickyj, Medical Director Palliative Care Service or seek assistance from a representative from Mission and Spiritual Care department (41-5175).

For more information on the POLST form and initiative, go to nursing online or:

<http://www.idph.state.il.us/public/books/advin.htm>

<http://www.ceocc.info/resource-links/physician-order-for-life-sustaining-treatment-polst>

<http://www.polst.org/>



Nurses Out and About – Rehabilitation Nursing Conference 2012

Diane LaPorta, BSN, CRRN and Irene Tranowski, MSN, CRRN

The 38th Annual Education Conference for Rehabilitation Nursing was held October 3-6, 2012 in Nashville, Tennessee. The focus "Rehabilitation Nursing and the Compassion of Caring: Notes to Success" began with the keynote session "Endeavor to Succeed" by Captain Mark Kelly, retired astronaut and husband of Congresswoman Gabrielle Giffords. Captain Kelly's inspirational session focused on his role as an astronaut and the obstacles he faced in life. He discussed the importance of safety, checking and double checking before a mission, completing checklists and aborting missions when necessary. He compared the importance of getting it right for his missions and getting it right in

health care and how it impacts the whole team. Upon closing, he did discuss his wife's rehabilitation and the caring role her nurses and therapists had in her recovery. Other sessions included clinical topics including brain injury, spinal cord and stroke. Fall prevention, pressure ulcer staging, documentation, FIM scoring, research, compassion and current fiscal challenges in health care were also addressed. Along with the speakers there were 70 poster presentations on different topics related to rehabilitation nursing. Irene Tranowski, MSN, CRRN and clinical practice partner (CPP) on 6 south did a paper presentation "Lateral Violence: Where is the Compassion?" Diane LaPorta, BSN, CRRN and

manager of the rehabilitation admissions department on 6 south presented a poster "The Compassion of Caring=The DAISY award" describing what the DAISY award is and how we recognize nurses at Advocate Christ Medical Center and the Children's Hospital for their compassion. The conference was also attended by three staff nurses from the rehabilitation unit. The conference was both inspirational as a rehabilitation nurse and educational. Those attending were able to bring back valuable information to share with their peers as educational materials, tools to improve documentation and facilitate our mission of providing compassion in our care. ▼

LEARN Model:
Research



Structural Empowerment

Simulation Training for Mock Codes: Preparing for Emergencies

Christina Oko, MSN, RN, clinical practice partner 5 west

LEARN Model:
Novice to Expert



Exemplary Professional Practice

Simulation mock code blue training is essential for adequate preparation of patients during a true emergency situation. Mock codes help nurses to feel more confident and comfortable when encountering a real life emergency situation. Even a stable patient's condition can deteriorate, resulting in the need for immediate intervention. When these situations do occur, nurses need to be prepared in order to increase the number of positive patient outcomes. Research shows that early interventions, such as chest compressions, and early defibrillation leads to better patient outcomes. Before the code team arrives, nurses need to have the defibrillator pads on the patient and chest compressions started, that way, if the patient does need to receive a shock, the code team can deliver it immediately after arrival.

Mock codes are being provided in the simulation laboratory (lab) or on the various units throughout the hospital depending on where

there was an empty bed. Mock codes are completed in a non-threatening environment, which enables the nurses to ask questions as needed. Implementation of mock codes throughout the organization requires a multi-disciplinary approach from the nurses, the trainers, medical residents, managers, educators, code team, and the respiratory therapy department. Mock codes performed on the floor utilizing residents and respiratory therapists, just as if it were a real code blue. Residents are given the opportunity to "run" a code blue and take charge of the situation. The chief resident (previously Dr. Quadri) will then provide a debriefing session to the residents, but it has proved to be beneficial to the nurses as well. Depending on the unit one works on determines if mock codes is one of their competencies for the year. The purpose of this program is to increase education and awareness about what to do during a real emergency situation and to increase

the number of positive patient outcomes.

The staff that has participated has liked the mock code training. Some of the feedback includes: "Mock codes should be performed at least twice a year," "Very beneficial for all nurses, whether experienced or a new graduate," "I wish they would have had something like this when I first started," and "The mock codes in the simulation lab have been excellent." In addition to the training, the nurses are also given an opportunity to ask Kathy Kamba, manager of clinical operations, central telemetry center, questions they have in regards to rapid responses or code situations. The nurses have also been giving positive feedback for the opportunity to ask Kathy questions.

If you are interested in more information about mock codes, please contact Kathy Kamba or Christina Oko. ▼

STEPS Promotions, Certifications and Research Recognized

LEARN Model:
Novice to Expert



Structural Empowerment

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 STEP's Promotions

CHF

Bernadine Brennan, BSN, RN, CCRN, NCIII

Invasive Cardiology

Wendy Ambrose-Gavin, BSN, MBA, NCIII

Neonatal Pediatric Transport Team

Karen Termuende, ADN, CCRN, NCIII

NICU

Rachel Bulthis, BSN, NIC-BC, NCIII

Joanne Stein, BSN, NIC-BC, NCIII

OP Infusion

Tracy McCarthy, NCIII

Pediatric Emergency Department

Amy Krupa, BSN, CPEN, TNS, ENPC, NCIII

Dorothy Mleczo, RN, CPEN, TNCC, ENPC, NCIII

PACU

Marvie Favila, BSN, RN, NCIII

Alicia Trevino, RN, CPAN, NCIII

PICU

Jennifer Hein, ADN, CCRN, NCIII

Whitney Tardi, BSN, CCRN, NCIII



Procedure Center

Margaret Ryan, BSN, NCIII

Venous Access

Cheryl Wilson, BSN, VA-BC, NCIII

4 East/West

Lauren Lestarczyk, BSN, RN, NCIII

4 Hope

Lauren Fishback, BSN, RN, CPN, NCIII

8 South

Lea Mae Shea, ADN, RN, NCIII



Daisy Award

Lisa Thomas Craft, BSN, RRT

Cheryl Hill, ADN, RN

Donna Marzullo, BSN, RN, NCII

Continued on next page

Nursing Recognition *continued*

Newly Certified Nurses

Central Telemetry Center

Ruth Allaway, RN, BS, CCRN
Elizabeth Neville, BSN, RN, CCRN

CDU

Tamara Boll, MSN, RN, PCCA, PCCN

MICCU

Cheryl Barnes-Reynolds, BSN, RN, CCRN
Heather Hughes, BSN, RN, CCRN
Kelly Keating, BSN, RN, CCRN
Trisha Kupczyk, BSN, RN, CCRN
Lindsay Leonard, BSN, RN, CCRN
Mavic Madrangca, BSN, RN, CCRN

SINI

Shari Borchardt, BSN, RN, CCRN
Christopher Doherty, RN, CCRN
Michelle Gryczewski, RN, CCRN
Nancy Sorensen, BSN, RN, CCRN
Elizabeth Wilson, ADN, RN, CCRN
Maggie Worby, BSN, RN, CCRN
Dana Eccles, ADN, RN, CNRN

8 East/West

Wendy Fischer, MSN, BSN, RN, PCCN
Laura Lopez, BSN, RN, PCCN
Joy Montilla, BSN, RN, PCCN
Cara Naegele, ADN, RN, PCCN
Jamie Partyka, BSN, RN, PCCN
Julie Realengo, BSN, RN, PCCN
Alexandra Rigor, BSN, RN, PCCN

9 South

Ericka Halloway, ADN, RN, PCCN
Michelle Throw, BSN, RN, PCCN



Emergency Department

Nancy Kelly, BSN, CEN

Heart & Vascular Institute

ASHU

Rachel Belino, BSN, CCRN

Cardiac Rehab

Mary Curran, BSN, CV-BC
Jennie Papa, BSN, MA, CV-BC
Lynne Schipma, BSN, CV-BC
Donna Schmeltzer, ADN, BS, CV-BC
Elizabeth Valen, BSN, CV-BC

Invasive Cardiology

Carol Lopez, ADN, CVRN
Thomas Meenan, ADN, RN, CVRN

SVTU

Emilia Stoia, RN, PCCN

9 East/West

Nancy Dell, ADN, PCCN
Kimberly Hickey, BSN, PCCN
Alison Moran, BSN, PCCN
Angeliza Montgomery, BSN, PCCN, NCIII
Kimberly Tenison, ADN, PCCN



Medical Surgical/PSAS/Procedure Center

Mike Moonan, RN, MBA, NEA-BC

4 East/West

Karen Babich, RN-BC
Barbara Frieling, CNRN, ACM, RN-BC
Jen Howe, BSN, ACM, RN-BC
Gwen Winding, RN-BC
Nick Michalko, RN-BC
Stephanie Miller, RN-BC
Debra Nevin, BSN, RN-BC
Lola Olusanya, RN-BC
Janet Villarreal, RN-BC

5 East

Susan Kimes, BSN, RN-BC
Michele Katz-McGowen, RN-BC
Reynald Requierme, BSN, RN-BC

5 South

Arlen Bonadurer, RN-BC
Randy Ciger, BSN, RN-BC
Barbara Soderstrom, BSN, RN-BC

7 East

Therese Brown, RN, VA-BC
Kristin Casarez, RN-BC
Kelli Yenter, RN-BC

Procedure Center

Deborah Devito, RN, CGRN
Kathy Janicki, BSN, CGRN
Heidi Hall, BSN, RN-BC
Patricia Hasten, RN, RN-BC
Cynthia Stapleton, RN, RN-BC
Patricia Wyrobek, BSN, RN-BC



Neurosciences Institute/Bone & Joint Institute

EEG/Pain Management

Eileen Burnson, BSN, RN, RN-BC
Linda Jabs-Carrarini, RN, BS, RN-BC

6 East/West

Kelly Cahall, BSN, RN, ONC
Rema Taupo, BSN, RN, ONC

8 South

Michelle Franklin, BS, RN-BC, ANCC



Surgical Services

Day Surgery

Barbara Bourke, BSN, RN, CAPA
Mary Pat Favia, BSN, RN, CAPA
Yvonne Gabryel, RN, CAPA
Marlene Grendzinski, RN, CAPA
Ruth Henrichs, RN, MS, CAPA
Margaret Higgins, BSN, RN, CAPA
Patti Jo Imhoff, RN, CAPA
Lynda Powers, BSN, RN, CAPA



Continued on next page

Nursing Recognition *continued*

Surgical Services (cont.)

PACU

Michael Gricus, BSN, RN, CPAN
Joy Lindahl, RN, CPAN
Linda Mlinarcik, RN, CPAN
Lynn Mitchell, RN, CPAN
Kevin Mooth, BSN, RN, CPAN
Susan Shinnick, BSN, RN, CPAN



Surgery

Joanne DeYoung, BSN, CNOR
Vicky Frenz, BSN, CNOR
Margaret Higgins, BSN, CNOR
Chris Iffland, BSN, CNOR
Nancy Jeffrey, BSN, CNOR
Susan Koelbl, Diploma, CNOR
Jennifer Lovitt, BSN, CNOR
Michele Meiner, MSN, CNOR
Teresa Protich, BSN, CNOR
Jessica Viste, BSN, CNOR



Pediatrics/Children's Hospital

Neonatal Pediatric Transport Team

Ryan Gagnon, BSN, RN, CPEN

4 Hope

Stacey Purpura, BSN, CPN
Kathleen Wilk, BSN, CPN

NICU

Jacqueline Booth, BSN, NIC-BC
Amy Daly, BSN, NIC-BC
Jaclyn Groom, BSN, NIC-BC
Jennifer Fortson, ADN, NPT-BC
Dawn Patrizi, ADN, NIC-BC
Katie Sullivan, BSN, NIC-BC
Valen Vega, BSN, NIC-BC



PICU

Eleni Arestis, BSN, CCRN, NCI
Jennifer Bolz, BSN, CCRN, Registry
Jennifer Brault, ADN, CCRN, NCII
Kristin Coleman, BSN, CCRN, NCII
Michelle Galbreath, ADN, RN, CCRN, NCII
Marcy Pluchar, BSN, CCRN, NCII

PSHU

Diane Clifton, MSN, RN, CCRN
Jean DiVovella, BSN, RN, CCRN
Nicole Fletcher, BSN, RN, CCRN
Kristine Friend, BSN, RN, CCRN
Lindsay Hederman, BSN, RN, CCRN
Kelly Ulrich, BSN, RN, CCRN



Cancer Institute

Marinella DiBenedetto, BSN, OCN
Joselyn Dolanas, BSN, OCN
Joselyn Mangila, BSN, OCN
Laura Mocha, BSN, OCN



Women & Infants Health Services

Family Centered Care

Marge Blough, ADN, RNC
Karen Brusich, BSN, RNC
Nancy Coorigan, RNC
Ramona Craig, BSN, RNC
Amanda Gaida, BSN, RNC
Nicole Huizinga, BSN, RNC
Lisa Kobel, ADN, RNC
Debbie Maher, BSN, RNC
Gloria Martinez, ADN, RNC
Elizabeth (Betty) Novak, BSN, RNC
Deb O'Connell, RNC
Elizabeth (Liz) Roberson, BSN, RNC
Sydney Elizabeth Roche, ADN, RNC



Labor & Delivery

Briana Bloembergen, BSN, RNC-OB
Barb Boerema, BSN, RNC-OB
Cathy Carbrey, BSN, RNC-OB
Lori Carroll, ADN, RNC-OB
Angela Dryier, BSN, RNC-OB
Kim Ryan, BSN, RNC-OB
Stephanie Rzepka, BSN, RNC-OB
Debbie Yankovich, BSN, RNC-OB



Surgical OB

Biji Abraham, RN-BC
Deb Kwaak, RN-BC
Leslie Moss, RN-BC
Vaiva Rasytinis, RN-BC
Marcy Weigel, RN-BC
Tamecia Wilson, BSN, RN-BC



Care Management

Gina Maughan, BSN, RN-BC
Kimisha Neely, BSN, RN-BC
Cindy Shaffer, BSN, RN-BC
Jane Venus-Nocentelli, MA, BSN, RN-BC



Clinical Education

Loretta Benton, MS, RN-BC
Elizabeth Kupczyk, MSN, RN-BC
Debbie O'Connell, MSN, RN-BC, NEA-BC



Epidemiology

Joanne Patton

Radiology - Imaging

Tammy O'Connor, BSN, CRN
Cristina Sokarda, MSN, CRN



Nursing Recognition *continued*

Degree Completion

Critical Care

MICCU

Marie Anderson, BSN, RN, CCRN
Jennifer Cavett, BSN, RN
Debra Simon, BSN, RN

SINI

Christina Jackson, BSN
Erin Hartman, MSN, BSN, ACNP

Heart & Vascular Institute

Laura Dudek, BSN

ASHU

Yvette Rideaux, MSN, CRRN



Medical Surgical/PSAS/Procedure Center

7 East

Diana Wittle, BSN

7 West

Nicole Dobrovolny, BSN, RN-BC

Procedure Recovery Center

Linda Seguin, BSN



Neurosciences Institute/Bone & Joint Institute

6 East/West

Michelle Bassett, MSN, RN



Degree Completion

Surgical Services

Maggie Colabuono, BSN, RN, CAPA, CPAN

Pediatrics/Children's Hospital NICU

Michelle Lambright, ADN, PCA

Cancer Institute

Renee Katz, BSN, RN
Juliana Coco, BSN, RN

Care Management

Mary Dwyer, MSN
Shaunette Pitts, MSN, RN-BC



Nursing Research – IRB Submission

Project Title: Diabetes Education and Self-Management Knowledge

Principal Investigator:

Eliva Ortiz, RN, CDE

Sub-Investigator:

Donna Ellis, MS, ACNS-BC



Educational Events Information — July through September 2013

ACLS

Gerry Brown Cc: Carol Piergies 41-3778
EMS Academy 5220 W. 105th St. Oak Lawn, IL
9/13/13 8 am to 5 pm EMS Academy

ACLS Renewal Course

Karen Bogdan 41-5883
Must show current ACLS Card
8/9/13 7:30 to 11:30 am 0614
8/9/13 12 pm to 4 pm 0614
9/13/13 7:30 to 11:30 am 0614
9/13/12 12 pm to 4 pm 0614

ACMC Nursing Research Council Meeting

Cheryl Lefaiver 41-4210
7/23/13 11 am to noon 0629AB
8/27/13 11 am to noon 0629AB
9/24/13 11 am to noon 0629AB

APN/CPP Council Meeting

Wendy Micek, Chairperson Joanne Brown, Co-Chair
Cc: Pat Morgan
7/17/13 1 pm to 2:30 pm 0636 A&B
8/21/13 1 pm to 2:30 pm 06236A&B
SEPTEMBER-NO MTG-LDI

BLS Courses – Healthcare Provider New

Annie Juett 41-5990
7/22/13 8am to 12pm Clinical Education
8/5/13 7am to 11am Clinical Education
8/26/13 8am to 12pm Clinical Education
9/16/13 8am to 12pm Clinical Education
9/30/13 9am to 1pm Clinical Education

BLS Courses – Healthcare Provider Renewal

Annie Juett 41-5990
7/15/13 8 to 11am
11:30am to 2:30pm Clinical Education
2:30 to 5:30pm
7/29/13 9am to 12pm
12:30 to 3:30pm
4 to 7pm Clinical Education
8/5/13 11:30am to 2:30pm
3 to 6pm Clinical Education
8/19/13 9am to 12pm
12:30 to 3:30pm
4 to 7pm Clinical Education
8/26/13 12:30 to 3:30pm
4 to 7pm Clinical Education
9/16/13 12:30 to 3:30pm
4 to 7pm Clinical Education

9/23/13 12:00 to 3:00pm
3:30 to 6:30pm
7 to 10pm Clinical Education
9/30/13 1:30 to 4:30pm
5 to 8pm Clinical Education

BLS Courses Heartsaver

Annie Juett 41-5990
10/7/13 8 to 11am
11:30am to 2:30pm Clinical Education
10/28/13 12:30 to 3:30pm
4 to 7pm Clinical Education
11/4/13 12:30 to 3:30pm
4 to 7pm Clinical Education
11/18/13 12:30 to 3:30pm
4 to 7pm Clinical Education
12/2/13 9am to 12pm
12:30 to 3:30pm
4 to 7pm Clinical Education
12/30/13 12:30 to 3:30pm
4 to 7pm Clinical Education

LEAN Fundamentals

Rebecca Hattle-Lechowicz 630-990-8118
8/29/13 8:30AM-4:30 PM Good Sam
Wellness Center

Continued on next page

Educational Events Information — July through September 2013

Care Management Education

Mary Jo Cronin

7/18/13	1:30 pm to 2:30 pm	0629A&B
8/15/13	1:30 pm to 2:30 pm	0636 A&B
9/19/13	1:30 pm to 2:30 pm	0629A&B

Clinical Coach Course

Liz Kupczyk 41-4050

TBD

Ethics for Lunch

Karen Darr 41-4189

8/23/13	12 to 1 pm	0629 AB
9/20/13	12 to 1 pm	0629 AB

Magnet Advisory Council

7/23/13	9:00 am to 10:00 am	0614
8/27/13	9:00 am to 10:00 am	0614
9/24/13	9:00 am to 10:00 am	0614

Neurovascular Conference

Lorri McCourt-O'Donnell 41-4472

7/18/13	1 to 2 pm	Auditorium
8/15/13	1 to 2 pm	Auditorium
9/12/13	1 to 2 pm	0629

Nursing Grand Rounds – Adult

Patti Mullenhoff 41-3798

7/30/13	12 to 1 pm	0629
9/10/13	12 to 1 pm	0629

Nursing Grand Rounds – Pediatrics

Laura Burokas 41-1012

8/13/13	11am to 12pm	0629 AB
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Nursing Residency

Kristin Brown 41-5995

September 2012 Cohort

7/15/13	7am to 3:30pm	0636
8/15/13	7am to 3:30pm	0629

January 2013 Cohort

8/1/13	7am to 11:30am	0629
9/5/13	7am to 11:30am	0613

March 2013 Cohort

7/16/13	7am to 11:30am	CE
8/20/13	7am to 11:30am	CE
9/19/13	7am to 11:30am	CE

May 2013 Cohort

8/6/13	8am-12:30pm	CE
9/4/13	8am-12:30pm	CE

NxStage CRRT Training

Karen Bogdan 41-5883

7/12/13	8am to 4:30pm	0614
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Peritoneal Dialysis Training

Karen Bogdan 41-5883

No Meeting

Pediatric Advanced Life Support (PALS)

Casey Gralewski 41-1308 Cc: Carol Piergies

EMS Academy, 5220 W. 105th St., Oak Lawn, IL		
8/23/13	8:00 am to 5 pm	EMS Academy
9/27/13	8:00 am to 5pm	EMS Academy
10/11/13	8:00 am to 5 pm	EMS Academy
10/25/13	8:00 am to 5 pm	EMS Academy

Psychiatric Grand Rounds

Mary Antos Cc: Kathy Marshall 41-5844

August No Mtg

Professional Clinical Practice Council

Elizabeth Scanlon, Chair

9/5/13	7:30 am to 4:00 pm	0629
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Julie Schaffner Research Fellowship- RNs

4 day research fellowship More info to follow 2013

Save the Date !!!

9/20/13	In the Midst of Chaos	
	All day	Tinley Pk Conv Ctr
9/TBA/13	International Event at the Congress Hotel Downtown.	
	Go to: www.inawebsite.org	

Steps Application Deadlines

Janet Finlon

9/1/13

Steps Pinning Ceremony

8/19/13	1 to 3pm	Auditorium/ Ann Skerrett Dining Rm
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System Courses

For questions about specific courses please contact:

Pat Juarez 54-3262; Joanne LaMantia Watts 52-5432;

Josie Howard-Ruben 53-3568; Pat Bielecki 53-3578

Intro to Critical Care 7 day course

contact: Pat Juarez 54-3262

Intro to Emergency Nursing Course 7 day course

contact: Pat Juarez 54-3262

CCRN Preparation Course 2 day course

contact: Pat Juarez 54-3262

PCCN Preparation Course 2 day course

contact: Pat Juarez 54-3262

12-Lead ECG 1 day course

contact: Pat Juarez 54-3262

Advanced Arrhythmia Interpretation 1 day course

contact: Pat Juarez 54-3262

Critical Care Preceptor Workshop 1 day course

contact: Pat Juarez 54-3262

Basic Chest X-ray Interpretation 1 day course

call: Joanne LaMantia Watts 52-5432

ECG Class for 2013 3 day course

call: Joanne LaMantia Watts 52-5432

Intro to Progressive Care Nursing 4 day course

call: Joanne LaMantia Watts 52-5432

Ortho Certification Review Course 1 day course

call: Joanne LaMantia Watts 52-5432

Physical Assessment for Med/Surg & Tele Nurses 2 day course

call: Joanne LaMantia Watts 52-5432

Stroke Phase 1 1 day course

call: Joanne LaMantia Watts 52-5432

Stroke Phase 2 1 day course

call: Joanne LaMantia Watts 52-5432

Stroke Phase 3 1 day course

call: Joanne LaMantia Watts 52-5432

Med/Surg Certification Review Course 3 day course

call: Joanne LaMantia Watts 52-5432

Nursing Research Fellowship Workshop 4 day course

call: Josie Howard-Ruben 53-3568

Smoking Cessation Counseling for Nurses 1 day course

call: Josie Howard-Ruben 53-3568

OCN Review 2 day course

call: Josie Howard-Ruben 53-3568

Planning Nursing Continuing Education 1 day course

call: Josie Howard-Ruben 53-3568

ONS Radiation 1 day course

call: Josie Howard-Ruben 53-3568

ONS Treatment Basics: Antineoplastic Therapy in the Non-Oncology Setting 1 day course

call: Josie Howard-Ruben 53-3568

Basics of Perinatal & Neonatal Nursing 1 day course

Contact: Pat Bielecki 53-3578

Basic Electronic Fetal Monitoring 1 day course

Contact: Pat Bielecki 53-3578

Basic Intrapartum & Postpartum Nursing 1 day course

Contact: Pat Bielecki 53-3578

High-Risk Perinatal Nursing 1 day course

Contact: Pat Bielecki 53-3578

STABLE 1 day course

Contact: Pat Bielecki 53-3578

Hi-Risk Neonatal Nursing – Part 1 1 of 2 day course

Call: Pat Bielecki 53-3578

Hi-Risk Neonatal Nursing – Part 2 2 of 2 day course

Call: Pat Bielecki 53-3578

AWHONN Intermediate EFM 2 day course

Contact: Pat Bielecki 53-3578

AWHONN Advanced EFM 1 day course

Contact: Pat Bielecki 53-3578

Perinatal RNC Cert Review 2 day course

Contact: Pat Bielecki 53-3578

In the News continued

MVP Nominations:

- Amy Podobnik, BSN, RN, CPN, nurse clinician II, 4th floor, ACH-OL for Partnership
- Peg Jagielski, RN, nurse clinician II, 4th floor, ACH-OL for Compassion
- Ginny Fowler, MS, APN, CPNP, CPN, CPON, advanced practice nurse, 4th floor, ACH-OL for Partnership
- Karla Thornton, BSN, RN, nurse clinician II, hemodialysis for Partnership

- Lisa Cozzi, BSN, RN, CPN, nurse clinician II and Meggan Mikal, APN, MS, PCNS-BC, CPNP, CHPPN of 2nd floor, ACH-OL are the recipients of the 2012 annual MVP for Excellence
- Eleni Arestis, BSN, RN, CCRN, nurse clinician I, pediatric intensive care unit for Partnership
- Flor Carranza, Patient Care Technician, pediatric intensive care unit for Compassion
- Jennifer Hein, ADN, RN, CCRN, nurse clinician III, pediatric intensive care unit for Partnership

Nurse's Notes Contact Hour

Depression: A Pharmacological Approach to the Silent Epidemic

Maureen Craigmile, MSN, RN-BC, nurse clinician III, 5 east

HOW TO EARN CONTACT HOURS

1. Read the Contact Hour article and take the test at the end of the article.
2. Complete the entire answer form. (Answer forms may be photocopied.) **DEADLINE:** Answer forms must be received in the Clinical Education Department no later than, October 1, 2013.
3. Return the answer forms through in-house mail or fax to:
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: Advocate Health Care (OH-368, 10/1/2014) is an approved provider of continuing nursing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

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 2013 Volume 13, Issue 1 Contact Hour Quiz: "Think Delirium"

1. The incidence of delirium in hospitalized older patients with hip fracture is approximately 50 percent.
a. True
b. False
2. Delirium is characterized by:
a. Hopelessness, somatic complaints, delusions noticed by family
b. Impaired judgment, depression, conceal deficits noticed by family
c. Altered consciousness, inattention with acute onset and fluctuating course
d. Self deprecation, perceptual disturbances, self-neglect
3. Predisposing factors for delirium include:
a. Advanced age, history of dementia, severe illness
b. Young adults, history of hypertension, obesity
c. Advanced age, history of diabetes, obesity
d. Young adults, severe illness and well-nourished.
4. Precipitating factors for delirium include:
a. Quiet environment, gentle lighting, supportive family
b. Structured environment, bed alarm, proper lighting
c. Consistent caregiver, structured activities, quiet environment
d. Use of indwelling bladder catheter, physical restraints, polypharmacy
5. The Confusion Assessment Method (CAM) is a standardized screening tool for delirium that addresses:
a. Predisposing factors, polypharmacy and nutritional habits
b. Functional ability, inattention and social support
c. Nutritional status, polypharmacy and functional ability
d. Altered level of consciousness, inattention and psychomotor agitation
6. A class of medications known to precipitate delirium include:
a. Antibiotics
b. Anticoagulants
c. Chemotherapeutic agents
d. Narcotics
7. An environmental intervention that may prevent delirium include:
a. Use of chair or bed alarm
b. Discourage family visits
c. Promote sleeping during daytime hours
d. Reorient patient frequently
8. The hallmark of delirium is an abnormal mental status examination.
a. True
b. False
9. A multicomponent approach that addresses identified risk factors is an effective method for the prevention and management of delirium.
a. True
b. False
10. There are two important aspects in the management of delirium: the recognition of delirium and the treatment of underlying cause.
a. True
b. False

Depression: A Pharmacological Approach to a Silent Epidemic Quiz

Volume 13, Issue 2 Contact Hour Quiz

- The nurse caring for Mr. Frank age 89, is reviewing his medication. The nurse would be most concerned about Mr. Frank taking which of the following drugs?
 - Escitalopram (Lexapro)
 - Paroxetine (Paxil)
 - Duloxetine (Cymbalta)
 - Amitriptyline (Elavil)
- A patient complains to the nurse that he has been experiencing erectile dysfunction since he was prescribed paroxetine (Paxil). The best response by the nurse would be to:
 - Encourage the patient to share this concern with the prescriber.
 - Instruct the patient not to take the antidepressant on weekends.
 - Suggest the patient ask the prescriber to change his prescription to bupropion.
 - Withhold the drug until the issue is resolved.
- Which patient statement would require the nurse to provide further teaching:
 - "I should report any unusual bleeding when I take Ginkgo biloba"
 - "I should not take St. Johns Worth with Zoloft."
 - "Herbal treatments are safe because they are made with all – natural ingredients."
 - "I will tell my doctor that I am taking an herbal supplement."
- The physician has written orders for your patient. Which medication order would the nurse question?
 - Buspar 10 mg po q am
 - Restoril 15mg po q hs
 - Ambien 5 mg po q am
 - Seroquel 25 mg po q hs
- The nurse understands that norepinephrine is involved with the stimulation of which bodily process?
 - The "fight –or–flight" response to stress.
 - The hypothalamus to release hormones.
 - Involvement in the inflammatory response.
 - The parasympathetic nervous system.
- The first-line treatment for depression are:
 - Selective serotonin reuptake inhibitors
 - Tricyclic antidepressants
 - Monoamine oxidase inhibitors (MAOI)
 - Mood stabilizers
- The FDA's black-box warning issued for all antidepressants, alerts the public to what risk?
 - Increased risk for suicidal thinking or attempts in children or adolescents.
 - Increased risk of arrhythmias.
 - Increased risk of agranulocytosis.
 - Increased risk of development of Tardive dyskinesia.
- Tricyclic antidepressants (TCAs) are effective in the treatment of depression. All of the following are side-effects of TCAs, except:
 - Orthostatic hypotension
 - Sedation
 - Dry mouth
 - Agranulocytosis
- The physician orders sertraline (Zoloft) 50 mg po bid for Mrs. Jones, a 68-year-old woman with major depression. After 3 days of taking the medications, Mrs. Jones states, "I don't think this medicine is doing any good. I don't feel a bit better." What is the most appropriate response by the nurse?
 - "Cheer up Mrs. Jones, you have so much to be happy about."
 - "Sometimes it takes a few weeks for the medicine to bring about an improvement in your symptoms."
 - "I will call your physician, maybe he will order something different."
 - "Try not to dwell on your symptoms, Mrs. Jones. Why don't you join us in the day room?"
- Serotonin syndrome is a rare but potentially life threatening condition. The risk is greatest:
 - In combination with a second serotonergic agent like an MAOI.
 - In combination with a lipid lowering agents.
 - In combination with tyramine rich food.
 - In combination with atypical antipsychotics.

Your Answers: Please submit to Clinical Education

INA CE # _____
Depression: Pharmacological Approach to a Silent Epidemic

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Minutes to read & answer quiz _____

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Evaluation

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| 1. Describe the key to effective treatment of depression | yes <input type="radio"/> | no <input type="radio"/> |
| 2. Define the purpose of a black box warning | yes <input type="radio"/> | no <input type="radio"/> |
| 3. List the first line of treatment in physician-diagnosed depression | yes <input type="radio"/> | no <input type="radio"/> |
| 4. Were the objectives relevant to the goal of this program? | yes <input type="radio"/> | no <input type="radio"/> |
| 5. Was the teaching method effective? | yes <input type="radio"/> | no <input type="radio"/> |
| 6. Did this offering meet your objectives? | yes <input type="radio"/> | no <input type="radio"/> |
| 7. Content was presented without bias of any commercial product or drug. | yes <input type="radio"/> | no <input type="radio"/> |

Additional comments/suggested future topics: _____

Depression: A Pharmacological Approach to the Silent Epidemic

Maureen Craigmile, MSN, RN-BC, nurse clinician III, 5 east

The last half a century saw remarkable progress in the treatment of mental illness. The extraordinary pace and productivity of scientific research produced a range of effective treatments for many mental disorders. However, mental health and mental illness continue to be shrouded in misunderstanding and stigma.

The stigma surrounding mental illness takes many forms, both subtle and overt. It appears as:

- Prejudice
- Misunderstanding
- Fear
- Distrust
- Stereotyping

People avoid treatment for fear that their diagnosis or illness will be revealed. According to the National Alliance on Mental Illness (NAMI), mental illness will affect 1 in 4 persons in their lifetime (NAMI, 2012). People have often made a distinction between mental illness and physical illnesses; however, they are two sides of the same coin. In the first ever report on mental health, the Surgeon General identified that "there is no health without mental health" (Department of Health and Human Services, 1999).

Depression is the leading cause of medical disability in the United States and Canada, accounting for nearly 10 percent of all medical disability (WHO, 2004). Although about 70 percent of individuals with depression have a full remission of the disorder with effective treatment, fewer than half of those suffering from this illness seek treatment (MHA, 2013). Too many people resist treatment because they believe depression is not serious, that they can treat it themselves or that it is a personal weakness rather than a serious medical illness (MHA, 2013). We fear that which we do not understand.

This article seeks to convey the notion that depression is in fact an illness with a biological basis both in the brain as well as the body, and that treatment is effective. It is important that we remember the foundation of all health is in the mind, the body and the spirit. Depression affects all three.

The origin of psychiatric illnesses lies in a number of factors including:

- Genetics
- Neurodevelopmental factors
- Drugs
- Infections
- Psychosocial factors.

Whatever the primary causes, there will eventually be an impact on brain function, with results in the person's behavior and / or mental experiences (Varcrolis & Halter, 2010). At this time, there is no single scientific theory to explain the causes of these disorders. In fact, rather than one specific cause, it is much more likely to be a combination of genetic, environmental, psychological, and biochemical factors. This is why no single factor is effective in the treatment of depression. Today, modern scientists

are working at an exciting pace in terms of the development of new ways of understanding complex brain function and the role of neurotransmitters.

Depression

Major depression is a complex, devastating and often misunderstood illness that affects more than 350 million people worldwide (World Health Organization, 2012). Clinical depression is one of the most common of all mental illnesses, affecting more than 19 million Americans each year (National Institute of Mental Health, 2008). The median age of onset is 32 and it is twice as prevalent in women as in men (Townsend, 2012). It is a relapsing and remitting disease in most patients. Following the first episode, there is a greater than 40 percent rate of recurrence (Katon, & Ciechanowski, 2012).

It is often misunderstood and very often misdiagnosed. Usually it is diagnosed as bipolar disorder, as they have similar presenting symptoms, but the treatment is very different. Complicating this fact, the prevalence of the word "depression" used to describe periodic states of sadness has added to society's misconception of the basis of depression. Feeling sad is a common human response to external events like stress, loss of a loved one, disappointment or frustration. However, depression and all of the mood disorders are neurobiological brain disorders that affect patterns of thinking, memory, energy, impulse control, sleep and appetite among other physiological processes and can be effectively treated (Aschenbrenner & Venable, 2012). Risk factors that make a person more vulnerable to depression include:

- Having previously been depressed
- Having a first degree relative diagnosed with depression
- Being a woman, an adolescent or young adult
- Coexisting medical disorder
- Substance use and/or abuse (Aschenbrenner & Venable, 2012) (Varcrolis & Halter, 2010)

Symptoms of clinical depression include:

- Persistent sad, anxious or "empty" mood
- Sleeping too much or too little, middle of the night or early morning waking
- Reduced appetite and weight loss, or increased appetite and weight gain
- Loss of pleasure and interest in activities once enjoyed, including sex
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment (such as chronic pain or digestive disorders)
- Difficulty concentrating, remembering or making decisions
- Fatigue or loss of energy
- Feeling guilty, hopeless or worthless
- Thoughts of suicide or death (MHA, 2013).

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Depression can affect anyone at any time in their life including children. It is important for nurses to assess all patients for depressive symptoms if it is suspected. This includes assessing patients who are taking antidepressant medications regardless if these drugs are treating their presenting symptoms or not. Depression occurs frequently in older adults and should not be considered a normal part of aging. It is often a comorbidity with stroke, diabetes, cancer, and Parkinson's disease.

Nurses who avoid assessing these symptoms can cause the patient to continue to suffer at best, and can have tragic consequences at worst. Suicide is the worst possible outcome, although, traditionally suicide rates have been highest among the male elderly. Rates among young people have been increasing to such an extent that young people are now the group at highest risk in a third of both developed and developing countries (CDC, 2012).

It is believed that mood disorders are caused in part by problems with neurotransmitters; it makes sense that medications

that alter brain chemistry are an important part of treatment. Medications are effective and are usually well tolerated. In fact, it has been shown that medications can be effective in up to 80 percent of people with depression (Mental Health America, 2008). Antidepressants are the first choice in the treatment of depression. There are three main classes of antidepressants:

- Selective serotonin reuptake inhibitors (SSRIs) & Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Tricyclic antidepressants (TCAs)
- Monoamine oxidase inhibitors (MAOIs).

As a result of this research, medications have been discovered that specifically target neurotransmitters that affect mood. In order to understand pathology, it is important to understand the neurotransmitter's known function and their association with mental health. This is an overview and is not meant to be comprehensive:

Neurotransmitter	Effects / Comments	Association with Mental Health
Dopamine	Involved in integration of emotion and thought, decision making, motivating behaviors, psychosis and mood.	<i>Decrease:</i> Parkinson's disease and depression <i>Increase:</i> Schizophrenia and mania
Norepinephrine	Levels in brain affects mood, attention and arousal Stimulates "fight or flight" in stress response Affects mood and memory and learning	<i>Decrease:</i> Depression <i>Increase:</i> Mania, anxiety states and schizophrenia
Serotonin	Sleep, hunger, mood regulation Pain perception Aggression Sexual behavior Anxiety	<i>Decrease:</i> Depression <i>Increase:</i> Anxiety states
Histamine	Alertness Inflammatory response Stimulates gastric secretions	<i>Decrease:</i> Sedation <i>Increase:</i> Weight gain
Gamma-aminobutyric acid (GABA)	Role in inhibition Reduces anxiety, excitation Plays a role in pain perception May impair cognition and psychomotor functioning	<i>Decrease:</i> Anxiety disorders, Schizophrenia, mania, Huntington's disease <i>Increase:</i> Reduction of anxiety
Glutamate	Learning and memory	<i>Decrease:</i> Psychosis <i>Increase:</i> Neurotoxic and neurodegeneration in Alzheimer's disease; can also play a role in cognitive performance and cognitive task
Acetylcholine (ACh)	Plays a role in learning Memory Mood Mania Sexual aggression	<i>Decrease:</i> Alzheimer's disease, Huntington's disease, and Parkinson's disease <i>Increase:</i> Depression

(Varcarolis and Hunter, 2012) (Hutchinson, K., 2012)

Blocking various neurotransmitters in the brain has other effects on the body.

- Blocking the reuptake of norepinephrine, may cause side effects of tremors, cardiac arrhythmias, sexual dysfunction and hypertension.
- Blocking serotonin reuptake can result in side effects that include GI disturbances, increased agitation, and sexual dysfunction.
- Blockage of dopamine reuptake may result in psychomotor activation.
- Blocking the reuptake of acetylcholine can result in dry mouth, blurred vision, constipation and urinary retention.
- Blocking histamine reuptake may result in weight gain, sedation and hypotension (Townsend, 2012).

The key to effective treatment is to maximize the benefits of the medication while minimizing the side effects.

Selective Serotonin Reuptake Inhibitors (SSRI) and Serotonin Norepinephrine Reuptake Inhibitors (SNRI)

The first choice in the treatment of depression is the SSRI's and the SNRI's. They are preferred because they have less cardiac side effects, have minimum anticholinergic side effects, and are less dangerous in an overdose (Aschenbrenner & Venable, 2012). SSRIs which include fluvoxamine (Luvox), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), and escitalopram (Lexapro), have a proven history of efficacy in the treatment of patients with depressive and anxiety disorders. Essentially, SSRIs selectively block the neuronal uptake of serotonin which increases the availability of serotonin at the synaptic cleft (Varcarolis & Halter, 2010). This leaves more of the neurotransmitter available in the synaptic cleft (Varcarolis & Halter, 2010). Fluoxetine (Prozac) was the first SSRI approved for use as an antidepressant in 1987. It became immediately popular because of its ease in dosing and relatively few side-effects. Currently, sertraline (Zoloft) is one of the most widely prescribed antidepressants in the United States (Aschenbrenner & Venable, 2012).

SNRI's block the reuptake of both serotonin and norepinephrine, however, with differing selectivity. These drugs include Venlafaxine (Effexor), Desvenlafaxine (Pristiq) and Duloxetine (Cymbalta). They are similar to the SSRIs and carry the same risk. In general, all of these agents appear to be effective in treating depression and they are chosen often based on the specific patient symptoms and the side effect profile (Hutchinson, 2012).

Indications: They have broad base for clinical use. In addition to depression, they are effective in the treatment of generalized anxiety disorders (GAD), obsessive-compulsive disorder (OCD), panic disorder, social anxiety disorder, posttraumatic stress disorder (PTSD), eating disorders and post-partum depression (Varcarolis & Halter, 2010).

Nursing considerations: These medications are not "happy pills" and do not work immediately. Nurses play a vital role in educating patients. Consistency and compliance is a key component to recovery. Just as the descent into depression is a process, recovery is as well. Teach the patient that it can be four to six weeks before the depressive symptoms ease.

Teach the patient that early side effects such as nervousness, headache and stomach upset occur frequently in the first few days but are often gone within a week (Katon & Ciechanowski,

2012). These medications must be used with caution in patients with liver disorders and they should avoid alcohol.

Side effects include: agitation, anxiety, sleep disturbance, and autonomic disturbances including, dry mouth, weight changes, mild nausea. One of the most undesirable outcomes reported by patients is its effect on sexual performance. These adverse effects include delayed ejaculation and inability to achieve orgasm.

Instruct the patient to be honest with the physician and to report all side effects, including sexual side effects. In addition, it is very important to instruct patients not to abruptly stop taking these medications as symptoms such as dizziness, insomnia, nervousness, irritability and nausea can occur following abrupt withdrawal. Some concern exists that these classes of medications can increase the risk of suicidal thinking or suicide attempts in both children and adults. It is important to continue to assess the patient for evidence of suicidal thoughts, especially as the depression lessens (Aschenbrenner & Venable, 2012).

Contrary to what you might think, as energy levels return with treatment, the suicidal patient is at a greater risk for completion. It is theorized that the medications give the patients the energy they need to complete the act. Therefore, it is extremely important for the nurse to assess every patient every shift for the presence of suicidal thoughts if there is an indication, especially patients who are taking these medications. The nurse must assess for intent, plan, and method especially in the early stages of treatment (Crumpacker, 2008).

Black Box Warning

A black box is a method of flagging a serious warning so the prescribers and the consumer do not miss seeing it. The warning has a black border printed around it. The warning emphasizes how the drug should be used only in patients with certain conditions, or who meet certain guidelines. Some of the antidepressants have black box warnings including most of the SSRIs. The warning for SSRI's is that there may be an increased risk of suicidality in children and adolescents. The issue of whether SSRIs increase the risk of suicidality is still hotly debated as some studies have shown that antidepressant medications may have a protective factor, including adults aged 18-25 (Varcarolis & Halter, 2010). Studies in children are more limited.

Tricyclic Antidepressants (TCA)

This category of antidepressants is known as the tricyclic antidepressants, named for their three ringed molecular structure. They also block the reuptake of serotonin, norepinephrine as other neurotransmitters including acetylcholine, histamine, and alpha adrenergic and sodium channels thus causing multiple side-effects. They have a strong history of efficacy; however, it is their unfavorable side effect profile and their lethality in an overdose that makes these drugs a second line of defense in the treatment of depression. Some of the tricyclic antidepressants include: Imipramine (Tofranil), Desipramine (Norpramine), Amitriptyline (Elavil), and Clomipramine (Anafranil). There are also other indications for the use of TCAs.

Indications: These drugs are effective in the treatment for both depression and panic disorders. In addition these drugs are used with caution in children with attention deficit/hyperactivity disorder (ADHD) and enuresis. Some of the drugs have shown strong efficacy in the management of pain and migraine headaches. Clomipramine has been effective in OCD in children and adults.

Nursing Considerations: TCAs are contraindicated in the elderly. Due to cardiac side effects, extreme caution should be used in all patients. It is important to watch for orthostatic hypotension, as well conduction defects, arrhythmias, and tachycardia. These drugs should be prescribed at night time due to the side effect of sedation. The nurse should provide suggestions to combat the anticholinergic side-effects including dry mouth, constipation, and urinary retention. Some tips include eating hard candy and increasing water consumption.

Monoamine Oxidase Inhibitors (MAOI)

This class of medications has also been shown to be effective in the treatment of depression. The monoamine oxidase system is widely distributed throughout the body. This system is responsible for metabolizing amines such as dopamine, epinephrine, norepinephrine, and serotonin. Drugs that inhibit the MAO enzymes increase the concentration of those amines and thus their benefits (Aschenbrenner & Venable, 2012). These medications work by inhibiting the MAO enzyme from metabolizing the monoamines (serotonin, norepinephrine, and dopamine) thereby allowing more of these monoamines in the synaptic cleft (Hutchinson, 2012). The other side of the coin is the high potential for drug-drug interactions and especially interactions with foods high in tyramine and that makes this drug a last resort.

Nursing considerations: The most frequent side effects include orthostatic hypotension, insomnia, weight gain, edema, sexual dysfunction, and the potential for drug to drug interactions. There is a risk for tyramine-induced hypertensive crisis and the potential for a cerebrovascular accident is high. However, these drugs are particularly effective for people with atypical depression. This type of depression is characterized by mood reactivity, oversleeping, and overeating, as well as panic disorder, OCD and bulimia. Drugs that can interact with MAOIs include over-the-counter cold medicine, TCAs, narcotics, antihypertensives, sedatives and stimulants. They are contraindicated in patients taking any other antidepressants. It is important to avoid tyramine rich foods and provide a list of tyramine rich foods to avoid an interaction. These drugs have many potential interactions as well as side effects making them a last resort in the treatment of depression.

Other Antidepressants

Bupropion (Wellbutrin) has significantly fewer side effects related to sexual dysfunction than SSRIs and may be especially effective for patients who are lethargic. In addition, it does not cause weight gain. However, it must be used with caution with any patients who have an increased seizure risk, and missed doses should never be doubled or a seizure could result (Katon & Ciechanowski, 2012). A form of bupropion known as Zyban is widely used for smoking cessation. Taking Zyban with other forms of bupropion is contraindicated and can be dangerous (Aschenbrenner & Venable, 2012).

Trazodone (Desyrel) is a weak serotonin inhibitor and has been known to cause sedation. For this reason, it is often used as a sleep aid, and is not usually prescribed as an antidepressant. Trazodone has been known to cause priapism, a prolonged and painful penile erection rarely associated with sexual arousal. Encourage the patient to notify their physician if they experience any untoward side-effects.

Herbal Treatments

Many people believe that herbal treatments are safer because they are "natural" and have fewer side-effects than traditional and more expensive medications (Varcariolis & Halter, 2010). There has been a growing concern among health care professionals about the potential long term effects of herbal agents especially involving nerve, kidney and liver damage. The nurse must be aware of the increased risk of adverse chemical reactions when taking herbal remedies with conventional medications (Varcariolis & Halter, 2010). Kava kava and St. Johns Wort has been studied extensively to determine their safety and efficacy in the treatment of mild depression (Sarris, 2007).

If St. Johns Wort is taken with other serotonergic agents (e.g., SSRIs, triptans) serotonin syndrome may occur. Serotonin syndrome is a relatively rare and potentially life threatening condition believed to be related to an overreaction to the central serotonin receptors caused by either too high a dose, or an interaction with other drugs. Symptoms include: abdominal pain, diarrhea, sweating, fever, tachycardia, elevated blood pressure, muscle spasms and delirium. The greatest risk occurs when an SSRI is administered in combination with a second serotonergic agent like an MAOI. It is important for the nurse to advise the patient of the need to be off a SSRI for two to five weeks prior to starting an MAOI.

Medication compliance

Patients, who begin treatment with an antidepressant of any kind, must remember to continue taking their medication *even if their symptoms are relieved*. It is very important to convey the importance of medication compliance to prevent a relapse. It is also very important to discuss any side effects that may complicate their recovery. Evidence shows that as many as 42 percent of patients discontinue their medications without discussing it with their primary health care provider. Reasons for discontinuing their medications may include people report feeling better or they are experiencing side effects. Discontinuing medication without physician consultation greatly increases the risk of relapse. The following are important reminders:

- Do not stop taking medications without talking with your primary health care provider
- There may be a period of four to six weeks before you experience relief of symptoms
- It is important to continue the full course of treatment (6 to 12 months) even if symptoms have been relieved, to prevent a relapse.
- Discuss any side effects with your health care provider
- Inform your health care provider if you are pregnant or plan to become pregnant

Children and Adolescents

There are special circumstances that must be considered for children, older adults and pregnant women. Many children and adolescents become depressed. One in five teens has experienced depression at some point. In primary care settings the rates of depression are higher still—as many as 28 percent for adolescents. Preschool depression has begun to attract interest in the literature but much more needs to be learned about how mood disorders may affect this age group (NAMI, 2012).

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The decision to use medication is based on severity of symptoms, the presence of suicidality, coexisting disorders, and the lack of effectiveness of other treatment modalities like psychotherapy. Currently, Fluoxetine (Prozac) is the only SSRI approved by the FDA for the treatment of depression in children and adolescents ages 8 to 17 (Moreland & Bonin, 2013). Citalopram (Celexa) is approved by the FDA for treatment of depression in adolescents age 12 to 17.

Many psychotropic medications have not been studied or approved for use with children. Researchers are not sure how these medications affect a child's growing body. A physician may prescribe a child an FDA-approved medication on an "off-label" basis. The FDA regulates drug approval, not drug prescribing; off-label means that doctors are able to prescribe a drug for any reason they think is medically appropriate. For these reasons, it is important to monitor children taking these medications.

Children may have different reactions and side effects than adults. Some medications, including antidepressants, carry a Black Box warning about potentially dangerous side effects for children and adolescents. In addition, it is important for the nurse to be aware that SSRI's may inhibit the metabolism of several other medications that are metabolized by the P450 enzymes, including the TCAs, neuroleptics, benzodiazepines, amphetamines, warfarin, theophylline, and terfenadine (Moreland & Bonin, 2013).

It is important for the nurse to convey the idea that suicidal ideation of any sort is a medical emergency. The nurse must ask the question "Do you want to hurt yourself"? The emergent administration of medication has no effectiveness in the treatment of the suicidal child or adolescent. Finally, when it comes to children, it is important to remember that 30 to 40 percent of children and adolescents do not respond to initial antidepressant treatment. This supports the idea that other treatment modalities may be appropriate including cognitive behavioral therapy (Moreland & Bonin, 2013).

Older Adults

Depressive illnesses in the older adult pose serious health concerns that can lead to unnecessary suffering, impaired functioning, increased mortality, and excessive use of health care resources (Espinoza & Unutzer, 2013). Because older adults often have more medical issues, they tend to take more medications including prescribed, over-the-counter, and herbal medications. As a result, elderly people have a higher risk for experiencing drug interactions, missed doses, or overdosing. Older adults also tend to be more sensitive to medications. Even healthy older adults react to medications differently than younger people because they metabolize medications more slowly. Therefore, lower or less frequent doses may be needed. Sometimes memory problems affect older people who take medications for mental disorders. An older adult may forget his or her regular dose and take too much or not enough. The risk factors for late life depression are different than that of any other life stage. They include:

- Female sex
- Social isolation
- Widowed divorced or separated
- Lower socioeconomic status
- Comorbid medical conditions

- Uncontrolled pain
- Insomnia
- Cognitive or functional impairment

Research shows that as many as 50 percent of nursing home residents are depressed (Espinoza & Unutzer, 2013). Depression is a major risk factor in the elderly, accounting for 13 percent of the United States population, but for nearly 24 percent of all completed suicides (Hoyert, Kochanek & Murphy, 1999). Elderly men bear the closest watching with the highest suicide rate of 28 per 100,000 in 2004 (Centers for the Disease Control, 2004). Particular care should be given to the elderly patient that presents with hopelessness, insomnia, agitation, restlessness, impaired concentration, alcohol intoxication and unremitting pain (Espinoza, & Unutzer, 2013). The difference between adult onset depression and late life depression is that late life depression tends to be chronic and more transient and has frequent relapses (Espinoza & Unutzer, 2013).

Women who are pregnant or may become pregnant

Research on the use of psychiatric medications during pregnancy is more limited. The decision to use medication for the pregnant woman is based on the number and frequency of depressive episodes, the history of response to medications, and the risk/benefit ratio (Misri & Lusskin, 2013). Failing to adequately treat the depressed mother may lead to worsening of the depressive symptoms and compromising the maternal and/or fetal health.

Health risks are different depending on what medication is taken, and at what point during the pregnancy the medication is taken. Research has shown that antidepressants, especially SSRIs, in general, are safe during pregnancy. Fluoxetine (Prozac) is the best studied SSRI in terms of safety and efficacy in pregnancy and lactation. In all cases, patients and their physicians must discuss the potential risk of medication exposure. Birth defects or other problems are always a possibility, but they are very rare and a woman should consult her health care provider if she is planning to become pregnant or is pregnant. It is important to instruct the patient that antidepressant medications do cross the placental barrier and may reach the fetus.

Studies have also found that fetuses exposed to SSRIs during the third trimester may be born with "withdrawal" symptoms such as apnea, jitteriness, irritability, trouble feeding, or hypoglycemia (Austin, 2006). These symptoms in babies are generally mild and short-lived, and no deaths have been reported. On the other hand, women who stop taking their antidepressant medication during pregnancy may experience depression again and may put both themselves and their infant at risk (Austin, 2006). The nurse plays a valuable role in helping the pregnant woman make these decisions. After a woman delivers, she should consult with her doctor to decide whether to resume taking her medications as she is at a much higher risk for postpartum depression. As with all mental health treatment, it must be individualized.

Conclusion

All nurses, no matter what their area of practice, encounter patients that have a mental illness and who are taking psychotropic medications. No one can adequately convey the personal pain or suffering experienced by the person with depression *except them*. An ongoing assessment of the patient's mental status *must* be part of the normal nursing assessment and should be done at least once every shift. The ultimate goal in the treatment

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with antidepressant therapy is to bring about the greatest relief of symptoms in the shortest amount of time, while minimizing the side effects. At the same time it is important to remember that safe and successful treatment of the depressed patient depends on much more than just medication.

Recovery from this depression is based on the patient's unique strengths and resiliencies, as well as the patient's own will for self-care and recovery and motivation for staying well. This

means having support, taking medications, utilizing positive coping skills, living in a healthy environment, and using all other healing processes to enhance their own wellness. Depression is one of the most treatable of all mental illnesses. We have more knowledge, better treatments, medications and tools available. Treatment works, people get better. We must be the stewards of their hope until they do.

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